Table of Contents

Title 48
PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 1. General

Chapter 1. Equal Delivery of Services 1
§101. Policy Statement 1
§103. Applicability 1
§105. Complaints 1
Chapter 2. Louisiana Physician Order for Scope of Treatment 2
§201. Statement of Policy 2
§203. Definitions 2
§205. LaPOST Form 2
§207. Execution of the LaPOST Form 2
§209. Review of the LaPOST Form 3
§211. Revocation of the LaPOST Form 3
Chapter 3. Meetings of Self-Help Organizations Dedicated to Recovery and Abstinence from Alcohol and Drugs in DHHR Facilities 3
§301. Purpose, Scope and Applicability 3
Chapter 5. Disclosure of Confidential Information 3
§501. General Provisions 3
§503. Definitions 4
§505. Confidentiality and Disclosure 4
§507. Disclosures with the Patient's Consent 5
§509. Disclosures without the Patient's Consent 6
§511. Disclosures to Patients 7
§513. Disclosure Forms 8
Chapter 6. Uses and Disclosures of Information for Public Health Emergency Preparedness Activities 9
§601. Purpose and Scope 9
§603. Definitions 9
§605. Permitted Uses and Disclosures for Public Health Emergency Preparedness Activities 9
§607. Treatment of Protected Health Information 10
Chapter 7. Disposition of an Unclaimed Body Held by a DHHR Hospital or Residential Facility 10
§701. Facility Responsibility 10
§703. Bureau of Anatomical Services 11
§705. Stillbirths 11
Chapter 9. Notification of Next of Kin in Cases of Death in a DHHR Institution/Facility 11
§901. Purpose and Scope 11
§903. Applicability 11
Chapter 11. DHHR Policy on use of Restraints, Seclusions and Medications with Gary W. Classmembers 12
§1101. Introduction 12
§1103. Definitions 12
§1105. Medication and Chemical Restraint 12
§1107. Seclusion and Time Out 12
§1109. Physical/Mechanical Restraint 13
§1111. Instructions to Offices 13

Chapter 13. DHH Policy on Reporting Alleged Abuse, Neglect, Mistreatment and Deaths of Gary W. Class Members 14
§1301. Policy Statement 14
§1303. Definitions 14
§1305. Where to Report Incidents 15
§1307. Responsibility for Investigations at Facilities Other than Small Facilities and Other than for Community Class Members 16
§1309. Format for Investigation 17
§1311. Employee Discipline 17
§1313. Local Oversight Committee 18
§1315. Procedures Following Receipt of Investigation Report 18
§1317. Death 19
§1319. Responsibilities of State Program Offices 19
§1321. Responsibilities of Gary W. Project Office 20
§1323. External Oversight Committee 20
§1325. Sanctions 21
§1327. Confidentiality 21
§1329. Training 21
§1331. Provider Contracts/Agreements 21
§1333. General 21
§1399. Appendices 21
Chapter 15. DHHR Pre-Movement Staffing Policy and Procedures for Gary W. Classmembers 22
§1501. Policy Statement 22
§1503. Notice of Intent to Move Classmembers (under ordinary circumstances) 22
§1505. Pre-Movement Staffing 23
§1507. Documentation 24
§1509. Extraordinary Circumstances 24
§1511. Exception to Pre-Movement Staffing Policy 24
§1513. Complications to Process 24
Chapter 16. Admissions Criteria for Inpatient Facilities 25
§1601. Purpose and Scope 25
§1603. Definitions 25
§1605. Inpatient Facilities Operated by the Office of the Secretary 26
§1607. Inpatient Mental Health Facilities Operated by the Office of Mental Health 26
§1609. Intermediate Care Facilities/Mental Retardation (ICF/MR) Facilities Operated by the Office of Mental Health 28
§1611. The Office for Citizens with Developmental Disabilities (OCDD) 28
§1613. Inpatient Substance Abuse Treatment Programs Operated by the Office for Addictive Disorders 29
Chapter 17. Block Grants 31
§1701. Funding 31
§1703. Administration 31
Chapter 18. Homeless Trust Fund 31
§1801. Definitions 31
§1803. Application Requests 31
§1805. Application Requirements and Deadlines 31
§1807. Review of Applications 32
§1809. Notification and Appeals 32
§1811. Emergency Grants 32
Chapter 19. Traumatic Head and Spinal Cord Injury 32
§1901. Program Profile [Formerly LAC 67:VII.1901] 32

§1903. Enabling Legislation [Formerly LAC 67:VII.1903] 33
§1905. Definitions [Formerly LAC 67:VII.1905] 33
§1907. General Requirements [Formerly LAC 67:VII.1907] 33
§1909. Individual Appeals Rights [Formerly LAC 67:VII.1911] 33
§1911. Program Eligibility [Formerly LAC 67:VII.1913] 34
§1913. Ineligibility [Formerly LAC 67:VII.1915] 34
§1915. Fiscal [Formerly LAC 67:VII.1917] 34
§1917. Service Plan [Formerly LAC 67:VII.1919] 35
§1919. Services [Formerly LAC 67:VII.1921] 35
§1921. Service Providers [Formerly LAC 67:VII.1923] 35
§1923. Conditions for Case Closure [Formerly LAC 67:VII.1925] 36
§1925. Limitation of Liability [Formerly LAC 67:VII.1927] 36
Chapter 21. Liability Limitation Schedule for DHH Provided Services 36
§2109. Services and Facilities Other than State General Hospitals 36
Chapter 23. Informed Consent 36
§2301. Disclosure of Risks/Patient Consent 36
§2303. Female Genital System Treatments and Procedures 38
§2305. Maternity and Related Cases 39
§2307. Anesthesia 40
§2309. Risks and Complications of General Anesthesia 41
§2311. Anesthesia and Pregnancy 41
§2313. Endocrine System Treatments and Procedures 41
§2315. Nervous System Treatments and Procedures 42
§2317. Oral Surgery 42
§2319. Digestive System Treatment and Procedures 44
§2321. Hematic and Lymphatic System 44
§2323. Integumentary System Treatment and Procedures 45
§2325. Radiology 45
§2327. Repair of Coarctation of Aorta 45
§2329. Repair of Aortic Dissection 45
§2331. Lung Resection 46
§2333. Any Procedure Requiring Cardiopulmonary Bypass 46
§2335. Insertion of Intra-Aortic Augmentation Balloon 46
§2337. Radiation Therapy (Radiation Oncology) 46
§2339. Musculo-Skeletal Procedures in the Extremities 50
§2340. Peripheral Nerve Procedures 50
§2341. Vascular Surgery 51
§2343. Craniotomy 52
§2345. Anterior or Posterior Diskectomy (with or without Fusion) 52
§2347. Plastic Surgery 52
§2349. Cardiology Procedures 53
§2351. Cataract Surgery with or without Implantation of Intraocular Lens (placement of lens into eye) 57
§2353. Glaucoma Surgery 57
§2355. Corneal Surgery: Corneal Transplant, Pterygium, or Other 57
§2357. Laser Capsulotomy (creation of opening in lens membrane) 57
§2359. Enucleation or Evisceration (removal of eye or its contents) 58
§2361. Radial Keratotomy (reshape cornea by multiple cuts) 58
§2363. Eye Muscle Surgery 58
§2365. Laser Treatment of Eye (glaucoma or retina problems) 58
§2367. Retina (nerve layer of eye)/Vitreous (central gel-like substance in eye) Surgery 58

§2371. Tubes in Ears 58
§2373. Adenoidectomy 58
§2375. Tonsillectomy 58
§2377. Septoplasty 59
§2379. Cauterization of Tissue in the Nose 59
§2381. Rhinoplasty 59
§2383. Endoscopic Sinus Surgery 59
§2385. Radical Neck (Extensive Neck Surgery) 59
§2387. Submandibular Gland Surgery 59
§2389. Tympanoplasty (Operation on Eardrum) 59
§2391. Tympanoplasty with Mastoidectomy (Operation on Eardrum and Removal of Bone behind Ear) 59
§2393. Direct Laryngoscopy (Passage of Lighted Tube into the Voice Box) 60
§2395. Parotidectomy (Removal of Salivary Gland near the Ear) 60
§2400. Esophageal Dilation/ Esophagogastroduodenoscopy 60
§2404. Diagnostic and Therapeutic ERCP (Endoscopic Retrograde Cholangio Pancreatogram) 60
§2406. Colonoscopy 60
§2408. Sigmoidoscopy/Proctoscopy 60
§2410. Esophageal Manometry 60
§2412. Percutaneous Needle Biopsy of the Liver 60
§2414. 24-Hour PH Monitoring 61
§2416. Gastrectomy or Vagotomy and Pyloroplasty 61
§2418. Colon Resection 61
§2420. Appendectomy 61
§2422. Hernia Repair 61
§2424. Hemorrhoidectomy or Excision of Anal Fistula or Fissure 61
§2426. Excisional Breast Biopsy 61
§2428. Lumpectomy (partial excision of breast) with Axillary Dissection 62
§2430. Intravenous Injection of Radiopaque Contrast Media (both ionic and nonionic) 62
§2432. Ventriculoperitoneal Shunt Placement 62
§2434. Ventricular Atrial Shunt Placement 62
§2436. Lumboperitoneal Shunt Placement 62
§2438. Hemodialysis 63
§2440. Peritoneal Dialysis 63
§2442. Insertion of Temporary Hemodialysis Access Catheter 63
§2444. Insertion of Temporary Peritoneal Dialysis Catheter 63
§2446. Percutaneous Renal Biopsy Complications 64
§2449. Urology 64
§2451. Gastric Lap Band for Obesity 66
§2453. Gastric Bypass with or without Liver Biopsy for Obesity 66
§2455. Thoracentesis (insertion of needle or tube for drainage of chest cavity fluid) 66
§2457. Cancer Chemotherapy (treatment of cancer using anti-cancer medications) 67
§2459. Intravenous Conscious Sedation 67
§2461. Cervical Manipulation/Adjustment 67
§2463. Thoracic or Lumbar Manipulation/Adjustment 67
Chapter 25. Departmental Research 67
§2501. Purpose 67
§2503. Applicability 67
§2505. Definitions 67
§2507. Statement of Principles 68

§2509. Policies and Procedures 69
Chapter 27. Capital Area Human Services District 73
§2701. Introduction 73
§2703. Purpose and General Agreement 73
§2705. Designation of Liaisons 73
§2709. Services to be Delivered 74
§2711. Responsibilities of Each Party 74
§2713. Reallocation of Resources/Staff and Financial Agreements 76
§2715. Joint Training and Meetings 77
§2717. Special Provisions 77
§2719. Renewal/Termination 77
Chapter 29. Organ Procurement 77
§2901. Definitions 77
§2903. Conditions for Participation 78
Chapter 39. Controlled Dangerous Substances 78
Subchapter A. Training and Monitoring Requirements 78
§3901. Opioid Antagonist Administration and Training 78
Subchapter B. Drug Testing 79
§3991. Applicability 79
§3993. Definitions 80
§3995. Policy Provisions 80
Chapter 40. Provider Fees 81
§4001. Specific Fees 81
§4003. Due Date for Submission of Reports and Payment 83
§4005. Delinquent and/or Unfiled Reports 83
§4007. Delinquent and/or Unpaid Fees 83
§4009. Appeals 84
§4011. Exceptions 84

Subpart 3. Licensing

Chapter 41. Expedited Licensing Process for Healthcare Facilities and Providers Licensed by the Department of Health 84
§4101. Definitions 84
§4103. General Provisions 84
§4105. Expedited Licensing Applications and Fees 85
§4107. Expedited Licensing Survey Types and Tiers 85
§4109. Expedited Licensing Application Review Process 86
§4111. Expedited Licensing Survey Process 86
§4113. Expedited Licensing Survey Refunds 87
Chapter 42. Adult Day Health Care 87
Subchapter A. General Provisions 87
§4201. Introduction 87
§4203. Definitions 87
§4205. Licensure Requirements 89
§4207. Initial License Application Process 89
§4209. Initial Licensing Surveys 90
§4211. Types of Licenses 91
§4212. Accredited Status 91
§4213. Renewal of License 92
§4215. Reporting Requirements 92

§4217. Denial of License, Revocation of License, Denial of License Renewal 92
§4219. Notice and Appeal of License Denial, Revocation, and Denial of License Renewal 93
§4220. Complaint Surveys (Formerly §4221) 94
§4221. Statement of Deficiencies (Formerly §4223) 94
§4222. Cessation of Business 95
§4223. Inactivation of License due to a Declared Disaster or Emergency 95
§4224. Inactivation of License due to a Non-Declared Disaster or Emergency 96
Subchapter B. Administration and Organization 97
§4225. Governing Body 97
§4227. Policy and Procedures 97
§4229. Fiscal Accountability 98
§4231. Administrative Records 98
§4233. Participant Case Records 98
§4235. Retention of Records 99
§4237. Confidentiality and Security of Records 100
Subchapter C. Participant Rights 100
§4239. Statement of Rights 100
Subchapter D. ADHC Center Services 101
§4241. Mandatory Daily Program Components 101
§4243. Core Services 101
§4245. Transportation Requirements 101
Subchapter E. Participant Care 102
§4249. Medical Services 102
§4251. Nursing Services 102
§4253. Nutrition Services 102
§4255. Social Work Services 103
Subchapter F. Human Resources 103
§4259. Personnel Policies 103
§4261. Orientation and Training 104
§4263. Personnel Files 104
Subchapter G. Center Responsibilities 104
§4265. General Provisions 104
§4267. Staffing Requirements 105
§4269. Incident Reports 106
Subchapter H. Direct Service Management 107
§4273. Admissions 107
§4275. Discharge 107
§4277. Interdisciplinary Team Responsibilities 108
§4279. Interdisciplinary Team-Composition 108
§4281. Individualized Service Plan 108
§4283. Individualized Service Plan Review 109
Subchapter I. Emergency and Safety 109
§4285. Emergency and Safety Procedures 109
§4287. General Safety Practices 109
Subchapter J. Physical Environment 110
§4289. General Appearance and Conditions 110
§4291. Space Requirements 110
§4293. ADHC Furnishings 110
§4295. Location of Center 110

Chapter 44. Abortion Facilities 111
Subchapter A. General Provisions 111
§4401. Definitions 111
§4403. General Licensing Provisions 112
§4405. Initial Licensing Application Process 113
§4407. Survey Activities 115
§4409. Changes in Outpatient Abortion Facility Information or Key Administrative Personnel 116
§4411. License Renewal Application Process 117
§4413. Cessation of Business 119
§4415. Denial of an Initial License, Denial of License Renewal Application, and License Revocation. 120
§4417. Immediate Suspension of License 122
Subchapter B. Administration and Organization 122
§4421. Governing Body 122
§4423. Staffing Requirements, Qualifications, and Responsibilities 124
§4425. Patient Medical Records and Reporting Requirements 127
§4427. Quality Assurance and Performance Improvement Program (QAPI) 129
Subchapter C. Pre-Operative, Intra-Operative, and Post-Operative Procedures 129
§4431. Screening and Pre-Operative Services 129
§4433. Drug or Chemically Induced Abortion 131
§4435. Intra-operative Procedures 132
§4437. Post-Operative Care, Procedures, and Discharge 132
§4439. Anesthesia Services 133
Subchapter D. Physical Environment 133
§4445. General Requirements 133
§4447. Infection Control 134
§4449. Laboratory Services 135
§4451. Pharmaceutical Services 135
§4453. Inactivation of License due to a Declared Disaster or Emergency 136
Chapter 45. Ambulatory Surgical Center 137
Subchapter A. General Provisions 137
§4501. Introduction 137
§4503. Definitions 137
§4505. Licensing Requirements 138
§4507. Initial Licensure Application Process 139
§4509. Initial Licensing Surveys 140
§4511. Types of Licenses and Expiration Dates 140
§4513. Changes in Licensee Information or Personnel 141
§4515. Renewal of License 142
§4517. Survey Activities 142
§4519. Statement of Deficiencies 143
§4521. Denial of Initial License, Revocation of License, Denial of License Renewal 143
§4523. Notice and Appeal of Initial License Denial, License Revocation and Denial of License Renewal 144
§4525. Cessation of Business 146
Subchapter B. Administration and Organization 146
§4531. Governing Body 146
§4533. Policy and Procedures 147
Subchapter C. Admissions, Transfers and Discharges 148
§4539. Admissions and Assessments 148
§4541. Transfer Agreements and Patient Transfers 148

§4543. Discharges 149
Subchapter D. Service Delivery 149
§4549. Surgical Services 149
§4551. Anesthesia Services 150
§4553. Radiology Services 152
§4555. Laboratory Services 153
§4557. Pharmaceutical Services 153
§4559. Stereotactic Radiosurgery Services 154
Subchapter E. Facility Responsibilities 155
§4565. General Provisions 155
§4567. Staffing Requirements 155
§4569. Medical Records 158
§4571. Other Records and Reports 159
§4573. Quality Assurance and Performance Improvement 160
Subchapter F. Safety, Sanitization and Emergency Preparedness 160
§4575. General Provisions 160
§4577. Infection Control 161
§4579. Laundry Handling and Sanitation 162
§4581. Emergency Preparedness and Emergency Procedures 162
§4583. Inactivation of License due to a Declared Disaster or Emergency 163
§4585. Inactivation of License due to a Non-Declared Emergency or Disaster 164
Subchapter G. Physical Environment 164
§4587. General Requirements 164
§4589. General Appearance and Space Requirements 165
Chapter 46. Health Care Facility Sanctions 167
Subchapter A. General Provisions 167
§4601. Introduction 167
§4603. Definitions 167
Subchapter B. Sanctions and Standards for the Imposition of Sanctions 169
§4611. General Provisions 169
§4613. Civil Fines 170
§4615. Denial of Medicaid Payment 171
§4617. Denial of New Admissions 171
§4619. Removal from the Freedom of Choice List 171
§4621. Transfer of Clients Receiving Services 172
§4623. License Suspension 172
§4625. Monitoring 173
§4627. Special Staffing Requirements 173
§4629. Temporary Management 173
§4631. Denial of Renewal License and Revocation of License 174
Subchapter C. Notice and Appeals 174
§4641. Notice of Sanctions and Appeals 174
§4643. Administrative Appeal Process 175
Subchapter D. Enforcement of Sanctions 177
§4651. Enforcement of Sanctions/Collection of Fines 177
Subchapter E. Funds 177
§4661. Nursing Home Residents' Trust Fund 177
§4663. Health Care Facility Fund 178
Chapter 47. Family Violence Shelter 178
§4701. General Requirements 178

§4703. Governing Body 179
§4705. Responsibilities of a Governing Body 179
§4707. Accessibility of Executive 179
§4709. Documentation of Authority to Operate 179
§4711. Program Description 179
§4713. Accounting and Recordkeeping 180
§4715. Confidentiality and Security of Files 180
§4717. Administrative File 180
§4719. Client's Case Record 181
§4721. Personnel File 181
§4723. Fundraising and Publicity 181
§4731. Staff Plan 181
§4733. Recruitment 181
§4735. Screening 181
§4737. Orientation 181
§4739. Training 182
§4741. Evaluation 182
§4743. Personnel Practices 182
§4745. Number and Qualifications of Staff 182
§4747. External Professional Services 182
§4749. Volunteers/Student Interns 182
§4751. Staff Communications 182
§4753. Physical Environment 183
§4755. Exterior Space 183
§4757. Interior Space 183
§4759. General Safety Practices 183
§4761. Transportation 183
§4763. Organization and Administration 184
§4765. Quality of Life 184
§4767. Direct Services Management 185
§4769. Physical Environment 186
§4771. Emergency and Safety 187
Chapter 49. Case Management 188
§4901. Personnel Standards 188
§4903. Caseload Size Standards 190
§4905. Standards on Protecting Client Rights, Health, and Safety 190
§4907. Application Procedure 190
§4909. Review of Applications 191
§4910. Types of Licenses and Expiration Dates 191
§4911. Issuance of a License 191
§4913. Types of Licenses and Expiration Dates 191
§4915. Reapplication 191
§4917. Refusal, Revocation and Fair Hearing 191
§4919. Terms of the Licensure 191
§4921. Services for Different Handicaps 192
§4923. Quarterly Staffing Report 192
§4925. Licensing Inspections 192
§4927. New Construction, Renovations of Existing Facilities and Conversion of any Residential or Commercial Building for Residential Care 192
§4929. General Waiver 192

§4931. Case Management/Service Coordination Services 193
§4933. General Requirements 194
§4935. Governing Body 194
§4937. Governing Body Responsibilities 194
§4939. Accessibility of Executive 195
§4941. Documentation of Authority to Operate 195
§4943. Administrative Files 195
§4945. Organizational Communication 195
§4947. Financial Management 195
§4949. Confidentiality and Security of Records 196
§4951. Records—Administrative and Consumer 196
§4953. Program Description 198
§4955. Transportation 198
§4957. External Professional Service 198
§4959. Staff Plan and Staff Coverage 198
§4961. Nondiscrimination 199
§4963. Recruitment 199
§4965. Screening 199
§4967. Orientation 199
§4969. Training 199
§4971. Program Evaluation 199
§4973. Personnel Practices 200
§4975. Abuse Reporting 200
§4977. Basic Rights 200
§4979. Self-Advocacy 201
§4981. Advocacy 201
§4983. Grievance Procedures for Consumers 201
Chapter 50. Home and Community-Based Services Providers Licensing Standards 202
Subchapter A. General Provisions 202
§5001. Introduction 202
§5003. Definitions 202
§5005. Licensure Requirements 204
§5007. Initial Licensure Application Process 205
§5009. Initial Licensing Surveys 206
§5011. Types of Licenses and Expiration Dates 207
§5012. Change in License by Addition or Deletion of a Service Module or Modules from the HCBS License 208
§5013. Changes in Licensee Information, Location, or Key Personnel 208
§5014. Change of Ownership of an HCBS Provider 209
§5015. Renewal of License 209
§5016. Deemed Status through Accreditation 210
§5017. Survey Activities 210
§5019. Statement of Deficiencies 210
§5021. Denial of Initial Licensure, Revocation of License, Denial of License Renewal 211
§5023. Notice and Appeal of Initial License Denial, License Revocation and Denial of License Renewal 212
§5024. Inactivation of License due to a Declared Disaster or Emergency [Formerly §5025] 214
§5025. Inactivation of License due to a Non-Declared Disaster or Emergency 215
§5026. Cessation of Business 215

Subchapter B. Administration and Organization 216
§5027. Governing Body 216
§5029. Policy and Procedures 217
§5031. Business Location 218
§5032. Branch Offices and Satellites of HCBS Providers 219
Subchapter C. Admission, Transfer and Discharge Criteria 220
§5033. Admissions 220
§5035. Voluntary Transfers and Discharges 220
§5037. Involuntary Transfers and Discharges 220
§5038. Provisions for Services to Clients Outside of Licensed Geographic Area in Event of a Gubernatorial Declared State of Emergency or Disaster 222
Subchapter D. Service Delivery 223
§5039. General Provisions 223
§5041. Individual Service Plan 224
§5043. Contract Services 224
§5045. Transportation 225
Subchapter E. Client Protections 225
§5049. Client Rights 225
§5051. Grievances 226
Subchapter F. Provider Responsibilities 227
§5053. General Provisions 227
§5055. Core Staffing Requirements 227
§5057. Client Records 230
§5059. Client Funds and Assets 231
§5061. Quality Enhancement Plan 232
§5063. Emergency Preparedness 232
Subchapter G. Adult Day Care Module 233
§5071. General Provisions 233
§5073. Operational Requirements for ADC Facilities 234
Subchapter H. Family Support Module 236
§5075. General Provisions 236
§5077. Operational Requirements for Family Support Providers 236
Subchapter I. Personal Care Attendant Module 236
§5079. General Provisions 236
§5081. Operational Requirements for PCA Providers 237
Subchapter J. Respite Care 237
§5083. General Provisions 237
§5085. Operational Requirements for In-Home Respite Care 237
§5087. Operational Requirements for Center-Based Respite Care 237
Subchapter K. Substitute Family Care Module 239
§5089. General Provisions 239
§5090. Operational Requirements for Substitute Family Care Providers 240
§5091. Operational Requirements for Substitute Family Care Caregivers 242
Subchapter L. Supervised Independent Living Module 244
§5093. General Provisions 244
§5094. Operational Requirements for the Supervised Independent Living Module 244
§5095. Supervised Independent Living Shared Living Conversion Process 245
Subchapter M. Supported Employment Module 246
§5099. General Provisions 246

Chapter 51. Home and Community-Based Services Providers 247
Subchapter A. Monitored In-Home Caregiving Module 247
§5101. General Provisions 247
§5103. Staffing Requirements, Qualifications, and Duties 247
§5105. Operational Requirements for Monitored In-Home Caregiving 249
§5107. Qualified Setting Provisions 250
§5109. Waiver of Module Provisions 251
Chapter 52. Pediatric Day Health Care Facilities 251
Subchapter A. General Provisions 251
§5201. Introduction 251
§5203. Definitions 251
Subchapter B. Licensing Procedures 252
§5205. General Provisions 252
§5207. Initial Licensing Application Process 252
§5209. Types of Licenses 253
§5211. Licensing Surveys 254
§5213. Changes in Licensee Information or Personnel 254
§5215. Cessation of Business 255
§5217. Renewal of License 255
§5219. Denial of License, Revocation of License, Denial of License Renewal 256
§5221. Notice and Appeal of License Denial, License Revocation and License Non-Renewal and Appeal of Provisional License 257
§5223. Complaint Surveys 259
§5225. Statement of Deficiencies 259
Subchapter C. Administration and Organization 260
§5231. Facility Administration and Management 260
§5233. Policy and Procedures 260
Subchapter D. Participation Requirements 260
§5237. Acceptance Criteria 260
§5239. Plan of Care 261
§5241. Participant Rights 262
Subchapter E. Pediatric Day Health Care Services 262
§5245. General Provisions 262
§5247. Developmental and Educational Services 262
§5249. Medication Administration 263
§5251. Nutritional Services 263
§5253. Social Services 264
§5255. Therapy Services 264
§5257. Transportation 264
Subchapter F. Facility Responsibilities 266
§5263. General Provisions 266
§5265. Staffing Requirements 267
§5267. Orientation, Staff Development and Training 270
§5269. Record Keeping 270
§5271. Infection Control 271
§5273. Quality Assurance 271
Subchapter G. Safety and Emergency Preparedness 272
§5279. Safety and Emergency Services 272
§5281. Emergency Preparedness 273

Subchapter H. Physical Environment 275
§5285. General Requirements 275
Chapter 53. Level III Crisis Receiving Centers 277
Subchapter A. General Provisions 277
§5301. Introduction 277
§5303. Definitions 277
Subchapter B. Licensing 279
§5309. General Licensing Provisions 279
§5311. Initial Licensure Application Process 281
§5313. Initial Licensing Surveys 282
§5315. Types of Licenses 282
§5317. Changes in Licensee Information or Personnel 283
§5319. Renewal of License 284
§5321. Licensing Surveys 284
§5323. Complaint Surveys 285
§5325. Statement of Deficiencies 285
§5327. Cessation of Business 285
§5329. Sanctions 286
§5331. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal 287
Subchapter C. Organization and Administration 289
§5337. General Provisions 289
§5339. Governing Body 289
§5341. Policies and Procedures 290
Subchapter D. Provider Operations 291
§5347. Client Records 291
§5349. Client Funds and Possessions 292
§5351. Quality Improvement Plan 292
Subchapter E. Personnel 293
§5357. General Requirements 293
§5359. Personnel Qualifications and Responsibilities 295
§5361. Personnel Records 296
Subchapter F. Admission, Transfer and Discharge 297
§5367. Admission Requirements 297
§5369. Discharge, Transfer and Referral Requirements 298
Subchapter G. Program Operations 298
§5375. Treatment Services 298
§5377. Laboratory Services 299
§5379. Pharmaceutical Services and Medication Administration 299
§5381. Transportation 300
§5383. Food and Diet 301
Subchapter H. Client Rights 301
§5389. General Provisions 301
§5391. Grievances 302
Subchapter I. Physical Environment 302
§5397. Interior Space 302
§5399. Exterior Space Requirements 305
Chapter 54. Crisis Receiving Centers 305
Subchapter A. Safety and Emergency Preparedness 305
§5401. General Safety Provisions 305
§5403. Infection Control 305

§5405. Emergency Preparedness 306
§5407. Inactivation of License due to a Declared Disaster or Emergency 307
§5409. Inactivation of License due to a Non-Declared Emergency or Disaster 308
Chapter 55. Day Developmental Training Centers 309
§5501. Glossary 309
§5503. Licensure Procedure 309
§5505. Relicensure Procedure 310
§5507. Appeal Procedure 310
§5509. General Standards 310
§5511. Compliance with Federal, State and Local Laws 310
§5513. Disclosure of Ownership 310
§5515. Governing Body and Administration 311
§5517. General Policies and Practices 311
§5519. Personnel Policies 313
§5521. Admission and Release 313
§5523. General Staffing Provisions 313
§5525. Staff Responsibilities and Activities 314
§5527. Health, Hygiene and Grooming 314
§5529. Food and Nutrition 315
§5531. Medical Services 315
§5533. Services for Education, Training and Habilitation 316
§5535. Social Services 317
§5537. Physical and Occupational Therapy Services 318
§5539. Speech Pathology and Audiology 318
§5541. Recreation Services 319
§5543. Design and Equipage 319
§5545. Safety and Sanitation 320
§5547. Records 321
§5549. Staff Composition and Organization 322
§5551. Records 323
§5553. Records 325
Chapter 56. Behavioral Health Service Providers 326
Subchapter A. General Provisions 326
§5601. Introduction 326
§5603. Definitions 327
Subchapter B. Licensing 333
§5605. General Provisions 333
§5606. License Restrictions 335
§5607. Initial Licensure Application Process 335
§5609. Initial Licensing Surveys 336
§5611. Types of Licenses 337
§5613. Changes in Licensee Information or Personnel 338
§5615. Renewal of License 338
§5617. Deemed Status 339
§5619. Licensing Surveys 340
§5621. Complaint Investigations 340
§5623. Statement of Deficiencies 340
§5625. Cessation of Business 341
§5627. Sanctions 341
§5629. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal 343

Subchapter C. Organization and Administration 344
§5631. General Provisions 344
§5633. Governing Body 344
§5635. Policies and Procedures 345
Subchapter D. Provider Operations 346
§5637. Client Records 346
§5639. Quality Improvement Plan 347
Subchapter E. Personnel 348
§5641. General Requirements 348
§5643. Core Staffing Personnel Qualifications and Responsibilities 350
§5645. Personnel Records 353
Subchapter F. Admission, Transfer and Discharge 353
§5647. Admission Requirements 353
§5649. Transfer and Discharge Requirements 354
Subchapter G. Services 355
§5651. Treatment Protocols 355
§5653. Treatment Plan 355
§5655. Core Services 356
§5657. Laboratory Services 356
§5659. Medications 357
Subchapter H. Client Rights 358
§5661. Client Rights 358
§5663. Grievances 359
Subchapter I. Physical Environment 359
§5665. Exterior Space Requirements 359
§5667. Interior Space for Residential Facilities and Outpatient Clinics 359
§5669. Interior Space for Residential Facilities 360
Subchapter J. Safety and Emergency Preparedness 361
§5671. Safety Provisions for Outpatient Clinics and Residential Facilities 361
§5673. Infection Control 362
§5675. Emergency Preparedness 363
§5677. Inactivation of License due to a Declared Disaster or Emergency 364
§5678. Inactivation of License due to a Non-Declared Emergency or Disaster 365
Subchapter K. Additional Requirements for Children/Adolescent Programs 366
§5679. General Provisions 366
§5681. Residential Programs for Children and/or Adolescents 366
Subchapter L. Additional Requirements for Mental Health Programs 367
§5683. Staffing Requirements 367
§5685. Psychosocial Rehabilitation Services 367
§5687. Crisis Intervention 367
§5689. Community Psychiatric Support and Treatment 368
§5691. Behavioral Health Service Providers with a Mental Health Program that Provide Services Only in the Home and Community 368
Subchapter M. Additional Requirements for Substance Abuse/Addiction Treatment Programs 369
§5693. General Requirements 369
§5695. Addiction Outpatient Treatment Program (ASAM Level I) 369
§5697. Intensive Outpatient Treatment Programs (ASAM Level II.1) 370
§5698. Partial Hospitalization Services (substance abuse only) (ASAM Level II.5) 370
§5699. Ambulatory Detoxification with Extended On-Site Monitoring (ASAM Level II-D) (Adults Only) 371

§5701. Clinically Managed Low-Intensity Residential Treatment Program (ASAM Level III.1) 371
§5703. Clinically Managed Residential Detoxification (Social Detoxification) (ASAM Level III.2D) 371
§5705. Clinically Managed Medium-Intensity Residential Treatment (ASAM Level III.3) (Adult Only) 372
§5707. Clinically Managed High-Intensity Residential (ASAM Level III.5) 374
§5709. Medically Monitored Intensive Residential (ASAM Level III.7) (Adults Only) 374
§5711. Medically Managed Residential Detoxification (Medical Detoxification) (ASAM Level III.7D) (Adults Only) 375
Subchapter N. Additional Requirement for Substance Abuse/Addictive Residential Treatment Programs 376
§5713. Client Funds and Assets 376
§5715. Dietary Services 376
§5717. Transportation 377
§5719. Staffing 377
§5721. Policies and Procedures 378
Subchapter O. Additional Requirements for Opioid Treatment Programs 378
§5723. General Provisions 378
§5725. Treatment 378
§5727. Additional Staffing Requirements 379
§5729. Medications 380
§5731. Client Records 381
Chapter 60. Emergency Medical Transportation Services 381
Subchapter A. General Provisions 381
§6001. Definitions 381
§6003. Licensing Requirements and Types of Licenses 383
§6005. Initial Licensing 384
§6007. Service Areas 385
§6009. Fees 385
§6011. Inspections 385
§6013. Changes 386
§6015. License Renewal 387
§6017. Denial, Revocation or Suspension of a License 387
§6019. Sanctions 388
§6021. Notices, Informal Reconsideration and Appeals 389
Subchapter B. Provider Responsibilities 390
§6031. General Provisions 390
§6033. Personnel 391
§6035. Medications 393
§6037. Medical Protocol 393
§6039. Records 394
§6041. Emergency Preparedness 395
§6043. Quality Assurance 395
Subchapter C. Emergency Vehicles—Ground Transportation 395
§6053. General Provisions 395
§6055. Emergency Medical Response Vehicles (Sprint Vehicles) 396
§6057. Ambulances 399
Subchapter D. Emergency Vehicles—Aircraft Transportation 402
§6065. General Provisions 402
§6067. Emergency Aircraft—Rotary-Winged (Reserved) 402

§6069. Emergency Aircraft—Fixed (Reserved) ... 402
Chapter 61. Automated External Defibrillators ... 402
§6101. Definitions ... 402
§6103. General Provisions ... 403
§6105. Regulations and Reports ... 404
Chapter 62. Therapeutic Group Homes ... 404
Subchapter A. General Provisions ... 404
§6201. Introduction ... 404
§6203. Definitions ... 405
Subchapter B. Licensing ... 406
§6207. General Provisions ... 406
§6209. Initial Licensing Application Process ... 407
§6210. Criminal Background Checks; Prohibitions to Ownership of and Employment at a Therapeutic Group Home; Process; Fees ... 408
§6211. Types of Licenses ... 411
§6213. Changes in Licensee Information or Personnel ... 412
§6215. Renewal of License ... 413
§6217. Deemed Status ... 413
§6219. Licensing Surveys ... 414
§6221. Complaint Surveys ... 414
§6223. Statement of Deficiencies ... 415
§6225. Cessation of Business ... 415
§6227. Denial of License, Revocation of License, or Denial of License Renewal ... 416
§6229. Notice and Appeal of License Denial, License Revocation, Denial of License Renewal, and Appeal of Provisional License ... 417
Subchapter C. Administration and Organization ... 419
§6233. General Provisions ... 419
§6237. Governing Body ... 419
§6239. Policies and Procedures ... 420
§6241. Personnel Records ... 421
Subchapter D. Provider Responsibilities ... 422
§6245. General Provisions ... 422
§6247. Staffing Requirements ... 422
§6249. Personnel Qualifications and Responsibilities ... 423
§6251. Client Records ... 426
§6253. Client Funds and Assets ... 427
§6255. Quality Improvement Plan ... 427
Subchapter E. Admission, Transfer, and Discharge ... 428
§6259. Admission Requirements ... 428
§6261. Transfer and Discharge Requirements ... 428
Subchapter F. Services ... 429
§6265. General Provisions ... 429
§6267. Comprehensive Treatment Plan ... 429
§6269. Client Services ... 429
§6271. Medications ... 430
§6273. Food and Diet ... 431
§6275. Transportation ... 432
Subchapter G. Client Protections ... 432
§6279. Client Rights ... 432
§6281. Grievances ... 433

Subchapter H. Physical Environment 433
§6285. General Provisions 433
§6287. Interior Space 434
§6289. Exterior Space Requirements 435
§6291. Equipment 436
Subchapter I. Facility Operations 436
§6293. Safety and Emergency Preparedness 436
§6295. Inactivation of License due to a Declared Disaster or Emergency 437
§6297. Inactivation of License due to a Non-Declared Emergency or Disaster 438
Chapter 67. Hospitals 439
§6700. General 439
§6701. Definitions 439
§6703. Licensing Procedures 440
§6705. Exceptions 440
§6707. Approval of Plans 440
§6709. Medical Staff 441
§6711. Personnel 441
§6713. Functions of the State Fire Marshal 441
§6715. New Hospitals 441
§6717. Existing Hospitals 441
§6717. Functions of the Office of Preventive and Public Health Services 443
§6719. Scope of Chapter 443
§6721. Buildings 443
§6723. Food Service 443
§6725. Equipment and Storage 444
§6727. Water Supply 444
§6729. Plumbing, Sewerage, Garbage, and Wastes 444
§6731. Radiation 444
§6733. Nursing Service Facilities 444
§6735. General Patient Care 445
§6737. Pediatric Department 446
§6739. Obstetrical Department 446
§6741. Delivery and Post-Partum 446
§6743. Nursery 446
§6745. Psychiatric Unit 447
§6747. Surgery Suite 447
§6749. Sterilizing and Supply Service 448
§6751. Diagnostic and Treatment Facilities 448
§6753. Medical Records 448
§6755. Denial, Suspension, or Revocation of License Appeals 449
Chapter 68. Adult Residential Care Providers 449
Subchapter A. General Provisions 449
§6801. Introduction 449
§6803. Definitions and Abbreviations 450
§6805. Licensure Requirements 452
§6807. Initial Licensure Application Process 452
§6809. Initial Licensing Surveys 453
§6811. Types of Licenses and Expiration Dates 454
§6813. Changes in Licensee Information or Personnel 455
§6815. Renewal of License 455

§6817. Denial of License, Revocation of License, Denial of License Renewal, Operation without License, Penalty 456
§6819. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal 457
§6821. Complaint Investigations 458
§6823. Statement of Deficiencies 458
§6825. Cessation of Business 459
Subchapter B. Administration and Organization 459
§6827. Governing Body 459
§6829. Policy and Procedures 460
Subchapter C. Residency Criteria, Person-Centered Service Plans, and Residency Agreements 461
§6833. Pre-Residency and Continued Residency 461
§6835. Person-Centered Service Plan 462
§6837. Termination of Residency Agreements 463
Subchapter D. Adult Residential Care Provider Services 464
§6839. General Provisions 464
§6841. Required and Optional Services 464
§6843. Medication Administration 464
§6845. Intermittent Nursing Services 467
§6847. Transportation 467
§6849. Meals Provided by the ARCP 468
§6851. Specialized Dementia Care Programs 469
Subchapter E. Resident Protection 470
§6855. Resident Rights 470
§6857. Restraints 471
§6859. Resident Representation and Grievance Procedures 471
§6861. Resident Personal Property and Funds 471
Subchapter F. Requirements Related to Staff, Record-Keeping and Incident Reports 472
§6863. General Provisions 472
§6865. Staffing Requirements 473
§6867. Staff Training 474
§6869. Record Keeping 476
§6871. Incident and Accident Reports 477
Subchapter G. Emergency Preparedness 478
§6875. Emergency Preparedness Plan 478
§6877. Emergency Plan Activation, Review and Summary 480
§6879. Notification 480
§6881. Authority to Re-open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation 481
Subchapter H. Physical Environment 482
§6885. General Requirements and Authority 482
§6887. Physical Appearance and Conditions 484
§6889. Resident Dining and Common Areas 485
§6891. Resident Personal Space 485
§6893. Furnishings and Equipment 487
Chapter 69. Juvenile Detention Centers 487
§6901. Definitions 487
§6903. General Provisions 488
§6905. Admission Criteria 489
§6907. Intake Procedures 490
§6909. Records 490

§6911. Child Supervision and Care 491
§6913. Food/Nutrition 492
§6915. Education 492
§6917. Recreation 492
§6919. Religion 493
§6921. Work 493
§6923. Discipline 493
§6925. Visitation 493
§6927. Correspondence 493
§6929. Safety 494
§6931. Personnel 494
§6933. Qualifications of Staff 495
§6935. Regulations 495
§6937. Training 495
§6939. Volunteers 496
§6941. Physical Plant 496
§6943. Design 496
§6945. Construction 497
§6947. Security 498
Chapter 72. Forensic Supervised Transitional Residential and Aftercare Facilities Licensing Standards 498
Subchapter A. General Provisions 498
§7201. Introduction 498
§7203. Definitions 499
§7205. Licensing Requirements 500
§7207. Initial Licensing Application Process 500
§7209. Types of Licenses 501
§7211. Licensing Surveys 502
§7213. Changes in Licensee Information or Personnel 502
§7215. Renewal of License 503
§7217. Denial of License, Revocation of License, Denial of License Renewal 503
§7219. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal 505
§7221. Complaint Surveys 506
§7223. Statement of Deficiencies 507
§7225. Cessation of Business 507
§7227. Temporary Inactivation of a License Due to a Declared Disaster or Emergency 508
§7228. Inactivation of License due to Non-Declared Emergency or Disaster 508
§7229. Temporary Inactivation of Licensed FSTRA Beds Due to Major Alterations 509
Subchapter B. Administration and Organization 510
§7231. Governing Body 510
§7233. Policy and Procedures 510
Subchapter C. Admissions, Transfers and Discharges 511
§7235. Admissions 511
§7237. Mandatory Transfers and Discharges 512
Subchapter D. Participation Requirements 512
§7241. Assessment, Service Coordination, and Monitoring 512
§7243. Personal and Supportive Services 513
§7245. Nutrition 514
§7247. Transportation Requirements 514
Subchapter E. Client Protection 514
§7251. Client Rights 514

Subchapter F. Facility Responsibilities 515
§7255. General Provisions 515
§7257. Core Staffing Requirements 516
§7259. Client Records 518
§7261. Abuse and Neglect 519
§7263. Critical Incidents 519
§7265. Personal Possessions 520
§7267. Client Funds 520
§7269. Contraband 521
Subchapter G. Safety and Emergency Preparedness 521
§7271. General Provisions 521
Subchapter H. Physical Environment 521
§7275. General Provisions 521
Subchapter I. Secure Community Supervised Transitional/Residential Facility Module 524
§7279. General Provisions 524
§7281. Operational Requirements 524
Subchapter J. Secure Forensic Facility Module 525
§7285. General Provisions 525
§7287. Operational Requirements 525
Chapter 75. Licensing of Rural Health Clinics 526
Subchapter A. General Provisions 526
§7501. Definitions and Acronyms 526
§7503. Licensing 526
§7505. Denial, Revocation, or Non-Renewal of License 527
§7507. Changes/Reporting 528
§7509. Annual Licensing Renewal 528
§7511. Notice and Appeal Procedures 529
§7513. Complaint Procedures 529
§7515. Voluntary Cessation of Business 529
§7517. Personnel Qualifications/Responsibilities 529
§7519. Services 530
§7521. Agency Operations 530
§7523. Procedural Standards 531
§7525. Record Keeping 532
§7529. Quality Assurance 532
§7531. Patient's Rights and Responsibilities 533
§7533. Advisory Committee 533
§7535. Physical Environment 534
Chapter 76. Medicare Rural Hospital Flexibility Program (MRHF) 535
Subchapter A. Critical Access Hospitals 535
§7601. Definitions 535
§7603. Criteria for Designation as a CAH 535
§7609. Application Submission and Review 536
§7611. Technical Assistance 536
§7613. Program Monitoring and Evaluation 536
Chapter 78. Pain Management Clinics 537
Subchapter A. General Provisions 537
§7801. Definitions 537
§7803. Ownership 538

Subchapter B. Licensing Procedures 538
§7811. General Provisions 538
§7813. Initial Application Process 539
§7815. Licensing Surveys 539
§7817. Issuance of Licenses 540
§7819. Initial License Denial, License Revocation or Denial of License Renewal 541
§7821. Notice and Appeal Procedures 542
§7823. Cessation of Business 543
§7825. Inactivation of License due to Declared Disaster or Emergency 543
Subchapter C. Clinic Administration 544
§7831. Medical Director 544
§7832. Administrator 545
§7833. Clinic Operations 545
§7835. Governing Body 546
§7837. Orientation and Training 547
Subchapter D. Facility Requirements 547
§7843. Facility Inspections 547
§7845. Physical Environment 548
§7847. Infection Control Requirements 548
§7849. Health and Safety Requirements 549
§7851. Quality Assurance 550
Subchapter E. Patient Records 550
§7861. Patient Records 550
Chapter 80. Children's Respite Care Centers 551
Subchapter A. General Provisions 551
§8001. Definitions 551
§8003. Licensing 553
§8005. Survey 557
§8007. License Renewal Process 557
§8009. Fees 558
§8011. Changes 558
§8013. Revocation or Denial of Renewal of License 558
§8015. Notice and Appeal 559
Subchapter B. Core Services 559
§8021. Core Services 559
Subchapter C. Personnel 559
§8027. Administrator 559
§8029. Counselor-Bereavement 560
§8031. Counselor-Pastoral 560
§8033. Dietician 560
§8035. Dietary Manager 561
§8037. Director of Nurses 561
§8039. Governing Body 561
§8041. Home Health Aide 562
§8043. Licensed Practical Nurse 563
§8045. Medical Director/Physician Designee 563
§8047. Occupational Therapist 564
§8049. Pharmacist 564
§8051. Physical Therapist 564
§8053. Registered Nurse 564

§8055. Social Worker 565
§8057. Speech Pathologist 565
§8059. Volunteers 565
Subchapter D. Patient Care Services 566
§8067. Admission Criteria 566
§8069. Plan of Care (POC) 566
§8071. Pharmaceutical Services 567
§8073. Pathology and Laboratory Services 569
§8075. Discharge/Transfer 569
§8077. Patient Rights and Responsibilities 569
§8079. Clinical Records 570
§8081. Nursing Services 570
§8083. Nutritional Services 571
Subchapter E. Administration 572
§8089. Agency Operations 572
§8091. Contract Services 573
§8093. Quality Assurance 573
§8095. Cessation of Business 574
Chapter 82. Minimum Standards for Licensure of Hospice Agencies 574
Subchapter A. General Provisions 574
§8201. Definitions 574
§8203. Licensing 577
§8205. Survey 578
§8207. Revocation or Denial of Initial License or Renewal of License 579
§8209. License Renewal Process 580
§8211. Notice and Appeal Procedure for Revocation of Licensure and Denial of Initial License or License Renewal 580
§8213. Fees 581
§8215. Changes 581
§8216. Emergency Preparedness 581
Subchapter B. Organization and Staffing 582
§8217. Personnel Qualifications/Responsibilities 582
Subchapter C. Patient Care Services 590
§8219. Patient Care Standard 590
§8221. Plan of Care (POC) 590
§8223. Pharmaceutical Services 592
§8225. Pathology and Laboratory Services 592
§8227. Radiology Services 592
§8229. Discharge/Revocation/Transfer 592
§8231. Patient Rights and Responsibilities 593
§8233. Clinical Records 593
Subchapter D. Administration 594
§8235. Agency Operations 594
§8237. Contract Services 596
§8239. Quality Assurance/Performance Improvement 597
§8241. Branch Offices 597
§8243. Cessation of Business 598
§8245. Inactivation of Licensure due to a Declared Disaster or Emergency 598
§8246. Inactivation of Licensure due to a Non-Declared Disaster or Emergency 599

Subchapter E. Hospice Inpatient Facility 600
§8247. Requirements for Licensure of Inpatient Hospice 600
§8253. Nursing Services 603
§8255. Nutritional Services 603
§8257. Pharmaceutical Services of Inpatient Hospice 605
Chapter 84. End Stage Renal Disease Treatment Facilities 607
Subchapter A. General Provisions 607
§8401. Acronyms and Definitions 607
§8403. Licensing 608
§8405. Fees, Fines, and Assessments 609
§8407. Survey 609
§8409. Adverse Actions 610
§8411. Appeals 610
Subchapter B. Facility Operations 611
§8423. Operational Procedures 611
§8425. Facility Records 611
§8427. Health and Safety 612
§8429. Physical Plant Requirements 613
Subchapter C. Personnel 614
§8439. General Provisions 614
§8441. Training 615
§8443. Personnel Qualifications and Responsibilities 616
Subchapter D. Patient Care 619
§8455. Patient's Rights 619
§8457. Treatment Services 619
§8459. Treatment Requirements 619
§8461. Patient Records. 620
Chapter 85. Intermediate Care Facilities for Persons with Developmental Disabilities 621
Subchapter A. General Provisions 621
§8501. Introduction 621
§8503. Definitions 621
§8505. Licensing Requirements 623
§8507. Initial Licensing Application Process 623
§8509. Initial Licensing Surveys 624
§8511. Types of Licenses and Expiration Dates 625
§8513. Changes in Licensee Information or Personnel 625
§8515. Renewal of License 626
§8517. Survey Activities 626
§8519. Statement of Deficiencies 627
§8521. Denial of License, Revocation of License, or Denial of License Renewal 627
§8523. Notice and Appeal of License Denial, Revocation or Non-Renewal 629
§8525. Cessation of Business 631
Subchapter B. Administration and Organization 631
§8531. Governing Body 631
§8533. Fund Raising and Publicity 632
§8535. Research 632
Subchapter C. Admission, Transfer, and Discharge Criteria 632
§8541. Admissions 632
§8543. Voluntary and Involuntary Transfers and Discharges 634

Subchapter D. Service Delivery 635
§8547. General Provisions 635
§8549. Individual Service Plan 635
§8551. Food Services 636
§8553. Health Care Services 637
§8555. Professional and Specialized Programs and Services 639
§8557. Transportation 641
Subchapter E. Client Protections 642
§8565. Client Rights 642
§8567. Grievances 643
§8569. Behavior Management 643
Subchapter F. Provider Responsibilities 644
§8575. General Provisions 644
§8577. Staffing Requirements 644
§8579. Staffing-Qualified Professional and Qualified Mental Retardation Professional 646
§8581. Record Keeping 647
§8583. Client Funds and Assets 648
§8585. Abuse and Neglect 649
§8587 Abuse/Neglect Reporting 649
§8589. Quality of Life 649
Subchapter G. Emergency Preparedness 651
§8595. Emergency Preparedness Plan 651
§8597. Emergency Plan Activation, Review and Summary 653
§8599. Notification of Evacuation, Relocation, or Temporary Cessation of Operations 654
§8601. Authority to Re-open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation 654
§8603. General Emergency Preparedness Training 655
§8605. Inactivation of License Due to Declared Disaster or Emergency 655
Subchapter H. Physical Environment 656
§8609. Physical Plant 656
§8611. Exterior Space 657
§8613. Interior Space 658
§8615. General Facility Safety Practices 660
Chapter 87. Adult Brain Injury Facilities Licensing Standards 660
Subchapter A. General Provisions 660
§8701. Introduction 660
§8703. Definitions 660
§8705. Licensure Requirements 663
§8707. Initial Licensure Application Process 663
§8709. Initial Licensure Surveys 664
§8711. Complaint Investigations 664
§8713. Statement of Deficiencies 665
§8715. Types of Licenses 665
§8717. Changes in Licensee Information or Key Personnel 666
§8719. Change of Ownership 666
§8721. Renewal of License 667
§8723. Denial of License, Revocation of License, License Suspension and Denial of License Renewal 667
§8725. Notice and Appeal of License Denial, License Revocation, License Suspension and Denial of License Renewal 668

§8727. Cessation of Business 669
§8729. Inactivation of a License Due to a Declared Disaster or Emergency 670
§8731. Inactivation of License due to Non-Declared Emergency or Disaster 671
§8733. Operating Without a License or in Violation of Departmental Regulations, Fines and Injunctive Relief 671
§8735. Fees 672
Subchapter B. Organization and Administration 672
§8741. Governing Body 672
§8743. Governing Body Responsibilities 672
§8745. Required Staffing 675
Subchapter C. Client Protection 676
§8751. Client Rights 676
§8753. Client Association 677
§8755. Grievance Procedure 677
§8757 Personal Possessions 677
§8759. Client Funds 677
§8761. Emergency and Evacuation Procedures 678
§8763. Incidents/Accidents 678
§8765. Abuse and Neglect 679
Subchapter D. Admissions, Transfers and Discharges 679
§8771. Admission 679
§8773. Transfer or Discharge 680
Subchapter E. Participation Requirements 680
§8777. Services 680
Subchapter F. Quality Enhancement Plan 683
§8781. Quality Enhancement 683
Subchapter G. Physical Environment 684
§8785. General Provisions 684
§8787. Residential Facilities 685
§8789. Community Living 686
§8791. Outpatient Services 687
Chapter 88. Nurse Licensure Compact 687
§8801. Definitions 687
§8803. General Administration 687
§8805. Licensed Facility and Agency Requirements 688
Chapter 89. Crisis Intervention 688
§8901. Purpose 688
§8903. Procedures 688
§8905. Organization and Administration 690
§8907. Program and Services 692
§8909. Personnel 692
§8911. Client Rights and Grievance Procedure 694
§8913. Glossary of Terms 694

Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 1. General

Chapter 1. Equal Delivery of Services

§101. Policy Statement

A. The Department of Health and Human Resources (DHHR) reaffirms its policy for the Equal Delivery of Services and will administer all programs and conduct its business, either directly or indirectly, or through contractual or other arrangements, in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.), Title 45 of the Code of Federal Regulations, Part 80, as amended through July 5, 1973, Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 706), and the agency's Statements of Compliance.

1. No person shall, on the grounds of race, color, national origin, or handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity conducted in this agency. The Department of Health and Human Resources will take appropriate action to insure that the above will be implemented at all levels of administration.

2. The Secretary, Department of Health and Human Resources, has overall responsibility for the policy and program development under Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973. Responsibility for the coordination and implementation has been placed with the director of the Civil Rights Bureau.

3. Any person who believes that he or she, or any specific class of persons, has been subjected to discrimination covered by Title VI or Section 504 of the Rehabilitation Act of 1973, as amended, may without fear of reprisal or coercion, file a written complaint with the Civil Rights Bureau, 200 Riverside Mall, Room 102, Baton Rouge, Louisiana 70821, or the Dallas Regional Office for Civil Rights, 1200 Main Tower, Dallas, Texas 75202.

4. It is the policy of the Department of Health and Human Resources to resolve all complaints alleging discrimination based on age, race, color, sex, handicap, religion, national original and political belief in the provision of any agency services. Any person who believes that he or she or any specific class of persons have been subjected to discrimination in any agency program, may personally or by a representative file a written complaint. The identity of the complainants will be kept confidential except to the extent necessary for conducting the investigation. Any act or acts of intimidation or retaliation against any individual making a complaint shall be prohibited.

AUTHORITY NOTE: Promulgated in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.); 45 CFR, Part 80; Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 706).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§103. Applicability

A. The policy shall apply to all DHHR Offices providing financial, social or health care services. The policy shall also apply to any agency providing these services whether directly or indirectly or through contractual or other arrangements in accordance with those provisions of federal and state laws which prohibit discrimination in the delivery of services. This complaint procedure carries out the regulations for: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (P.L. 97-35), and federal block grants.

AUTHORITY NOTE: Promulgated in accordance with Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§105. Complaints

A. A complaint may be filed with DHHR-Civil Rights Bureau, DHHS-Office of Civil Rights or USDA at the following addresses:

1. Department of Health and Human Resources (DHHR), Office of the Secretary, Civil Rights Bureau, 200 Riverside Mall, Suite 102, Baton Rouge, LA 70802.

2. Department of Health and Human Services (DHHS), Regional Office for Civil Rights, 1200 Main Tower, Suite 1900, Dallas, Texas 75202.

3. U.S. Department of Agriculture, Office of the Secretary, Washington, D.C. 20250.

4. Those Food and Nutrition Service Program complaints (FNS) administered by the Office of Family Services, including food stamps, that allege discrimination but have other programmatic problems will be referred to the Appeals Section, DHHR, Office of the Secretary.

5. Those Civil Rights complaints received by the Appeals Section, DHHR, Office of the Secretary, will be referred to the Civil Rights Bureau.

B. The complaint must be filed no later than 180 days from the date of the alleged discriminatory act or acts.

C. The complaint must describe the type of discrimination alleged, indicate when and where such discrimination took place, and describe all pertinent facts and circumstances surrounding the alleged discrimination.

D. After determining that the complaint falls within the jurisdiction of DHHR-Office of Civil Rights, the director of Civil Rights Bureau-DHHR will initiate a prompt and thorough investigation of the complaint.

E. The complainant must be given a status report within 30 days of receipt of the complaint.

F. DHHR-Civil Rights Bureau will maintain records to show the nature of the complaint, the details of the investigation and the actions taken.

G. Quarterly reports of complaints will be submitted to the secretary.

H. All complaint records will be available for review by DHHS, USDA and other responsible officials.

AUTHORITY NOTE: Promulgated in accordance with Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 2. Louisiana Physician Order for Scope of Treatment

§201. Statement of Policy

A. The Department of Health and Hospitals is committed to the following.

1. It is important for people to make health care decisions before a medical crisis presents itself.

2. Health care planning is a process, rather than a single decision, that helps individuals to consider the kind of care they would want if they become seriously ill or incapacitated, and encourages them to talk to their family members or legal representative about such issues.

3. The Louisiana Physician Order for Scope of Treatment "LaPOST" form documents the wishes of a qualified patient in a physician order.

4. The hallmarks of the LaPOST form are the following:

a. immediately actionable, signed physician orders on a standardized form;

b. orders that address a range of life-sustaining interventions as well as the patient's preferred treatment for each intervention;

c. a brightly colored, clearly identifiable form;

d. a form that is recognized, adopted, and honored across treatment settings.

B. The provisions of this rule are permissive and voluntary. The completion of the Louisiana Physician Order for Scope of Treatment form merely illustrates a means of documenting a decision of a patient relative to withholding or withdrawal of medical treatment or life-sustaining procedures.

1. Nothing in this rule shall be construed to require the completion of a Louisiana physician order for scope of treatment form.

2. Nothing in this rule shall be construed to be the exclusive means by which life-sustaining procedures may be withheld or withdrawn, nor shall this rule be construed to require the application of medically inappropriate treatment or life-sustaining procedures to any patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.64.1-1299.64.6.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 37:1604 (June 2011).

§203. Definitions

A. The definitions found in R.S. 40:1299.64.2 apply to this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.64.1-1299.64.6.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 37:1604 (June 2011).

§205. LaPOST Form

A. An individual who desires to execute a LaPOST form must use the form created by the Department of Health and Hospitals. The form may not be altered in layout or style, without the express written permission of the Department of Health and Hospitals.

B. The form to be used for the Louisiana physician order scope of treatment, as provided in R.S. 40:1299.64.1-64.6, can be found at www.La-POST.org.

C. The LaPOST form found at www.La-POST.org is the exclusive form that shall be used to document the wishes of a qualified patient in a physician order for scope of treatment under this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.64.1-1299.64.6.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 37:1604 (June 2011).

§207. Execution of the LaPOST Form

A. A LaPOST form can only be executed by a competent adult patient or if the patient is incompetent or otherwise lacks capacity, a personal health care representative.

B. The LaPOST form must be completed by a physician based on patient preferences and medical indications.

C. The LaPOST form shall:

1. list the qualified patient’s last name, first name and middle initial, and date of birth;

2. list the qualified patient’s life-limiting and irreversible condition;

3. check all physician orders that apply. Any section not completed implies full treatment for that section;

4. indicate with whom the physician discussed summary of goals and the basis for the orders;

5. contain the physician's signature;

6. contain the patient or personal health care representative's signature and date.

D. The LaPOST form can be executed on behalf of a qualified patient by a personal health care representative only if the patient is incompetent to make their own decisions or lacks capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.64.1-1299.64.6

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 37:1604 (June 2011).

§209. Review of the LaPOST Form

A. The LaPOST form should be reviewed periodically by the physician and the patient, including, but not limited to, when:

1. the patient is transferred from one care setting to another;

2. there is a substantial change in the person's health care status; or

3. the patient's treatment preferences change.

B. A new LaPOST form should be completed if the patient wishes to make a substantive change to their treatment goal (eg., reversal of prior directive).

C. When completing a new LaPOST form, the old LaPOST form must be properly voided and retained in the medical chart. A notation that a new form has been executed should be stated on the old LaPOST form.

D. To void a LaPOST form, a line should be drawn through the "Physician's Orders" section of the LaPOST form and "VOID" should be written in large letters. The notation should be signed and dated by the physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.64.1-1299.64.6.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 37:1604 (June 2011).

§211. Revocation of the LaPOST Form

A. The LaPOST form may be revoked at any time by the patient or his/her personal health care representative by expressing his/her intent verbally, in writing, or by destroying the LaPOST form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.64.1-1299.64.6.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 37:1605 (June 2011).

Chapter 3. Meetings of Self-Help Organizations Dedicated to Recovery and Abstinence from Alcohol and Drugs in DHHR Facilities

§301. Purpose, Scope and Applicability

A. It is the policy of the Department of Health and Human Resources to encourage members of self-help groups, such as, but not limited to, Alcoholic Anonymous (AA), Narcotic Anonymous (N.A.), Tough Love, Women For Sobriety (W.F.S.) and other bonafide self-help organizations dedicated to recovery and abstinence from alcohol and drugs to establish regularly scheduled meetings in the department's general hospitals with alcoholism and drug abuse treatment programs, in mental health hospitals with such programs, and in outpatient facilities operated and managed by OPRADA; and where appropriate, to support patient access to community based meetings of such self-help groups.

B. The Office of Prevention and Recovery from Alcohol and Drug Abuse is directed to develop written guidelines to assist DHHR facilities and members of self-help groups in initiating a plan of cooperation for implementing viable self-help groups within the department's general hospitals, mental hospitals, and OPRADA community treatment facilities. These guidelines shall incorporate a statement of the department's commitment to utilize the A.A./N.A. and other bonafide self-help recovery programs in its treatment of persons with alcohol and drug problems; provisions for designating a DHHR staff person to serve as liaison with these groups, and with volunteer members of such groups; recommendations for format and content of formal agreements between DHHR facilities and group volunteers conducting group meetings, such as: support of patient participation, protection of patients' rights, confidentiality, specific agreement on time, place conduct of meeting, responsibilities of facilities' staff and volunteers and facilities' security.

C. These guidelines shall also address recommended provisions for patients' access to community based self-help group meetings. In developing these guidelines, OPRADA shall be mindful of the department's ultimate responsibility for the patient, responsibility which cannot be subject to contradictory decisions by self-help group representatives.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 5. Disclosure of Confidential Information

§501. General Provisions

A. These rules implement Section 7 of Title 44 of the Louisiana Revised Statutes by establishing procedures whereby medical records may be exhibited to or copied by

persons legitimately and properly interested in the disease or condition of patients.

B. It is the policy of the department to protect, to the fullest extent possible, the privacy of individuals, while permitting the disclosure of confidential information as is required to fulfill the administrative responsibilities of the department, to further scientific research, and to assist the patient/client.

C. These rules apply to every agency within the department which maintains or makes use of medical or confidential information concerning individuals. If an agency is governed by federal regulations which provide stricter standards or confidentiality, these rules shall be deemed superseded by the federal regulations, to the extent that they are in conflict with the federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§503. Definitions

Agency—each hospital, clinic, institution, school for the mentally deficient, mental health facility, office, bureau, division, board, commission or other entity which has been placed within the Department of Health and Human Resources, which maintains or makes use of medical information concerning individuals.

Department—the Department of Health and Human Resources.

Designated Representative—a physician or mental health professional selected by a patient to review the patient's medical record for the purpose of determining what information in the patient's record will be disclosed to the patient.

Medical Emergency—a situation where, in competent medical judgement, disclosure of medical information is reasonably necessary and any delay in attempting to procure the patient's consent to disclosure of medical information would jeopardize the life or health of the patient or could reasonably result in disfigurement or impairment of faculties.

Medical Information—the charts, records, reports, documents, and other memoranda prepared by physicians, surgeons, psychiatrists, nurses, and employees of the public hospitals, public mental health facilities, public schools for the mentally deficient, public health facilities and other agencies to record or indicate the past or present, mental or physical condition of parents.

Mental Health Professional—psychiatrists, psychiatric social workers, psychiatric nurses and psychologists.

Minor—any unemancipated individual who has not attained the age of eighteen years.

Patient Identifying Information—the name, address, social security number, or similar information by which a patient's identity can be determined with reasonable accuracy and speed.

Person—any individual, partnership, corporation, association, organization, state or federal department, or state or federal agency.

Superintendent—the superintendent of any hospital that is an agency of the department and includes the director or the highest ranking official of an agency not headed by a superintendent.

Tutor—either parent of a minor where both parents are living and married to each other; the parent having legal custody of the minor; where the parents are separated or divorced; the surviving parent of the minor if one of the parents is deceased; any court appointed tutor or guardian; and the secretary of the department where custody of the minor has been awarded to an office or agency of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§505. Confidentiality and Disclosure

A. Medical records shall be confidential and may only be disclosed as authorized by these rules.

B. Patient's medical records shall continue to be confidential after the patient is discharged from an agency or is no longer receiving treatment from an agency.

C. Secondary medical information shall be disclosed in the same manner as primary medical information for disclosures made pursuant to §509 of these rules. For disclosures made pursuant to §§507 and 511 an agency shall disclose secondary medical information only if such disclosure is clearly intended by the patient and if the preparer of the secondary medical information authorizes its disclosure. Whenever an agency denies a request for disclosure of secondary medical information pursuant to this rule, the agency shall refer the person requesting the secondary medical information to the preparer of the information. For purposes of this rule, primary medical information means medical information that has been prepared by a person who is an employee of or a contractor with the agency which has custody of the information. Secondary medical information means medical information that is contained in the agency's patient record that was prepared by someone who is not an employee of or a contractor with the agency.

D. Any disclosure made pursuant to these rules, whether with or without the patient's consent, shall be limited to information necessary in light of the need or purpose for the disclosure, as is determined by the superintendent.

E. Records Concerning Disclosure

1. When medical information is disclosed pursuant to §507 of these rules, a copy of the consent form shall be placed in the patient's record. A notation shall be made on

the consent form indicating the time and date disclosure was made and the name of the person by whom disclosure was made. When medical information is disclosed pursuant to §509 of these rules, except pursuant to §509.A, a written memorandum shall be made in the patient's record containing the following information:

a. the name of the patient;

b. the time and date on which disclosure was made;

c. the purpose of the disclosure;

d. the person to whom disclosure was made;

e. the person by whom disclosure was made;

f. the information disclosed;

g. a brief description of the basis for disclosure such as patient consent, medical emergency, scientific research, program evaluation, audit, etc. If disclosure does not contain any patient identifying information, no disclosure record is required. (A sample disclosure record is attached.)

2. No person or agency to whom medical information has been disclosed shall further disclose such information except as authorized by these rules.

3. Whenever a written disclosure of medical information is made under the authority of these rules, a notice shall accompany the medical information. This notice shall state: "The medical information contained herewith is confidential pursuant to the law of Louisiana and the rules of the Department of Health and Human Resources. Further disclosure of this information in a form which contains patient identifying information and in a manner inconsistent with state law and regulations is prohibited." Whenever medical information is disclosed orally, the recipient shall be warned that redisclosure is prohibited.

4. Before any disclosure of medical information is made, the superintendent shall use reasonable means to verify the identity and/or status of the person whom disclosure is to be made.

F. Copies of Records. The agency shall charge the person to whom disclosure is made a fee of $1 per copied page to defray the cost of photocopying. If the person to whom disclosure is to be made is a court of competent jurisdiction, a physician, a health facility, a state or federal agency or a school, no fee shall be charged.

G. Medical Information Concerning Minors. Except as is provided in §§509 and 1311 of these rules, medical information concerning a minor can only be disclosed upon the written consent of the parent or tutor of the minor. However, if the minor has consented to medical treatment pursuant to R.S. 40:1095 (treatment for illness or disease), R.S. 40:1095 (treatment for drug abuse), or R.S. 40:1065.1 (treatment for venereal disease), medical information can only be disclosed upon the consent of the minor. Consent to disclosure of medical information which has been executed by a minor shall not be subject to a later disaffirmance by reason of his minority. Upon the advice and direction of a treating physician, a physician or a member of a medical staff may, but shall not be obligated to, inform the spouse, parent or tutor of the minor as to the treatment given or needed and this information may be given or withheld without the consent and over the express objection of the minor.

H. Medical Information Concerning Interdicts. Except as provided in §509 of these rules, medical information concerning an interdict shall only be disclosed upon the written consent of the curator of the interdicted patient.

I. Medical Information Concerning Deceased Persons. Except as provided in §509 of these rules, medical information concerning a deceased person shall be disclosed upon the written consent of the administrator or executor of the succession of the decedent. In the event no administrator or executor has been appointed, the decedent's spouse, parent, or any child of the age of majority is authorized to execute the written consent.

J. Medical Information Concerning Incapacitated Patients. Except as is provided in §509 of these rules, medical information concerning a patient who is temporarily incapacitated from consenting to disclosure because of physical or mental infirmities as is determined by the attending physician, shall be disclosed only upon the written consent of the patient's spouse, major child, or parent.

K. Refusal to Consent to Disclosure of Records. Except as otherwise provided in these rules, all patients have the right to refuse to consent to the disclosure of medical information concerning themselves and no agency shall refuse medical treatment to a patient solely because he refuses to consent to the disclosure of medical information about himself.

L. Delegation of Authority by the Superintendent. Whenever these rules assign a function or responsibility to a superintendent, the superintendent may delegate this function or responsibility to any employee under his control, who, in the superintendent's opinion, is qualified to perform the function or responsibility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§507. Disclosures with the Patient's Consent

A. Consent to disclosure of medical information must be in writing and must contain the following:

1. the name of the patient;

2. the name of the agency which is to make the disclosure;

3. the name or title of the person to whom disclosure is to be made;

4. the purpose or need for disclosure;

5. the extent or nature of the information to be disclosed;

6. the date on which the consent is given;

7. statement that consent is subject to written revocation at any time, except to the extent that action has already been taken on it;

8. specification of the date, event or condition upon which consent will expire without written revocation;

9. the signature of the patient or person authorized by these rules to sign in lieu of the patient;

10. the signature of at least one witness. Each consent form must bear original signatures. Copies of signed consent forms are not acceptable. (Sample consent forms are attached in appendix.)

a. Any consent given under these rules is revocable in writing at any time, except to the extent that action has been taken in reliance thereon. Consent shall continue to be effective until it is specifically revoked in writing, or until the time, date or condition specified has occurred.

B. Disclosures for the Purpose of Diagnosis, Treatment, or Education. Where consent is given in accordance with §507.A, disclosure of medical information may be made to medical personnel, to treatment programs, or to educational facilities where disclosure is needed to better enable them to furnish services or instruction to the patient to whom the information pertains.

C. Disclosure to Family Members

1. Where consent is given in accordance with §507.A, disclosure of medical information may be made to a member of the patient's family.

2. Disclosures to third party payers and funding sources including insurance companies.

3. Where consent is given in accordance with §507.A, disclosure of medical information may be made to third party payers and funding sources including insurance companies, but such disclosure must be limited to that information which is reasonably necessary for the discharge of the legal or contractual obligations of the third party payer or funding source. Ordinarily, disclosures under this rule will consist of the patient's name and address, diagnosis, treatment and the charges for the treatment provided.

E. Disclosures to Employers. Where consent is given in accordance with §507.A, disclosure of medical information may be made to a current or prospective employer of a patient. Ordinarily, disclosures under this rule will be limited to verification of medical treatment or a general evaluation of the patient's progress or prognosis.

F. Disclosures to a Patient's Attorney. Where consent is given in accordance with §507.A.20, disclosure of medical information may be made to a patient's attorney upon the attorney's written request.

G. Disclosures to Persons Not Covered by These Rules. In any situation not otherwise provided for in these rules, where consent is given in accordance with §507.A, disclosure of medical information may be made to any person if the superintendent determines that the disclosure was clearly intended by the patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§509. Disclosures without the Patient's Consent

A. Disclosures among Office and Department Employees

1. Disclosure of medical information among the employees of an agency is authorized without the consent of the patient where the employee has a legitimate need for the information in connection with his duties. For purposes of this rule, "employees of an agency" shall include persons under contract with the agency and the employees of private contractors providing services to an agency. The superintendent is authorized to determine what constitutes legitimate need.

2. Disclosure of medical information from one agency to an employee of another agency is authorized without the consent of the patient only in the following situations:

a. when the disclosing agency is required by state law or regulation to provide medical information to the receiving agency;

b. when the disclosing agency and the receiving agency participate in a cooperative program and the medical information is maintained for the purposes of the cooperative program;

c. when an agency has referred one of its patients, clients or residents to another agency for evaluation or treatment; and

d. when an agency cannot perform its function without access to medical information and consent to disclosure of medical information cannot reasonably be obtained.

3. The superintendent of the disclosing agency shall determine whether one of the four enumerated situations exists.

B. Disclosures in Case of Medical Emergencies. Disclosure of medical information to medical personnel and law enforcement personnel is authorized without the consent of the patient to the extent necessary to meet a genuine medical emergency.

C. Disclosures to Qualified Personnel for the Purpose of Scientific Research, Statistical Compilation, Audit or Evaluation

1. Disclosure of medical information to qualified personnel is authorized without the consent of the patient, for the purposes of scientific research, statistical compilation, audit and evaluation when the information disclosed does not contain patient identifying information. The term *qualified personnel* means persons whose training and experience are appropriate to the nature and level of the

work in personnel. The superintendent shall use reasonable means to determine the qualifications of the personnel requesting disclosure under this rule. If the person compiling the scientific research, statistical analysis, audit or evaluation report believes that patient identifying information is essential to his compilation, he shall direct his request for information in writing to the secretary of the department. This request shall contain an explanation of the nature and purpose of the compilation and of the reason patient identifying information is deemed essential. The secretary shall review the request and shall authorize the disclosure of the medical information containing patient identifying information only if he determines that the value of the compilation outweighs the patient's right to privacy. If the request is granted, the secretary shall advise the person making the request that his request is granted subject to the following conditions:

a. that the final compilation will not contain any patient identifying information;

b. that the recipient will be given access, during regular working hours, to medical information containing patient identifying information from which he may abstract the information sought, but that he will not be allowed to remove medical records containing patient identifying information or copies thereof from the agency's premises;

c. that, as soon as the compilation is complete, the recipient will either destroy the abstracts of the medical information in its entirety or will remove the patient identifying information therefrom and will destroy the patient identifying information;

d. that the person receiving the medical information will assume all civil responsibility for invasion of privacy if he violates either of the above conditions;

e. that the person receiving the medical information will sign an agreement to abide by these conditions.

2. Upon receipt of the agreement of compliance, the secretary shall authorize the agencies involved to release the medical information. If the secretary determines that the value of the compilation does not outweight the patient's right to privacy he may either deny the request or may authorize disclosure of the medical records with the patient identifying information deleted.

D. Disclosures to Law Enforcement Personnel. When a patient commits or threatens to commit a crime on an agency's premises, disclosure of the following information to law enforcement personnel is authorized without the consent of the patient: the patient's name, location at the time the crime was threatened or committed, address and last known whereabouts. When an agency receives for treatment a child who has been the subject of abuse or neglect, as is determined by the treating physician or mental health professional, the agency may disclose to law enforcement personnel, without the consent of the child or his parent or tutor, the name and address of the child, the name and address of the person presenting the child for treatment, and such medical information about the child that would support the conclusion that the child had been abused or neglected. Nothing in this rule shall be construed as limiting the right of law enforcement personnel to medical information where such information is needed to meet a genuine medical or law enforcement emergency.

E. Disclosures for Purposes of Disciplinary Action. When the appointing authority of an agency seeks to take disciplinary action against an employee of the agency on the grounds of inadequate or improper patient care, the appointing authority shall describe the inadequate or improper patient care in the letter effecting or confirming the disciplinary action. The letter shall refer to the patient by number only. Upon the request of the attorney representing the agency or of the disciplined employee or his attorney, the agency shall provide copies of the medical records relied upon for the disciplinary action. These copies shall contain the patient number, but shall not contain the name of the patient. Thereafter, these copies may be filed as exhibits with the Civil Service Commission or a court of competent jurisdiction. Disclosures under this rule do not require the consent of the patient to whom the information pertains.

F. Disclosures Pursuant to Court Orders and Subpoenas. Nothing in these rules in intended to impede the disclosure of medical information pursuant to an order of a court of competent jurisdiction, a subpoena, or other discovery device including, but not limited to, interrogatories, depositions, requests for production, and requests for admissions, where a patient's condition is at issue in or relevant to a judicial proceeding. The superintendent shall take reasonable measures to ascertain whether a patient's condition is at issue or relevant before disclosure is made.

G. Disclosures Required by State or Federal Law. Nothing in these rules is intended to impede the disclosure of medical information when such disclosure is required by state or federal law. (Cross references: R.S. 14:403, 40:18, 40:39; 40:1065; 40:1065.1, 40:1095, 40:1096, 40:1102, 40:1299.21, 40:1299.76, 40:2013.3, 40:2014.1, 40:2017.9, 40:2124,40:2143, 44:7).

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§511. Disclosures to Patients

A. Patient's Right of Access to Medical Information

1. Every patient has a qualified right of access to medical information concerning himself which is maintained by an agency.

2. Any patient who seeks to exercise his right of access to medical information concerning himself shall direct his request in writing to the superintendent of the agency which maintains the records. This request shall contain sufficient information to enable the agency to locate the records sought and shall designate a representative who would be willing to review the records and inform the

patient of its contents or allow the patient to inspect his record, at the representative's discretion.

3. The patient shall be granted direct access to medical information concerning himself only if the superintendent determines that direct access is not likely to have an adverse effect on the patient. If the superintendent believes that he is not qualified to determine, or if he does determine, that direct access to the patient is likely to have an adverse effect on the patient, the record shall be sent to the designated representative. The patient shall be notified in writing when the record is sent to the designated representative. The designated representative shall review the patient's record and shall inform the patient of its contents or allow the patient to inspect the record, at the representative's discretion.

B. Minor Patients' Access to Medical Information

1. A minor patient who seeks to exercise his right of access to medical information shall direct his request in writing to the superintendent in accordance with §511.A.

2. A minor patient shall not be granted direct access to medical information concerning himself. Whenever a minor patient seeks access to medical information about himself, the superintendent shall send the records to the designated representative who will review the minor patient's record and inform the minor of its contents or allow the minor to inspect his record at the representative's discretion.

C. Access to Medical Information Concerning a Minor Patient by Persons Other Than the Minor Patient. A parent or tutor of a minor patient who seeks access to medical information concerning his minor child or ward shall direct his request in writing to the superintendent in accordance with §511.A.

D. Use of the Designated Representative Where a Parent or Tutor Requests Access to a Minor Patient's Medical Records. A parent or tutor of a minor patient shall not be granted direct access to medical information concerning his minor child or ward. Whenever a parent or tutor seeks access to medical information concerning his minor child or ward, the superintendent shall determine whether disclosure of the information would constitute an unwarranted invasion of the minor's privacy. If the superintendent determines that disclosure would constitute an unwarranted invasion of the minor's privacy, he will bring this to the attention of the designated representative. The designated representative will then consider the effect that disclosure of the information to the parent or tutor would have on the minor patient in determining what information contained in the minor's medical record will be made available to the parent or tutor.

E. Patient's Right to Disclosure Record. Upon the written request of a patient or of a person authorized by these rules to give consent on behalf of a patient, the superintendent shall provide the patient with a copy of the disclosure record required by §505.A.

F. Reports Concerning Patients. Upon the written request of a patient or his attorney or of a patient's heirs or their attorney, the superintendent shall furnish a full report on the patient.

G. Disclosures to Patients at Physician's Initiative. Nothing in this Section shall be construed as prohibiting a physician or mental health professional from permitting a major or minor patient to review his own medical record where the physician or mental health professionals considers this disclosure to be in the patient's best interest.

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§513. Disclosure Forms

A. Patient /Client Form

DISCLOSURE RECORD
FOR
(Name of Patient)

FOR INITIATING OFFICE USE ONLY
(For Optional Use Only)

Care record name: _____
Care record number: _____
Social Security #: _____
Return to: _____

DDHR Form 1
Issued 12/80

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
CONSENT TO DISCLOSURE OF CASE INFORMATION
WAIVER OF CONFIEDNTIALITY
PATIENT/CLIENT FORM

I, _____, understand that the information contained in my record is confidential. However, I give my consent for _____ to release to _____ the following specific information:

_____

_____

The above-listed information is to be disclosed for the specific purposes of _____. This consent is subject to written revocation at any time except to the extent that action has already been taken upon this consent. This consent will automatically expire _____.

_____ Witness

_____ Signature of Patient/Client

_____ Witness

_____ Date

B. Authorized Representative Form

FOR INITIATING OFFICE USE ONLY
(For Optional Use Only)

Care record name: _____
Care record number: _____
Social Security #: _____
Return to: _____

DDHR Form 2
Issued 12/80

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
CONSENT TO DISCLOSURE OF CASE INFORMATION
WAIVER OF CONFIEDNTIALITY
FORM FOR AUTHORIZED REPRESENTATIVE

I, _____, am the _____ of _____, a _____. I understand that the information constined in _____'s record is confidential. However, I give my consent for _____ to release to _____ thr following information :

_____

_____

The above-listed information is to be disclosed for the specific purposes of _____. This consent is subject to written revocation at any time except to the extent that action has already been taken upon this consent. This consent will automatically expire _____.

_____ Date	_____ Signature of Authorized Representative
_____ Witness	
_____ Witness	_____ Signature of Patient/ Client, if a minor (if applicable see instruction)

C. Primary Source Form

FOR INITIATING OFFICE USE ONLY
(For Optional Use Only)

Care record name: _____
Care record number: _____
Social Security #: _____
Return to: _____

DDHR Form 3
Issued 12/80

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
CONSENT TO DISCLOSURE OF CASE INFORMATION
WAIVER OF CONFIEDNTIALITY
PRIMARY SOURCE FORM

_____ hereby authorizes _____ to release to _____ the following specific information:

_____
_____

_____ Witness	_____ Authorized Signature of Health Care Provider
_____ Witness	_____ Date

AUTHORITY NOTE: Promulgated in accordance with R.S. 44:7.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 6. Uses and Disclosures of Information for Public Health Emergency Preparedness Activities

§601. Purpose and Scope

A. The purpose of this rule is to authorize health care providers operating in the state of Louisiana to use and disclose protected health information (PHI) to the Louisiana AtRisk Registry, or any other reporting database or registry employed by the Louisiana Emergency Support Function (ESF) 8, for the sole purpose of participating in emergency preparedness training activities, which includes exercises to test the AtRisk Registry.

B. The scope of this rule covers all hospitals, home health agencies, hospice agencies, and other health care providers who are enrolled in the Louisiana AtRisk Registry. The rule authorizes health care providers to use and disclose PHI to the Louisiana AtRisk Registry, or any other reporting database or registry employed by ESF 8, for the purpose of participating in public health emergency preparedness activities, unless prohibited by other state or federal law or regulation. This Chapter does not authorize unlawful disclosure of patient PHI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, 40:5 and 29:766(E).

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 46:356 (March 2020).

§603. Definitions

A. Unless otherwise specifically provided herein, the following words and terms used in this Part are defined for the purposes thereof as follows:

AtRisk Registry—a database used by Louisiana Emergency Support Function (ESF) 8 to manage patient information related to the Medical Institution Evacuation Plan.

Disclosure—has the same meaning as set forth in 45 C.F.R. §160.103.

Emergency Preparedness—has the same meaning as set forth in R.S. 29:723.

Health Care Provider—has the same meaning as set forth in 45 C.F.R. §160.103.

Home Health Agency—has the same meaning as set forth in LAC 48:I.9101.

Hospice—has the same meaning as set forth in LAC 48:I.8201.

Hospital—has the same meaning as set forth in LAC 48:I.9303.

Protected Health Information (PHI)—has the same meaning as set forth in 45 C.F.R. §160.103.

Public Health Authority—has the same meaning as set forth in 45 C.F.R. §160.501.

Use—has the same meaning as set forth in 45 C.F.R. §160.103.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, 40:5 and 29:766(E).

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 46:357 (March 2020).

§605. Permitted Uses and Disclosures for Public Health Emergency Preparedness Activities

A. Protected health information (PHI) of patients of home health agencies and hospice agencies may be used and disclosed for emergency preparedness training activities and for an actual event when:

1. the patient of the home health agency or hospice agency or the patient's legal representative has signed a Health Insurance Portability and Accountability Act (HIPAA)-compliant authorization for use and disclosure of PHI; and

2. the home health agency or hospice agency certifies on a weekly basis that the patient meets at least one of the following criteria:

a. the patient lives alone, without a caregiver and is unable to evacuate himself;

b. the patient has a caregiver, but the caregiver is physically or mentally incapable of complying with an evacuation order;

c. the patient does not have the financial means to comply with an evacuation order; or

d. the patient refuses to evacuate.

B. A hospital may use and disclose PHI without the patient's consent or knowledge for the purpose of its participation in public health emergency preparedness activities, including, but not limited to, training, assessment, and program development, if the provider's use of the PHI meets the requirements of Paragraph 1 below, or if the provider's disclosure of the PHI meets the requirements of Paragraphs 1 and 2 below.

1. The use or disclosure is necessary for the treatment of the individual or for public health activities authorized by law, including public health emergency preparedness activities.

2. The disclosure is made to a public health authority, its agent, or to another hospital or other health care provider involved in the public health emergency preparedness activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, 40:5 and 29:766(E).

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 46:357 (March 2020).

§607. Treatment of Protected Health Information

A. For both emergency preparedness training activities and actual public health emergency events, the health care provider shall upload patient protected health information (PHI) to the Louisiana AtRisk Registry.

1. The Louisiana AtRisk Registry shall maintain PHI on a secure File Transfer Protocol (FTP) server.

2. After an event or training, all data uploaded to the Louisiana AtRisk Registry FTP server shall be deleted and be non-recoverable.

B. Access to PHI on the Louisiana AtRisk Registry shall be limited to the following entities.

1. Louisiana Department of Health (LDH) shall have access to all patient PHI in the Louisiana AtRisk Registry throughout the state.

2. The Regional Disaster Recovery Center (DRC) shall have access to PHI for patients within its region.

3. Enrolled hospitals shall have access only to its patient's PHI. If a patient is transferred to another hospital, both the sending and receiving hospitals shall have access to the patient's PHI.

4. Enrolled hospice and home health agencies shall have access only to its patient's PHI.

5. The Louisiana-Mississippi Hospice and Palliative Care Organization (LMHPCO) shall have access to PHI of patients of all enrolled hospice and home health agencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4, 40:5 and 29:766(E).

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 46:357 (March 2020).

Chapter 7. Disposition of an Unclaimed Body Held by a DHHR Hospital or Residential Facility

§701. Facility Responsibility

A. It is the policy of the Department of Health and Human Resources that Superintendents of all DHHR hospitals and residential facilities adhere to R.S. 9:1551; 17:2274, 2275; regarding the disposition of a body unclaimed by relative or friends.

1. Under the language of R.S. 17:2274(A), the DHHR institution in which the deceased lived prior to death would temporarily retain the custody of the unclaimed body. If the decedent had no known assets or property of sufficient value to defray the expenses of burial and burial must be at public expense, the superintendents of such facilities shall first notify the department's Office of Hospitals, Bureau of Anatomical Services that they have custody of an unclaimed body and that there are no legal impediments to releasing the body. This notice shall be given to the Bureau of Anatomical Services (hereafter referred to as BAS), no later than 36 hours after the death of the patient.

B. For purposes of convenience and economy of transportation, the state has been subdivided into two regions by a line drawn diagonally across the state just southeast of Monroe, Alexandria and Lake Charles. Institutions in the southeast region (including New Orleans-Jefferson, Baton Rouge, Lafayette, etc.) may contact the Bureau of Anatomical Services at the main office in New Orleans [AC:(504) 568-4012, or LINC 621-4012] (24 hour service). Those institutions in the northwest region (including Shreveport, Bossier City, Monroe, Ruston, Alexandria, Lake Charles, etc.) may contact the BAS for the purpose of reporting a body by calling the LSU Shreveport Medical School Security Office [AC:(318) 226-3369] (24 hour service).

C. When contacting the BAS, the following information should be made available:

1. name;

2. age;

3. sex;

4. race;

4. cause of death;

5. signed copy of death certificate; and

6. burial transit permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:1551, 17:2274, 17:2275.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§703. Bureau of Anatomical Services

A. Upon receipt of this notice, the BAS may accept the unclaimed body solely for the purposes of promoting anatomical knowledge and research and organ transplant. BAS may authorize immediate eye enucleation from any body made available to it. Expenses incurred in connection with the notice or delivery and transportation of bodies are paid by the BAS. The bureau distributes bodies to Louisiana medical and dental schools and the schools must hold any body received from BAS for at least 90 days during which time any friend or relative of the decedent may claim the body for burial.

B. In the event the BAS declines to accept the body, and the body remains unclaimed, the institution would then notify the coroner and the coroner would arrange for burial. Coroners may also authorize eye enucleation from unclaimed bodies (R.S. 17:2352, 2354.1 and 33.1561).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:1551, 17:2274, 17:2275, 17:2352, 17:2354.1, 13:1561.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§705. Stillbirths

A. The BAS must be notified of unclaimed stillbirths (DHHR's Office of General Counsel Opinion No. 79-20). A stillbirth is defined as a birth "... after at least 20 weeks of gestation, or a weight of 350 grams or more, in which the child shows no evidence of life after complete birth" (R.S. 40:32(5).

B. It should be noted, however, that the BAS has little need for stillborns and normally cannot bear the transportation costs involved, especially from distant parts of the state. Therefore, the bureau will most likely decline to accept the unclaimed stillbirth. If the bureau declines to accept the unclaimed stillbirth, the coroner is notified and is responsible for burial in a manner which complies with R.S. 8:651-662, 9:1551, and 33:1561.1.

C. As there is no requirement that death certificates be issued for fetal deaths where the fetus is less than 20 weeks in gestation or weighs less than 350 grams, burial is not required and a DHHR hospital may dispose of such fetuses as it deems appropriate in the best interest of public health (DHHR's Office of General Counsel Opinion 79-20).

D. Each DHHR hospital and residential facility shall accept this as their policy and procedure on the disposition of bodies unclaimed by relatives or friends, and if the decedent had no known assets or property of sufficient value to defray the expenses of burial, and burial must be at public expense. This material shall be made available to all appropriate staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:1551, 17:2274, 17:2275, 40:32(5), 8:651-662, 33:1561.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 9. Notification of Next of Kin in Cases of Death in a DHHR Institution/Facility

§901. Purpose and Scope

A. It is the policy of DHHR that every reasonable effort shall be made to locate and notify promptly the next of kin (or guardian/custodian) of any patient/client who dies in a DHHR institution or facility. Written procedures shall be adopted in every institution or facility for the notification of next of kin to minimize any emotional stress or undue hardship in the event of the death of patient/client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:1568.1, 33:1561.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§903. Applicability

A. In accordance with R.S. 33:1568.1, it is the duty of the coroner to make every reasonable effort to notify the next of kin in all cases of deaths for which he has jurisdiction, including but not limited to deaths enumerated in R.S. 33:1561(A).

B. Additionally, Act 250 passed in the 1983 regular session of the Louisiana Legislature states that in all other cases, including cases where a person dies of natural causes, the following persons, or their designees, shall make every reasonable effort to notify the next of kin within 48 hours of discovery of the death:

1. the attending physician, if the patient has been examined by the physician within 36 hours prior to death or the medical officer on duty at the time of death; or

2. the administrator of the hospital in which the person dies; or

3. the administrator or executive director of the nursing home or other facility in which the person dies; or

4. the chief of police or other chief officer of a local law enforcement agency which discovers the body of the deceased; or

5. if the patient/client is a prisoner from a penal facility the physician shall notify the penal institution which has the responsibility to notify the next of kin.

C. If a body remains unclaimed, procedures for the disposition of an unclaimed body (DHHR Policy 0010-80) shall be followed. Every DHHR institution/facility shall comply with all other federal and state laws and licensing requirements regarding notification of next of kin.

AUTHORITY NOTE: Promulgated in accordance with R.S. 33:1568.1, 33:15161, Act 250 of 1983.

HISTORICAL NOTE: Promulgated by Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 11. DHHR Policy on use of Restraints, Seclusions and Medications with Gary W. Classmembers

§1101. Introduction

A. The Department of Health and Human Resources, through negotiating sessions with parties before the special master in the Gary W. case, agreed to disseminate behavior management policies interactive of those outlined in the Principal Order of Gary W. et al vs. State of Louisiana et al, dated October 28, 1976. Each office is responsible for assuring that internal behavior management practices comply with this order. Illustrations of non-compliance as used in this policy were provided by the special master's office. Reference numbers as used in this policy (examples 3.8, 3.12) refer to specific sections of the Principal Order.

AUTHORITY NOTE: Promulgated in accordance with R.S. Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1103. Definitions

Active Physical Restraints—any device which acts to limit or restrict mobility of an individual's body or body part or parts excepting those devices specifically prescribed by a physician for bracing or for therapeutic positioning. Examples of active physical restraints include posey belts, ankle cuffs, safety restraints, and straight jackets.

Legend Drug—those drugs requiring a prescription for dispensing under federal law.

Non-Legend Drugs—those drugs which do not require a prescription for dispensing under federal law (i.e., aspirin, petroleum jelly, etc.).

Superintendent—the person who is primarily responsible for the operation of any facility; director; administrator. This definition also includes the individual specifically designated by the superintendent to act on his behalf during his absence from the facility, such as the duty officer.

Qualified Professional—

1. A psychologist with at least a master's degree from an accredited program and with specialized training or two years of experience in treating emotionally disturbed, mentally retarded or learning disabled children whose condition is similar to the condition of the children being served.

2. A physician licensed under state law to practice medicine or osteopathy and with specialized training or two years of experience in treating emotionally disturbed, mentally retarded or learning disabled children whose condition is similar to that of the children being served.

AUTHORITY NOTE: Promulgated in accordance with R.S. Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1105. Medication and Chemical Restraint

A. (3.8) The medication prescribed for each child (classmember) shall be noted in his records. At least monthly the attending physician shall review the drug regimen of each child (classmember) under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. The child's (classmember's) records shall state the effects of psychoactive medication on the child (classmember). Unnecessary or excessive medication shall not be administered by any child (classmember).

B. (3.9) Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the child's (classmember's) treatment program.

C. (3.10) No medication shall be administered except by persons who have been appropriately trained.

D. Illustrations

1. A classmember was reported to be receiving a high dosage of psychoactive medications, but was not participating in any behavior modification program.

2.a. A classmember receiving the following medications was observed sleeping when he or she should have been in class and at lunch:

i. haldol;

ii. dilantin;

iii. thorazine;

iv. phenobarbital; and

v. mellaril.

b. Staff described the classmember as lazy and as one who sleeps excessively.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987)

§1107. Seclusion and Time Out

A. (3.11) No child (classmember) shall be placed alone in a locked room, either as punishment or for any other purpose. Legitimate "time out" procedures may be utilized under close and direct professional supervision. DHHR interprets this requirement as applicable to prescriptions for legend drugs only.

B. (3.12) These standards shall apply to "time out" procedures:

1. (3.121) they are to be imposed only when less restrictive measures are not feasible;

2. (3.122) placement shall be in an unlocked room with a staff member constantly nearby in a place where the staff member can supervise the child (classmember);

3. (3.123) the child (classmember) shall have access to bathroom facilities as needed;

4. (3.124) the period of isolation or segregation shall not exceed 12 hours unless renewed by a qualified professional;

5. (3.125) except in an emergency situation in which it is likely that a child (classmember) would harm himself or others, the decision to a place a child (classmember) in "time out" shall be made pursuant to a written order by a qualified professional, following a personal interview with the child (classmember) and an evaluation of the episode or situation said to require isolation or segregation. Any such order must specify the terms and conditions of "time out" and the rationale for the decision; and

6. (3.126) emergency use of "time out" shall be limited to a period of not more than one hour and shall conform to all of the provisions set forth in Paragraphs B.1-6 of this Section. (The attention of the parties is invited to the situation that may be presented by a child (classmember) who may harm himself or others by running away repeatedly. Their suggestions with respect to appropriate additional provisions are invited.)

C. Illustrations

1. An auditor reported that seclusion was frequently employed as punishment.

2. An auditor reported that on a specific date a classmember was left in the quiet room by staff. The auditor also observed that the classmember was left unattended in the quiet room for more than an hour and that the classmember was not checked during that time.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1109. Physical/Mechanical Restraint

A. (3.13) Physical restraints shall be employed only when absolutely necessary to protect the child (classmember) from injury to himself or to prevent injury to others. Restraints shall not be employed as punishment, for the convenience of staff, or as a substitute for a treatment program. A child (classmember) shall be restrained only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose; and then only in accordance with the following standards.

1. (3.131) An order for restraint shall be in writing and shall not be in force for longer than 12 hours.

2. (3.132) Except in an emergency situation only qualified professionals may authorize the use of restraints.

3. (3.133) A child (classmember) placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be kept.

4. (3.134) Mechanical restraints shall be designed and used so as not to cause physical injury to the child (classmember) and so as to cause the least possible discomfort.

5. (3.135) Opportunity for motion and exercise shall be provided for a period of not less than 10 minutes during each two hours in which restraint is employed.

6. (3.136) Daily reports shall be made to the superintendent by those qualified professionals ordering the use of restraints, summarizing all such use of restraints, the types used, the duration, and the reasons therefore.

7. (3.137) Emergency use of restraints shall be authorized only by the superintendent of the institution, shall be limited to a period of not more than one hour and shall conform to all of the provisions set forth in Pararaphs 3, 4 and 5 of this Section.

8. Illustrations

a. Staff reported to an auditor that restraints were used with a classmember, but the auditor found no record of it in the classmember's file.

b. Staff of the special master's office were told that staff ties a classmember to his/her wheelchair to avoid having to pursue him/her as the classmember is active.

c. An ambulatory classmember was observed by the judge and the special master restrained in a rocking chair due to staff shortage.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1111. Instructions to Offices

A. Each office will immediately notify its employees and those service providers for whom it has funding authority of the following.

1. The use of active physical restraints except as provided for in the Gary W. Court Order is strictly prohibited by DHHR.

2. The use of medication for non-therapeutic reasons as a chemical restraint is strictly prohibited by DHHR.

3. The use of seclusion is strictly prohibited by DHHR.

B. The above will be required information for dissemination to all new employees, where appropriate, prior to assumption of duties.

C. Any DHHR employee found to be in violation of this policy will be subject to disciplinary actions such as official reprimand, suspension, and dismissal.

D. Individuals and agencies in the private sector serving DHHR clients shall adopt this policy and enforce it including provisions for disciplinary action with employees found to violate the policy. The DHHR will enforce this policy through progressive sanctions which could include a plan of corrective action, a moratorium on placements, and the removal of DHHR funded clients.

E. Where more stringent federal or state regulations govern a facility's behavior management practices, this policy will not supercede those regulations.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana, et al Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 13. DHH Policy on Reporting Alleged Abuse, Neglect, Mistreatment and Deaths of Gary W. Class Members

§1301. Policy Statement

A. This document is a revision to 13:299 (May, 1987), DHH Policy on Reporting Alleged Abuse, Neglect, Mistreatment and/ or Deaths of Gary W. Classmembers. The primary purpose of this document is to ensure a more effective, efficient and responsive system of reporting incidents involving Gary W. class members. Additional purposes include:

1. to differentiate types of incident:

2. to differentiate allegations of abuse/neglect from unusual occurrences which are reported directly to the Gary W. Project Office and unusual occurrences which are reported to the designated agency representative:

3. to provide procedures for reporting unusual occurrences, abuse/neglect allegations and the death of a class member;

4. to outline the responsibilities of significant parties: E. to explain corrective action and note the consequences for failure to implement corrective action.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 4-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987). amended LR 14:535 (August 1988).

§1303. Definitions

Abuse—any act which would endanger the well-being of a class member through the action of any individual, whether or not the class member is or appears to be injured or harmed. Abuse is categorized as follows:

1. *Physical Abuse*—physical contact including, but not limited to, hitting, slapping, pinching, kicking, hurling, strangling, shoving or otherwise mishandling of a class member. Physical contact that endangers the safety of the class member as well as handling of a class member with more force than is reasonably necessary also constitutes physical abuse.

2. *Sexual Abuse*—any sexual activity between the class member and educators, day care providers, employees, consultants, contractors and class members. Additionally, sexual abuse is any sexual activity between class members and others, or among class members unless the class member(s) involved is a consenting adult. Sexual abuse includes any touching or fondling of a class member directly or through clothing for the arousal or gratification of sexual desires of the perpetrator. It also includes encouraging a class member to touch or engage in any sexual activity with another person for the purpose of arousing or gratifying sexual desires.

3. *Psychological (Emotional) Abuse*—the use of verbal or non-verbal expressions in a tone of voice or in such a manner that subjects a class member to ridicule, humiliation, scorn or contempt.

4. *Seclusion*—the placement of a class member alone in a secured room from which he or she cannot leave at will. Seclusion is considered to be a form of abuse and is prohibited. Time out is not to be confused with seclusion. Time out, when used in accordance with the procedures set forth in Appendix A to this policy, is permissible.

Corrective Action Plan—a specific plan of action to minimize the harmful impact or rectify incidents and to eliminate and control the potential for abuse/neglect. The plan outlines specific action to be taken by specific parties with target dates for completion.

Facility—any place, however named, that provides:

1. any form of residential services; or

2. any form of day program services to class members.

Facility Administrator—the individual with ultimate responsibility for the daily operations of a facility.

Incident—the occurrence or suspected occurrence of any of the following: *abuse*, *neglect*, or *unusual occurrence*.

Multiple Incidents—the occurrence of three or more incidents to a class member in any six-month period shall constitute a multiple incident.

Neglect—a negligent act or omission by any individual responsible for providing services or supervision to a class member which caused or may have caused injury to the class member or which placed the class member at risk or injury, and includes an act or omission such as the failure to provide adequate nutrition, supervision, clothing, or health care, or the failure to provide a safe environment for the class member.

Responsible Individual—the individual such as a foster parent, substitute family parent or staff person ultimately responsible for a supervised apartment, who is responsible for the care and program of a class member who is residing in a small facility.

Small Facility—any facility which has no employees and/or any facility which serves three or fewer class members, including, but not limited to, foster care, substitute family care and supervised apartment (but not including community class members).

State Investigation Report—any investigation report prepared by a State agency.

Unusual Occurrences—

1. *Elopement*—any absence of a class member from a program or placement which constitutes a danger to the wellbeing of that class member.

2. *Restraint*—any device which prevents the free movement of either/or both arms or legs, totally immobilizes a class member, or any medication ordered by a physician which renders the class member unable to participate in therapeutic, programmatic, or leisure activities.

3. *Medication Error*—the administration of medication in an incorrect form, not as prescribed or ordered, to the wrong class member, the failure to administer a prescribed medication, or the failure to correctly record (i.e. chart) a prescribed medication where such failure produces one of the aforementioned.

4. *Criminal Acts*—alleged actions by a class member such as homicide, attempted homicide, rape, public lewdness, robbery, theft, or any violations of the law.

5. *Accidents*—any injury to a class member which was caused accidentally or unintentionally.

6. *Fights Involving Class Members*—any use of physical force between or including one or more class members, whether or not injury occurs, in which staff were not involved except for purposes of stopping the fight.

7. *Injuries Whose Cause Cannot be Determined*—any suspected or confirmed wound or harm to a class member whose cause cannot be determined, which results in a class member requiring medical attention by a physician, dentist, nurse, or any health care provider.

8. *Sensitive Situations*—delicate situations, not included in the aforementioned, which may have the potential to affect adversely the care, safety and/or well-being of a class member.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:535 (August 1988).

§1305. Where to Report Incidents

A. Incidents which must be Reported to the Gary W. Project Office. All incidents of:

1. physical abuse, sexual abuse, seclusion, unauthorized or inappropriate use of restraint, and neglect must be reported to the Gary W. Project Office;

2. any injury to a class member, no matter what the cause, which requires more than first aid (for example, any injury which requires: treatment by a physician, hospitalization, stitches, or more than one visit by a health care provider); or

3. elopement of class members whose absence constitutes a recognized danger to the possible well being of that class member or others would be reported immediately to the project office. For class members not in this category, the decision for reporting the absence shall be based on reasoned judgment, by taking into consideration the client's habits, deficits, mental status, capabilities, health problems, and similar considerations, but shall in no instance exceed 72 hours.

4. the occurrence of any of the above incidents shall be reported by the project office to the Quality Assurance Monitoring Group/Independent Monitoring Unit within 24 hours of their receipt of the report.

B. Incidents which must be Reported to the Designated Representative of the Local Oversight Committee

1. All incidents involving psychological abuse, all elopements in excess of 24 hours, and all unusual occurrences must be reported to the Local Oversight Committee, except those noted above in Paragraphs A.2-3. In case of reasonable doubt about whether an incident should be reported to the Gary W. Project Office or to the local oversight committee, the incident must be reported to the Gary W. Project Office with a comment or notation that the person who is reporting the incident is in doubt as to whom the incident should be reported.

C. Flow and When to Report an Incident

1. Each facility shall at all times have two designated representatives who are available to receive incident reports from employees at any time.

2. Every employee of a facility must report any incident both in writing and by telephone to either the Gary W. Project Office or to the designated representative in accordance with Subsections A-B of this Section of this policy whenever the employee becomes aware of or has reason to believe that an incident has occurred.

3. The written report shall be filed on a Standard Incident Report Form and must be filed (or mailed) immediately, but in no event later than 24 hours following the incident. A copy of the incident report must also be sent to the class member's case-manager. The telephone report, containing all available information regarding the incident, must be made immediately, but in no event later than 12 hours following the incident.

4. Any employee who reports an incident to the Gary W. Project Office shall also report the incident to a designated representative and the facility administrator. If the employee believes that the designated representatives are involved in the incident, the employee shall report the incident to the Gary W. Project Office and to the facility administrator, his or her designee, or some other member of

management of the facility and note his or her belief regarding the involvement of the designated representative.

5. The designated representative shall immediately review the incident report to ensure that it has been properly reported in accordance with this recommendation. If further reporting is required, the designated representative shall immediately (i.e. not later than 24 hours after receiving the employee's report) forward the report to the Gary W. Project Office and/or the casemanager. In addition, the designated representative shall send a copy of each incident report to the local oversight committee.

6. In the event that a verbal or telephone report of an incident involving a community class member is received by DHH from any individual, the DHH employee who receives the report will immediately communicate the information by telephone to the Gary W. Project Office. The project office will immediately communicate the report by telephone to the class member's casemanager. The casemanager will take appropriate action to prepare and file a standard incident report form immediately, but in no event later than 24 hours from the time the casemanager was notified by the project office of the incident.

D. Casemanager

1. Whenever a casemanager has reason to believe that an incident has occurred, he/she shall immediately determine whether an incident report has been filed under these rules. If an incident report has not been filed, the casemanager shall immediately report both the suspected incident and the failure of the facility to file an incident report to the Gary W. Project Office.

E. Special Rules for Small Facilities

1. Any person associated with a small facility who has responsibility to provide care and/or service to one or more Gary W. classmembers must report any incident both in writing and by telephone to the Gary W. Project Office whenever that person becomes aware of or has reason to believe that an incident has occurred.

2. The written report shall be filed on a standard incident report form and must be filed immediately, but in no event later than 24 hours following the incident. A copy of the incident report must also be sent to the class member's casemanager. The telephone report, containing all available information regarding the incident, must be made immediately, but in no event later than 24 hours following the incident.

3. Responsibility for investigation of allegations of incidents in small facilities shall be as follows: The state will investigate all incidents of abuse and neglect and the following unusual occurrences: restraint, medication error, injuries whose cause cannot be determined, and elopement of the kind described in A.3 of this Section. For all other incidents, the Gary W. Project office may, in its discretion, request the responsible individual to conduct the investigation, but the state must conduct the investigation if:

a. there is any reason to believe that the responsible individual or any member of his/her family or staff were involved in the incident; and

b. this is a multiple incident.

4. Investigation of all incidents in small facilities shall commence within 12 hours of the receipt of the telephone report of the incident. During this 12-hour period, the investigator shall visit the facility and meet with the class member. The investigation shall be completed as soon as possible but, in any event, no later than 30 days after it was started.

5. The provision of this policy contained in Subsections A-C of this Section and §1307 and any references to the local oversight committee shall not apply to small facilities.

6. All other provisions of this policy shall apply to small facilities.

F. Special Rules for Community Class Members. The following rules govern investigations of incidents involving community class members:

1. The OHD investigative unit will investigate all incidents of abuse and neglect and the following unusual occurrences: restraint and injuries whose cause cannot be determined. For all other incidents, the casemanager shall conduct the investigation.

2. Investigation of all incidents involving community class members shall commence within 12 hours of the receipt by the Gary W. Project Office of a telephone report of an incident. During the 12-hour period, the investigator shall visit with the class member. The investigation shall be completed as soon as possible but, in any event, no later than 30 days after it was started.

3. The provision of this policy contained in Subsections A-C of this Section and §1307 and any references to the local oversight committee shall not apply to community class members.

4. All other provisions of this policy shall apply in small facilities.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:536 (August 1988).

§1307. Responsibility for Investigations at Facilities Other than Small Facilities and Other than for Community Class Members

A. Except as otherwise provided in the following subsection, the state is responsible for investigating all incidents which are reported to the Gary W. Project Office.

B. In its discretion, the Gary W. Project Office may instruct the facility to investigate any incident which is reported to the Gary W. Project Office, except that the state must investigate all incidents listed in §1305. A .1 and 3 of

this policy. In addition, the state must investigate any injury to a class member which requires more than first aid whose cause cannot be determined or which occurs at the facility and may investigate any other injury which, in the discretion of the Gary W. Project Office, should be investigated by the state.

C. The facility shall be responsible for investigating all incidents which are reported exclusively to a designated representative under §1305.B. of this policy. The designated representative who receives the incident report shall conduct the investigation.

D. If the Gary W. Project Office makes a decision to have the facility conduct an investigation of an incident reported to the project office, it shall communicate that instruction by telephone to a designated representative within 12 hours of receipt of the incident report.

E. Investigation of all incidents shall commence within 12 hours of the receipt of the phone report of the incident. During this 12-hour period, the investigator will visit the facility and meet with the class member. The investigation shall be completed as soon as possible but, in any event, no later than 30 days after it was started.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:537 (August 1988).

§1309. Format for Investigation

A. Purpose and Standard of Proof. The purpose of the investigation is to determine if the allegation of abuse, neglect or other unusual occurrence can be substantiated by a fair preponderance of the credible evidence. That means that based upon a review of the believable evidence, an incident is more likely than not to have either occurred or not occurred. The investigator is to determine whether or not an incident occurred, even if the investigator cannot determine the cause or perpetrator of the incident. All investigations must use the standard form entitled Investigation Report.

B. Content of Investigation

1. Each investigation shall contain:

a. a summary description of any allegations, including the name and job title (or address) of the person making the allegation;

b. a summary of any injuries or other harm to the class member;

c. summaries or verbatim transcripts of any statements made by witnesses;

d. an evaluation by the investigator of the credibility of any witnesses, including any reasons for conclusions about the witnesses' credibility (e.g. personal involvement, bias);

e. a summary of any statements made by experts concerning their opinions as to the cause of any incident (e.g. statements by a physician whether an injury is likely to have been accidental);

f. an evaluation of the evidence by the investigator and his/her conclusion whether the allegation is valid, invalid, or invalid with concerns (listing the concerns);

g. any recommendations for corrective action;

h. steps taken to protect class member(s) during pendency of investigation.

C. Method of Proceeding

1. As a minimum, each investigator must:

a. review all medical reports connected with the alleged incident;

b. interview all witnesses to the incident;

c. interview all staff who were responsible for the class member at the time of the incident;

d. take notes or record each interview and prepare a summary of each interview;

e. where appropriate, take photographs of any injuries;

f. where appropriate, seek an evaluation of the incident from professionals who either work with the class member or who treated any injuries associated with an alleged incident.

D. Filing of Investigation Report

1. Upon completion of the investigation and preparation of the investigation report, the person responsible for conducting the investigation shall immediately send a copy to the Gary W. Project Office, the local oversight committee, the casemanager for the class member(s) involved in the incident and the facility administrator. The Gary W. Project Office shall immediately send a copy of the investigation report to the Quality Assurance Monitoring Group/Independent Monitoring Unit, and plaintiff's counsel. In addition, the investigator shall conduct an exit interview with the facility administrator or his/her designee to outline findings and to cite recommendations.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:537 (August 1988).

§1311. Employee Discipline

A. Responsibility and authority for imposition of discipline rests with the facility administrator.

B. Each facility shall maintain and disseminate to its employees a written policy which shall include the following:

1. a clear prohibition of abuse/neglect of residents as those terms are defined herein;

2. the concept of progressive discipline. This means that except in instances of extremely serious or repeated misconduct, discipline should focus on providing additional training or support for staff along with disciplinary measures short of termination (e.g. probation, suspension) rather than seeking termination of the employee as the first option;

3. measures to protect class members from an employee suspected of abuse/neglect during the pendency of any investigation. Such measures may include suspension, removing the employee from contact with and/or responsibility for the class member, transferring the employee to another facility or other measures as may be appropriate for the circumstance;

4. a requirement that final disciplinary action, if any, be taken within 48 hours of receipt of the investigation report, unless an employee admits responsibility for an incident of abuse/ neglect or other compelling circumstances warrant immediate final action. Final disciplinary action should generally await the receipt of the investigation report.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil 'Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:538 (August 1988).

§1313. Local Oversight Committee

A. Responsibility

1. Each facility shall have a local oversight committee whose responsibility it is to:

a. review all reported incidents;

b. monitor, review and analyze investigations of incidents;

c. make recommendations to the facility administrator regarding corrective actions which are designed to reduce the risk of future incidents, including but not limited to recommendations regarding: staff training and orientation programs; personnel policies regarding employee discipline; staffing patterns; pre employment screening procedures; staff recruitment, and criteria for hiring;

d. make recommendations to the facility administrator regarding any corrective action plan which may be requested by the Gary W. Project Office.

2. The minutes of all meetings of the Local Oversight Committee along with any recommendations issued by the committee shall be forwarded within three days of the Committee's meeting to a) the facility administrator and b) the Gary W. Project Office.

B. Composition of Local Oversight Committee

1. The Local Oversight Committee shall include, at a minimum:

a. the facility administrator/or designee

b. a direct care staff member

c. at least two of the following:

i. a relative

ii. consumer

iii. advocacy group representative

iv. consultant (nurse, social worker, etc.) not employed by the facility or the DHH.

2. Meetings of the local oversight committee cannot proceed until the representative of each of the above groups is present.

3. The Human Rights Committee of any facility may perform the functions of the local oversight committee so long as the Human Rights Committee contains representatives from each of the groups designated in this Paragraph. Where the facility's Human Rights Committee is composed of a majority of facility personnel, a subcommittee reflecting the composition in B1., 2., and 3. shall serve as local oversight committee.

4. There shall be equal representation on the local oversight committee between non-facility representatives (Subparagraph B.3.) and the combined number of facility representatives (Subparagraphs B.1. and B.2.). Further, no meeting of the local oversight committee may proceed unless there are at least as many non-facility representatives present at the meeting as facility representatives.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:538 (August 1988).

§1315. Procedures Following Receipt of Investigation Report

A.1. Within 24 hours of its completion, copies of the investigation report shall be sent to:

a. the facility administrator;

b. the Local Oversight Committee; and

c. the Gary W. Project Office.

2. Within 24 hours of receipt of the Investigation Report, the Gary W. Project Office will send a copy of the investigation report to the Quality Assurance Monitoring Group/Independent Monitoring Unit and plaintiff's counsel.

B. The facility administrator shall take final disciplinary action, if any, in accordance with §1311.

C. The local oversight committee shall review all investigation reports of any incident which was investigated by a designated representative.

D. Within seven business days of receipt of a state investigation report the Gary W. Project Office, either directly or upon request of a program office, shall request a

corrective action plan from a facility in any of the following instances:

1. in the case of death (when deemed appropriate or when requested by the Quality Assurance Monitoring Group/Independent Monitoring Unit) or serious injury to a class member;

2. in any instance in which there appears to be a pattern of abuse or neglect within a facility;

3. in any instance in which there appears to be inadequate supervision of staff within a facility;

4. in any other instances in which the Gary W. Project Office or a program office determines that such a corrective action plan is necessary or desirable to protect class members.

E. The Gary W. Project Office may include certain minimum actions which must be included in the corrective action plan. All corrective action plans shall state what disciplinary action, if any, was taken relative to the incident.

F. All corrective action plans shall be implemented within 15 days unless the Gary W. Project Office agrees to an extension of not more than 30 additional days.

G. Copies of the corrective action plan shall be sent to those persons and entities listed in A. of this Section.

H. The secretary and appropriate program offices of DHH shall be responsible for ensuring that corrective action plans have been implemented. The Gary W. Project Office shall be responsible for monitoring and tracking corrective action plans and shall request documentation from the facility for this purpose. In addition, the Gary W. Project Office, through the case-manager, shall conduct at least two on-site inspections of the facility in the six-month period following the preparation of the corrective action plan to ensure that the plan is being implemented. Deficiencies in the implementation of the plan shall be called to the attention of the facility administrator and corrected within 30 days. Verification of the corrections shall take place within 30 days thereafter by an on-site inspection by the case-manager. A certification of correction will be issued by the Gary W. Project Office upon verification of all corrections. Copies of the certification of corrections shall be sent to those persons and entities listed in A. of this Section.

1. Technical assistance in the development and implementation of corrective action plans will be available to a facility at any time, upon request, through the Gary W. Project Office. In addition, a facility may be required to accept technical assistance as part of a corrective action plan.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:539 (August 1988).

§1317. Death

A. In addition to the other requirements of this policy, in the case of death of a class member, the case manager will submit as soon as available to the Gary W. Project Office, the Quality Assurance Monitoring Group/Independent Monitoring Unit, and plaintiff's counsel, a summary, inclusive of the following:

1. the incident report;

2. a copy of the death certificate;

3. the date and time of day parents/guardians were notified and how they were notified;

4. an autopsy report (if performed);

5. a copy of social summary inclusive of class member's legal status and placement history;

6. a copy of the investigation prepared or arranged by the Attorney General's office, as mandated by law. DHH shall request such an investigation; and

7. other information as may be requested by the external oversight committee or Quality Assurance Monitoring Group/Independent Monitoring Unit.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:539 (August 1988).

§1319. Responsibilities of State Program Offices

A. The primary responsibility of a state program office (Office of Community Services; Office of Mental Health, Mental Retardation and Prevention and Recovery from Alcohol and Drug Abuse - Mental Health; Office of Mental Health, Mental Retardation and Prevention and Recovery from Alcohol and Drug Abuse - Mental Retardation; and the Office of Eligibility Determinations) relative to abuse/neglect is to provide assistance and information to the Gary W. Project Office and to casemanagers. Additional responsibilities include:

1. providing direction, information and technical assistance to providers and facility administrators as needed and directed;

2. serving as consultant to service providers on specific issues pertinent to enhancing services and eliminating and/or controlling problems, as directed;

3. serving as a consultant to the Gary W. Project Office with respect to requests for corrective action plans;

4. making recommendations to the secretary of DHH regarding sanctions and ensuring implementation of corrective action plans.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246

(April, 1987), amended LR 13:299 (May, 1987), amended LR 14:539 (August 1988).

§1321. Responsibilities of Gary W. Project Office

A. The primary responsibility of the Gary W. Project Office is to serve as the initial contact to facilities on incidents and abuse/ neglect allegations. In addition to other responsibilities, the Gary W. Project Office will:

1. collect and analyze data generated by incident and abuse/neglect allegation reporting;

2. draw inferences from this data to make recommendations to enhance the delivery of services and to eliminate and/or control incidents and abuse/neglect allegations:

3. identify trends in incidents and/or allegations of abuse/neglect and recommend action if needed;

4. arrange the initial training on incident and abuse/neglect policy and procedures as needed and as directed;

5. provide facilities with updated information pertinent to abuse/neglect:

6. forward pertinent information to casemanagers. the state program offices, the Quality Assurance Monitoring Group/ Independent Monitoring Unit; the Investigative Unit; facilities, DHH's Executive Management and significant others deemed appropriate;

7. serve as liaison to the Quality Assurance Monitoring Group/Independent Monitoring Unit;

8. consult with the appropriate state program office regarding the need for and/or content of a corrective action plan in cases involving serious incidents of abuse/neglect or a pattern of abuse/neglect;

9. review the minutes and recommendations prepared by local oversight committees;

10. prepare a summary report every six months which includes the following information:

a. data related to the circumstances of allegations, when and where the allegation reportedly occurred, specific precipitating factors and repeated alleged victims or perpetrators:

b. timeframe within which investigations were reported, investigated, and reviewed for follow-up of recommendations,

c. whether allegations were found to be sustained;

d. the degree of employee/agency supervisory culpability;

e. type of discipline imposed and corrective actions;

f. narrative summation statements identifying trends and corresponding preventive/corrective actions;

g. regional and provider trends vis-a-vis abuse-neglect incidents.

B. The Gary W. Project Office has responsibility for determining the presence of multiple incidents for all class members on a monthly basis. If a class member is involved in a multiple incident, the Project Office shall immediately notify that class member's casemanager as well as plaintiff's counsel and the Quality Assurance Monitoring Group/Independent Monitoring Unit and/or external oversight committee. The casemanager shall convene an interdisciplinary team meeting to review the cause of the incidents and to discuss any action which may be appropriate to reduce the risk of further incidents. Such actions may include technical assistance to the facility, a modification of the client's program or living arrangements or a change in placement. The casemanager shall ensure that any such needed actions are in fact implemented.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April. 1987), amended LR 13:299 (May, 1987), amended LR 14:540 (August 1988).

§1323. External Oversight Committee

A. DHH will ensure the development and maintenance of an External Oversight Committee. The function of the committee is to review and monitor the entire system of abuse/neglect reporting, investigation and correction, and all issues associated with the operation of the DHH policy on reporting abuse, neglect, death and/or mistreatment of Gary W. class-members.

B. In addition to the other reporting requirements established in this policy, the Gary W. Project Office will send the committee copies of its six-month summary reports. The committee will review these reports to determine compliance with state policies and procedures and to make recommendations for preventive/corrective action. The committee may recommend new policies, legislation or administrative rules to further reduce the risk of abuse/neglect of class members. Recommendations prepared by the external oversight committee shall be sent to the secretary of DHH: the Gary W. Project Office: the state program office and plaintiff's counsel.

C. DHH shall assure that the external oversight committee has access to technical expertise in the administration of programs for persons with developmental disabilities to carry out its responsibilities under this policy.

D. As long as the Office of the Special Master and/or the Quality Assurance Monitoring Group exists, it shall perform all the functions of the committee set out above. Upon the termination of the order relating to the Independent Monitoring Unit, the parties shall submit recommendations for an independent monitoring unit to the court and the court will select and appoint a unit to undertake these activities and serve as the external oversight committee.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al.. vs. State of Louisiana. Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246

(April. 1987). amended LR 13:299 (May. 1987), amended LR 14:540 (August 1988).

§1325. Sanctions

A. The provider will be subject to sanctions, penalties, or possible withdrawal of client for failure to comply with this policy or with requests issued by DHH pursuant to this policy. The severity of such action will depend on:

1. the nature of the violation (degree to which a class member's safety. well-being and care have been jeopardized):

2. the frequency of the violation:

3. the persistent failure to follow DHH/facility policy and procedure.

B. Penalties and/or sanctions include:

1. loss of funding;

2. closure;

3. cancellation of contract;

4. criminal charges;

5. fines up to $1,000 a day.

C. The state program office and/or the Gary W. Project Office will recommend sanctions to the secretary of DHH as appropriate.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May1987), amended LR 14:540 (August 1988).

§1327. Confidentiality

A. In accordance with R.S. 46:56 and 14:403, the identity of a reporter of an abuse/neglect allegation cannot be revealed.

B. All state and federal laws as well as DHH's policy on confidentiality apply to this policy.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary. LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:541 (August 1988).

§1329. Training

A. Coordination of training for the policy shall be the responsibility of DHH.

AUTHORITY NOTE: Promulgated in accordance with Gary W.. et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:541 (August 1988).

§1331. Provider Contracts/Agreements

A. All contracts/agreements between DHH and providers of day and residential services to class members shall state that the provider agrees to be bound by the terms and provisions of this policy.

AUTHORITY NOTE: Promulgated in accordance with Gary W.. et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:541 (August 1988).

§1333. General

A. None of the above is intended to replace, modify or otherwise change existing office/departmental procedures regarding the investigation of deaths or allegations of abuse, neglect or mistreatment. This procedure is solely for the purpose of ensuring that Gary W. classmembers are protected from harm and are provided safe environments.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April, 1987), amended LR 13:299 (May, 1987), amended LR 14:541 (August 1988).

§1399. Appendices

Appendix A

Procedures Governing Time Out

No class member shall be placed alone in a locked room, either as punishment or for any other purpose; Legitimate "timeout" procedures may be utilized under close and direct professional supervision.

These standards shall apply to "time out" procedures:

1. They are to be imposed only when less restrictive measures are not feasible;

2. Placement shall be in an unlocked room with a staff member constantly nearby in a place where the staff member can supervise the class member;

3. The class member shall have access to bathroom facilities as needed;

4. The period of isolation or segregation shall not exceed 12 hours unless renewed by a qualified professional;

5. Except in an emergency situation in which it is likely that a class member would harm himself or others, the decision to place a class member in "time out" shall be made pursuant to a written order by a qualified professional, following a personal interview with the class member, and an evaluation of the episode or situation said to require isolation or segregation. Any such order must specify the terms and conditions of "time out" and the rationale for the decision; and

6. Emergency use of "time out" shall be authorized only by the facility administrator, shall be limited to a period

of not more than one hour and shall conform to all of the provisions set forth in subparagraphs 1 - 3 of this Appendix.

Appendix B

Procedures Governing Use of Physical Restraints

Physical restraints shall be employed only when absolutely necessary to protect the class member from injury to himself or to prevent injury to others. Restraints shall not be employed as punishment, for the convenience of staff, or as a substitute for a treatment program. A class member shall be restrained only if alternative techniques have failed and only if such restraint imposes the least possible restriction consistent with its purpose; and then only in accordance with the following standards:

1. An order for restraint shall be in writing and shall not be in force for longer than 12 hours.

2. Except in an emergency situation, only qualified professionals may authorize the use of restraints.

3. A class member placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be made.

4. Mechanical restraints shall be designed and used so as not to cause physical injury to the class member and so as to cause the least possible discomfort.

5. Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed.

6. Daily reports shall be made to the facility administrator by those qualified professionals ordering the use of restraints, summarizing all such use of restraint, the types used, the duration, and the reasons therefor.

7. Emergency use of restraints shall be authorized only by the facility administrator, shall be limited to a period of not more than one hour, and shall conform to all of the provisions set forth in subparagraphs 3 - 5 of this Appendix.

Appendix C

Procedures Governing the Use of Medications

1. No medication shall be administered unless a written order of a physician prescribes it in writing.

2. The medication prescribed for each class member shall be noted in his records. At least monthly the attending physician shall review the drug regimen of each class member under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. The class member's records shall state the effects of psychoactive medication on the class member. Unnecessary or excessive medication shall not be administered to any class member.

3. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the class member's treatment program.

4. No medication shall be administered except by persons who have been appropriately trained.

AUTHORITY NOTE: Promulgated in accordance with Gary W., et al., vs. State of Louisiana, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 14:541 (August 1988).

Chapter 15. DHHR Pre-Movement Staffing Policy and Procedures for Gary W. Classmembers

§1501. Policy Statement

A. The following policy and procedures are in effect immediately and remain in effect for each classmember pending completion of the 2.1 evaluation process and implementation of a final individual comprehensive service plan. While DHHR intends to hold the movement of classmembers to a minimum during the evaluation process, it must be recognized that in some instances delaying a move may not be possible or in a classmember's long-ranged interests. It is, therefore, the intent of the process outlined below that careful review, planning, and consideration, with accompanying documentation, will be required in transferring a classmember to another facility or community-based residence. The policy assumes that, where appropriate, proposed residential placements have been reviewed and approved through the regional review process. Pre-movement staffing procedures will in no way replace the Regional Review Committee within its defined scope of responsibility.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1503. Notice of Intent to Move Classmembers (under ordinary circumstances)

A. Responsibility for notification rests with the facility from which transfer will be made.

B. Time of notification is 30 days prior to date of transfer.

C. Parties to be notified include the following:

l. classmember;

2. classmember's parent or guardian or representative;

3. responsible office (OMR, OHD, OMHSA, etc.) headquarters;

4. Gary W. Project Office;

5. OHD Case Coordinator.

D. Additional notifications will be made in the following manner:

1. the Gary W. project coordinator will notify the special master;

2. the special master will notify plaintiff's counsel.

E. The facility will notify the Gary W. coordinator in writing within five working days of determination of plans to transfer a classmember. The Gary W. project office will notify the special master's office in writing promptly upon receipt of written notification from the facility or impending transfer.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1505. Pre-Movement Staffing

A. The purpose of the staffing is to review appropriateness of proposed new living arrangements and associated program components to meeting the habilitative needs of a classmember for whom movement is planned.

B. Functions of the team are defined below:

1. to assure adequacy of the plan; and

2. to accept the plan as presented; or

3. to reject the plan as presented; or

4. to modify the plan or make recommendations for its enhancement.

C. The pre-movement staffing will be held during the 30 day period prior to classmember's transfer.

D. Components of the plan for transfer:

1. classmember's identifying information and legal status;

2. current placement individualized plans of treatment (if relevant);

3. proposed placement plan which includes a comprehensive description of services to be provided, logistical considerations, and transitional follow-up. The following information must be presented:

a. proposed placement's address, telephone number, and contact person's name;

b. anticipated date of placement;

c. proposed educational, pre-vocational, vocational, or other day program;

d. proposed date of enrollment or other starting date for daytime activity;

e. method through which consent for placement was obtained including any steps taken to assure that classmember was made knowledgeable of placement for which consent was requested;

f. significant others' nature or degree of relationship(s), location(s), frequency of contact, an attitude(s) toward proposed placement;

g. history of any previous placements relevant to the proposed placement, successes and/or reason for failure of placements;

h. current social functioning: peer relationships, degree of participation in recreational activities, relationships with authority figures;

i. classmember's strengths and personal or vocational aspirations;

j. significant behavior problems and information concerning any existing behavior management program which may be useful in new placement: target behavior(s), data collection method, reinforcers, consequences (if any);

k. medical history and current status including names, dosages, and purpose of medications and prescribing physican's name and phone number;

l. financial status and plans for transferring benefits, resources, and other entitlements (i.e., Medicaid card);

m. inventory of personal property and plans for transfer of property to new placement location;

n. plans for transporting classmember to new placement;

o. plan for transitional follow-up or supervision of new placement including case manager's name, address, and phone number;

p. identification of community resources which classmember will use in new placement:

i. transportation;

ii. recreational;

iii. religious;

iv. therapeutic; etc.

E. The following individuals will be invited to attend the pre-movement staffing:

1. a representative of facility from which movement is being made;

2. a representative of facility to which movement is being made;

3. a representative from current day program (i.e., SSD #1, LEA personnel, or vocational personnel);

4. OHD case coordinator;

5. any other assigned DHHR case coordinators;

6. classmember, if appropriate;

7. parent, guardian, or representative;

8. other staff of current placement who have either direct knowledge of the classmember or professional expertise relevant to classmember's condition and educational or habilitative needs;

9. a representative from the long term care section, if appropriate;

10. the special master or her designee. (The special master or her designee will monitor the staffing process and participate in discussion of plans, but will not be a party to team decision making.)

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1507. Documentation

A. A report of the pre-movement staffing will include significant items of discussion and rationale for decisions made by the team.

B. Parties present for the staffing, including classmember, parent or guardian or representative, and the special master or her designee, will sign an attendance sheet.

C. The report of the meeting, the movement plan, and the attendance sheet will be filed in the classmember's case record. A copy will be sent to the Gary W. coordinator for DHHR. The Gary W. coordinator will forward a copy to the special master.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1509. Extraordinary Circumstances

A. Extraordinary circumstances include the following:

1. medical emergency with implications for extended disability, and when such disability or serious threat to health requires a change in residential placement before the pre-movement conference could reasonably be scheduled;

2. behavioral emergency wherein classmember's behavior represents a serious threat to his/her safety or to the safety of others. (Property damage with significant financial or legal consequences or with concurrent risk of physical harm may also be considered.);

3. loss of current placement as a residential resource for classmember;

4. sudden opportunity for a less restrictive placement where prior planning has indicated that this is appropriate;

5. demand for movement by parent or guardian of a voluntary minor or by tutor of curator of an adult under continuing tutorship or interdiction;

6. demand for movement, presented in writing, by a voluntarily admitted classmember of majority age who has not been interdicted;

7. arrest or judicial commitment to another facility.

B. The procedure for staffing classmembers whose movement takes place under extraordinary circumstances follows.

1. The physical movement of a classmember may take place as necessary under conditions described above.

2. The movement will not, however, be considered a definite plan until the staffing requirements as outlined under §2705 have been met.

3. Notification requirements are modified such that verbal notification of the Gary W. project office must take place as soon as possible and be confirmed in writing within five working days. Written notificaton will include a thorough review of the extraordinary circumstances, and the date movement did (or will) take place.

4. Responsibility for planning and holding the pre-movement staffing conference will shift to the new facility. A representative of the former residential facility should attend the staffing.

5. Pre-movement staffing will be held at the earliest time at which informational and staff participation requirements can be met, but not later than 20 working days from date of first notification.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1511. Exception to Pre-Movement Staffing Policy

A. Acute treatment of medical or psychiatric illness, when it is reasonable to expect that the classmember will return to his/her previous residential placement, will not require implementation of the procedures outlined in this policy. Should it, however, become evident during the course of acute treatment, that the classmember will require extended medical or psychiatric care or a new residential placement, notification and staffing requirements will be met. Timelines will begin with the time at which a determination is made that the classmember is not likely to return to his/her residential placement within a reasonably predictable period of time.

B. Elopement, when the whereabouts of a classmember is unknown, will not require publication and staffing as described in this policy.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1513. Complications to Process

A. The Department of Health and Human Resources or its offices will not be deemed to be in violation of this policy because of any of the following events when every reasonable effort has been made to comply or to reach compromise solutions:

1. refusal or inability of a classmember, parent, guardian or representative to attend a staffing conference within prescribed time frames;

2. refusal of any staff person not employed by or through contract with the Department of Health and Human Resources to attend a staffing conference within prescribed time frames;

3. refusal or inability of a classmember or his/her parent, guardian, or representative to provide placement or program information within prescribed time frames for the staffing conference;

4. refusal of any person or agency not a part of or under contract with DHHR to provide placement or program information for the staffing conference within prescribed time frames;

5. refusal of the special master to attend or to appoint a representative to the staffing conference within prescribed time frames;

6. refusal of the classmember, or his/her parent, guardian, or representative to accept or follow the recommendations of the pre-movement staffing team;

7. refusal of residential or program provider to accept or follow the recommendations of the pre-placement staffing team when that provider is not a part of or under contract with DHHR;

8. Any other circumstances beyond the direct control of DHHR.

B. Such complications and all efforts to resolve them must be thoroughly documented and filed in the classmember's record.

C. Copies of documentation will be provided to the headquarters of the office responsible for the facility from which movement occurred.

D. Copies of documentation will be provided to the Gary W. project coordinator who will forward and discuss events with the special master's office.

E. Complications will not preclude the need for a staffing meeting.

AUTHORITY NOTE: Promulgated in accordance with Gary W. et al vs. State of Louisiana et al, Civil Action 74-2412.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 16. Admissions Criteria for Inpatient Facilities

§1601. Purpose and Scope

A. In accordance with the requirements of Act 1249 of the 2003 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals adopts admission criteria for inpatient facilities operated by the Department of Health and Hospitals. Admission criteria are specific to each DHH Office that operates inpatient facilities as indicated in this Rule. In accordance with R.S. 28:20(B) no person shall be admitted voluntarily, involuntarily, by court order, or by commitment to a department facility unless the person meets the criteria set forth in this Rule and Act 1249.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20 and R.S. 28:311(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:47 (January 2004).

§1603. Definitions

Adult—anyone age 18 and over.

Axis I Diagnosis—a reporting group in the Diagnostic and Statistical Manual for all the various mental disorders or conditions in the Classification except for Personality Disorders and Mental Retardation.

Child—anyone under age 18.

DSM—the Diagnostic and Statistical Manual that has a multi-axial system that includes an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcomes.

Level of Functioning Scale—assessment tool that passes defined standards for use as an evaluative tool and is thereby provided for professional use to define the degree to which an individual is capable of accomplishing various skills associated with managing activities of daily living.

Mental Retardation—significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

OAD—the Office for Addictive Disorders in the Department of Health and Hospitals.

OMH—the Office of Mental Health in the Department of Health and Hospitals.

Related Condition—a severe chronic disability that meets all the following criteria:

1. it is attributable to:

a. cerebral palsy or epilepsy; or

b. any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons;

2. it is manifested before the person reached age 22;

3. it is likely to continue indefinitely; and

4. it results in substantial functional limitations in three or more of the following areas of major life activity:

a. self-care;

b. understanding and use of language;

c. learning;

d. mobility;

e. self-direction; or

f. capacity for independent living.

Single Point of Entry (SPOE)—that process by which an individual is screened by an agent within an Office of Mental Health *(OMH)* service area who is responsible for certifying that the individual meets the criteria for admission to an *OMH* inpatient facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20 and R.S. 28:311(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:47 (January 2004).

§1605. Inpatient Facilities Operated by the Office of the Secretary

A. The following admission requirements apply to New Orleans Home and Rehabilitation Center and Villa Feliciana Medical Complex, both of which are long term care facilities operated by the Office of the Secretary.

B. Initial Requirements for Admission Consideration

1. The person has a medical condition(s) that require the supervision and treatment in a facility that provides 24-hour nursing care.

2. Pre-admission screening procedures for the Medicaid program must be followed to ensure appropriateness of admission.

C. Facilities Admission Criteria:

1. the person's medical/rehabilitation needs can be met within the resources and staffing available at the facilities;

2. the admission does not exceed the capacity, the services and/or population for which the facility is budgeted and operated; and

3. a means of financing the cost of care for each person admitted is available.

D. Exclusions

1. Persons who are dangerous to self and others, or who are charged with a crime, and who require the availability of a secure and locked area in order to ensure the safety and well being of other residents and employees of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20 and R.S. 28:311(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:47 (January 2004).

§1607. Inpatient Mental Health Facilities Operated by the Office of Mental Health

A. In order to be admitted a person must qualify as a candidate for services in an inpatient setting as indicated on a published Level of Functioning Scale or other instrument identified by the Office of Mental Health as clinically appropriate. Such Level of Functioning Scale must be based on scientifically accepted practice standards and must demonstrate adequate psychometric properties of validity and reliability. The person must also meet the standard for inpatient care as specified in the Office of Mental Health Single Point of Entry (SPOE) Admissions Criteria, which is specified in the following.

B. Adult Admission Criteria. At least one criterion from Severity of Illness must be met and all of the Intensity of Service Criteria must be met.

1. Severity of Illness Criteria (Must meet one or more of a, b, or c)

a. Patient presents as a danger to self as evidenced by:

i. a suicide attempt within the past 72 hours; or

ii. documentation that the patient has a current suicide plan, specific suicide intent, or recurring suicidal ideation; or

iii. documentation of self-mutilative behavior occurring within the past 72 hours.

b. Patient presents as a danger to others due to a DSM Axis I diagnosis as evidenced by any of the following:

i. dangerously aggressive behavior during the past seven days due to a DSM Axis I diagnosis; or

ii. threats to kill or seriously injure another person with the means to carry out the threat and the threatening behavior is due to a DSM Axis I diagnosis; or

iii. documentation that the patient has a current homicide plan, specific homicidal intent, or recurrent homicidal ideation and this is due to a DSM Axis I diagnosis.

c. Patient is gravely disabled and unable to care for self due to a DSM Axis I diagnosis as evidenced by:

i. documentation of a serious impairment in function (as compared to others of the same age) in one or more major life roles (school, job, family, interpersonal relations, self-care, etc.) due to a DSM Axis I diagnosis; and

ii. patient presents with acute onset or acute exacerbation of hallucinations, delusions, or illusions of such magnitude that the patient's well-being is threatened; or

iii. an inability of the patient to comply with prescribed psychiatric and/or medical health regimens as evidenced by the following:

(a). patient has a history of de-compensation without psychotropic medications and patient refuses to use these medications as an outpatient; or

(b). patient is at risk of health or life due to non-compliance with medical regimens (e.g., insulin-dependent diabetes, etc.) and patient refuses these medical regimens as an outpatient.

2. Intensity of Service Criteria

a. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis. These services include, but are not limited to:

i. suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others;

ii. active intervention by a psychiatric team to prevent assaultive behavior;

iii. 24 hour observation and medication stabilization necessitated by patient behaviors that indicate a therapeutic level of medication has not been reached; and

b. services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed by the patient; and

c. services in the community do not meet, and/or do not exist to meet the treatment needs of the patient, or the patient has been unresponsive to treatment at a less intensive level of care.

C. Children's Admission Criteria. At least one criterion from Severity of Illness must be met, and all of the Intensity of Service Criteria must be met.

1. Severity of illness criteria must meet one or more of Subparagraph a, b, or c:

a. the child is a danger to self (Clauses i, ii, iii or iv and v must exist to meet this criterion):

i. the child has made an attempt to take his/her own life in the last 24 hours. Details of the attempt must be documented; or

ii. the child has demonstrated self-mutilative behavior within the past 24-hours. Details of behavior must be documented; or

iii. the child has a clear plan to seriously harm him/herself, overt suicidal intent, recurrent suicide thoughts, and lethal means available to follow the plan. This information can be from the child or a reliable source. Details of the plan must be documented; or

iv. due to a DSM Axis I diagnosis, the child is in serious danger of dying or sustaining grave bodily injury to him/her self; and

v. it is the judgment of a mental health professional that the child is at a significant risk of making a suicide attempt or due to a DSM Axis I diagnosis, is in serious danger of dying or sustaining grave bodily injury to him/herself without immediate inpatient intervention;

b. the child is a danger to others or property due to a DSM Axis I diagnosis as indicated by: (Clauses i, ii, or iii and iv must exist and include the specific DSM criteria that justify this diagnosis):

i. the child has actually engaged in behavior harmful or potentially harmful to others or caused serious damage to property, which would pose a serious threat of injury, or harm to others within the last 24 hours. Description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to present; or

ii. the child has made threats to kill or seriously injure others or seriously damage property, which would pose a threat of injury or harm to others, and has effective means to carry out the threats. Details of the threats must be documented; or

iii. a mental health professional has information from the child or a reliable source that the child has a current plan, specific intent, or recurrent thoughts to seriously harm others or property. Details must be documented; and

iv. it is the judgment of a mental health professional that the child is at a significant risk of making a homicide attempt or engaging in other seriously aggressive behavior without immediate inpatient intervention;

c. the child is gravely disabled due to a DSM Axis I diagnosis as indicated by (Clauses i, and either ii, iii or iv must exist and include the specific DSM criteria that justify this diagnosis):

i. the child has serious impairment of functioning compared to others of the same age in one or more major life roles (school, family, interpersonal relations, self-care, etc.) Specific descriptions of the following must be documented:

(a). deficits in control, cognition or judgment;

(b). circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance;

(c). prognostic indicators which predict the effectiveness of inpatient treatment; and

ii. severe thought disorganization or clinical deterioration or the acute onset of psychosis has rendered the child unmanageable and unable to cooperate in non-hospital treatment; or

iii. there is a need for medication therapy or complex diagnostic testing where the child's level of functioning precludes cooperation with treatment in an outpatient or non-hospital based regimen, and may require close supervision of medication and/or forced administration of medication; or

iv. a medical condition co-exists with a DSM Axis I diagnosis which, if not monitored/treated appropriately, places the child's life or well-being at serious risk.

2. Intensity of Service Criteria

a. Treatment of the patient's psychiatric condition requires services on an inpatient hospital basis. These services include, but are not limited to:

i. suicide precautions, unit restrictions, and continual observation and limiting of behavior to protect self or others;

ii. active intervention by a psychiatric team to prevent assaultive behavior;

iii. 24 hour observation and medication stabilization necessitated by patient behaviors that indicate a therapeutic level of medication has not been reached; and

b. services provided in the hospital can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed by the patient; and

c. services in the community do not meet, and/or do not exist to meet the treatment needs of the patient, or the patient has been unresponsive to treatment at a less intensive level of care.

D. Exclusionary Criteria-Adult. If one or more of the following is met, admission is denied.

1. Patient has a major medical or surgical illness or injury that would prevent active participation in a psychiatric treatment program (patients must be medically stable).

2. Patient has criminal charges pending and does not have a DSM Axis I diagnosis.

3. Patient has anti-social behaviors that are a danger to others and those anti-social behaviors are characterological rather than due to a DSM Axis I diagnosis.

4. Patient has a DSM Axis II diagnosis of mental retardation without an accompanying DSM Axis I diagnosis.

5. Patient has a Substance Abuse Disorder as defined in DSM and does not otherwise meet the severity of illness and intensity of service criteria.

E. Exclusionary Criteria-Children. If one or more of the following is met, admission is denied.

1. The child has a major medical or surgical illness or injury that prevents active participation in a psychiatric treatment program.

2. The child has criminal charges pending and does not otherwise meet severity of illness and intensity of service criteria.

3. The child has anti-social behaviors that are a danger to others and does not have a DSM Axis I diagnosis.

4. The child has a DSM Axis II diagnosis of mental retardation and does not otherwise meet severity of illness and intensity of service criteria.

5. The child lacks a place to live and/or family supports and does not otherwise meet severity of illness and intensity of service criteria.

6. The child has been suspended or expelled from school and does not otherwise meet severity of illness and intensity of service criteria.

7. The child has a substance abuse disorder as defined in DSM and does not otherwise meet the severity of illness and intensity of service criteria.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:47 (January 2004), repromulgated LR 30:241 (February 2004).

§1609. Intermediate Care Facilities/Mental Retardation (ICF/MR) Facilities Operated by the Office of Mental Health

A. Referral for persons not currently residents of an ICF/MR facility should come through the State Office for Citizens with Developmental Disabilities (OCDD) Regional Office System responsible for serving the individual but referrals from other community sources or the individual's family will also be considered. Persons seeking admission or for whom admission is sought to an ICF/MR facility must meet the following admissions criteria:

1. age 18 years or above;

2. DSM diagnosis of Mental Retardation and/or Developmental Disability;

3. DSM diagnosis of mental illness;

4. can reasonably be expected to benefit from Community Home (CH) active treatment program;

5. must demonstrate compatibility with the physical, cognitive, social and behavioral development exhibited by the individuals in the home where the applicant is to reside and also in the day program as indicated by a published Level of Functioning Scale or other instrument identified by the Office of Mental Health (OMH) as clinically appropriate. Such Level of Functioning Scale must be based on scientifically accepted practice standards and must demonstrate adequate psychometric properties of validity and reliability;

6. must be certifiable for SSI and Medicaid Services;

7. must demonstrate ability to control self and not present a danger to self or others as evidenced by a lack of suicide attempts, suicide plans or self-injurious behaviors within the last three months, and a lack of aggressive behaviors or threatening behaviors towards others within the last three months; and

8. must volunteer for admission and agree to follow rules and actively participate in the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20 and R.S. 28:311(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:49 (January 2004).

§1611. The Office for Citizens with Developmental Disabilities (OCDD)

A. The following admission requirements apply to the developmental centers and community- homes operated by the OCDD.

1. Initial Requirements for Admission Consideration

a. The person must meet the criteria for participation in the Mental Retardation/Developmental Disabilities (MR/DD) Services System in Louisiana's MR/DD law. The person's generic service plan (Plan of Support) must contain a recommendation for admission to an Intermediate Care Facility for the Mentally Retarded. The plan must also document the team (which includes the individual and/or family) consideration of what meets the individual's needs, and no more, and the most natural living option available, consistent with an individual's community peers.

2. Residential Facilities Admission Criteria

a. The person has mental retardation or a related condition and has additional complex medical or behavioral needs; and

b. the person's programmatic and supervisory needs as established in the person's Individual Program Plan (IPP) can be met within the resources and staffing available at the developmental center or community home; and

c. the person's age and sex as well as physical, cognitive, social and behavioral development are compatible with the individuals currently residing within the developmental center or community home wherein the vacancy exists; and

d. the admission does not exceed the capacity, the services and/or population for which the facility is licensed.

3. Exclusions:

a. persons who cannot benefit from active treatment services in an Intermediate Care Facility for the Mentally Retarded (ICF-MR);

b. persons who have a primary diagnosis of mental illness;

c. persons who are dangerous to self or others, or are charged with a crime, and who require the availability of a secure and locked area in order to ensure the safety and well being of other residents and employees of the developmental center or community home.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20 and R.S. 28:311(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:50 (January 2004).

§1613. Inpatient Substance Abuse Treatment Programs Operated by the Office for Addictive Disorders

A. Admissions

1. Admission to primary treatment centers will be from a statewide population.

2. Any client exhibiting major medical symptoms or major psychiatric symptoms, indicating immediate need, will be referred for services of an acute care hospital or acute psychiatric unit. Once stabilized, OAD will evaluate for admission to an inpatient treatment program.

B. Eligibility Criteria

1. The client must have been screened by a single point of entry, which includes:

a. OAD Outpatient or Detoxification Programs or other programs approved by the accepting facility;

b. have a primary diagnosis of no less than alcohol abuse, drug abuse, or compulsive gambling;

c. have a recent history of uncontrollable alcohol or drug use or compulsive gambling and have been unable to remain drug-free through outpatient intervention; or

d. have been unable to access outpatient services due to unavailability related to distance and transportation; and

2. the client shall be involved in an intensive outpatient substance abuse treatment program while awaiting placement in an inpatient facility. If intensive treatment is not available at the referring clinic, the client should be evaluated and provided the maximum level of services available while awaiting admission;

3. the patient who is appropriately admitted to an inpatient program meets specifications in two of the six dimensions, at least one of which is in Dimension 1,2, or 3.

a. Dimension 1: Acute Intoxication and/or Withdrawal. The patient has no signs or symptoms of withdrawal, or his or her withdrawal needs can be safely managed in a inpatient program setting.

b. Dimension 2: Biomedical Conditions and Complications. The patient's status in Dimension 2 is characterized by one of the following.

i. The interaction of the patient's biomedical condition and continued alcohol or other drug use places the patient in imminent danger of serious damage to physical health or concomitant biomedical conditions (such as pregnancy with vaginal bleeding or ruptured membranes).

ii. A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute care hospital. The patient who has a biomedical problem that requires a degree of staff attention (such as monitoring of medications or assistance with mobility) that is not available on other inpatient programs is in need of Biomedical enhanced services.

c. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications. Problems in Dimension 3 are not necessary for admission to an inpatient program. However, if any of the Dimension 3 conditions are present, the patient must be admitted to a Dual Diagnosis Enhanced program (depending on his or her level of function, stability, and degree of impairment).

i. The patient's psychiatric condition is unstable. Depression and/or other emotional, behavioral, or cognitive symptoms (which may include compulsive behaviors, suicidal or homicidal ideation with a recent history of attempts but no specific plan, or hallucinations and delusions without acute risk to self or others) are interfering with

abstinence, recovery, and stability to such a degree that the patient needs a structured 24-hour, medically monitored (but not medically managed) environment to address recovery efforts; or

ii. the patient exhibits stress behaviors associated with recent or threatened losses in work, family, or social domains, to a degree that his or her ability to manage the activities of daily living are significantly impaired. The patient thus requires a secure, medically monitored environment in which to address self-care problems (such as those associated with eating, weight loss, sleeplessness or personal hygiene) and to focus on his or her substance abuse or mental health problems; or

iii. the patient has significant functional deficits that require active psychiatric monitoring. They may include-but are not limited to- problems with activities of daily living, problems with self-care, lethality or dangerousness, and problems with social functioning. These deficits may be complicated by problems in Dimensions 2 through 6; or

iv. the patient is at moderate risk of behaviors endangering self, others, or property, and is in imminent danger of relapse (with dangerous emotional, behavioral, or cognitive consequences) without 24-hour support and structure of an inpatient program; or

v. the patient is actively intoxicated, with resulting violent or disruptive behavior that poses imminent danger to self or others; or

vi. the patient has a thought disorder or cognitive limitations that require stabilization but not medical management.

d. Dimension 4: Readiness to Change. The patient's status in Dimension 4 is characterized by one of the following:

i. despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the patient does not accept or relate the addictive disorder to the severity of these problems; or

ii. the patient is in need of intensive motivation strategies, activities, and processes available only in a 24-hour structured, medically monitored setting; or

iii. the patient needs ongoing 24-hour psychiatric monitoring to assure persistence with the treatment regimen and to deal with issues such as ambivalence about compliance with psychiatric medications.

e. Dimension 5: Relapse, Continued Use, or Continued Problem Potential. The patient's status in Dimension 5 is characterized by one of the following:

i. the patient is experiencing acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder (such as difficulty postponing immediate gratification, drug-seeking behavior, or increasing severity of anxiety or depressive symptoms). This situation poses an imminent danger of harm to self or others in the absence of 24-hour monitoring and structured support; or

ii. the patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms. This situation poses an imminent danger of harm to self or others in the absence of the type of 24-hour monitoring and structured support found in a medically monitored setting; or

iii. the modality of treatment or protocols to address relapse (such as aversion therapy and similar behavioral therapy techniques) require that the patient receive care in an inpatient program.

f. Dimension 6: Recovery Environment. The patient's status in Dimension 6 is characterized by one of the following:

i. the patient requires continuous medical monitoring while addressing his or her substance use and/or psychiatric problems because his or her current living situation is characterized by a high risk of initiation or repetition of physical, sexual, or emotional abuse, or substance abuse so endemic that the patient is assessed as being unable to achieve or maintain recovery at a less intensive level of care. For example, because of mania (which is treated with mood stabilizing medications), the patient believes he or she is able to control the people in his or her environment who pose the risk; or

ii. family members or significant others living with the patient are not supportive of his or her recovery goals and are actively sabotaging treatment. This situation requires structured treatment services and relief from the home environment in order for the patient to focus on recovery; or

iii. the patient is unable to cope, for even limited periods of time, outside of 24-hour care. The patient needs staff monitoring to learn to cope with Dimension 6 problems before he or she can be transferred safely to a less intensive setting.

C. Incarcerated Individuals

1. Persons referred for inpatient care who are incarcerated at the time of referral must meet the above criteria and be eligible for full release from incarceration within 15 days after the planned admission to an inpatient unit, or otherwise be able to participate in any and all follow-up recovery programs which would be recommended within a continuum of care treatment plan, including aftercare, half-way house, and self-help support groups.

2. Persons being detained in criminal justice programs who are awaiting arraignment, trial or post-trial sentencing must meet the above criteria and have an agreement from the District Attorney, prosecuting attorney, or trial judge.

a. This agreement must be binding on the client and provide the client with assurance of ability to participate in continuum of care as recommended by the treatment team, unless the client violates any judicial agreement, or condition placed upon him and in effect during the term of recommended treatment.

3. Clients are not to be admitted who are subject to return to incarceration during the period of recommended treatment, including after-care, absent a new violation, infraction of probation or condition of suspension, or charge being filed.

D. Special Populations

1. Treatment facilities shall make arrangements for the temporary employment of staff/equipment/specialized services which may be reasonably needed in order for the program to adequately serve persons with special needs or physical disabilities, specifically, but not limited to, the hearing and speech impaired.

a. Specialized service arrangements will be within reason and only when similar services are not available through an alternate resource for which the client is eligible and/or entitled. Funding for the specialized service must have prior approval of the Assistant Secretary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:20 and R.S. 28:311(11).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 30:50 (January 2004).

Chapter 17. Block Grants

§1701. Funding

A. The Louisiana Department of Health and Human Resources (DHHR) has adopted and will continue to adopt a rule to administer block grant federal funding for each fiscal year 1985-86. These federal funds will be administered in accordance with P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, and federal regulations as published in the Federal Register, Vol. 45, No. 190, Thursday October 1, 1981 pp. 48582-48598 and Vol. 47, No. 129, Tuesday, July 6, 1982, pp. 29472-29493. The rules apply to the Alcohol and Drug Abuse and Mental Health Services Block Grant, the Maternal and Child Health Services Block Grant and the Preventive Health Services Block Grant, the Low-Income Home Energy Assistance Block Grant, and the Social Services Block Grant.

AUTHORITY NOTE: Promulgated in accordance with P.L. 97-35.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

§1703. Administration

A. The DHHR offices responsible for administration of programs and services in the block grants are as follows:

1. Alcohol and Drug Abuse and Mental Health Services, Office of Mental Health and the Office of Prevention from Alcohol and Drug Abuse;

2. Maternal and Child Health Services, Office of Preventive and Public Health Services;

3. Preventive Health and Health Services, Office of Preventive and Public Health Services;

4. Low Income Home Energy Assistance, Office of Human Development;

5. Social Services, Office of Human Development.

AUTHORITY NOTE: Promulgated in accordance with P.L. 97-35.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987).

Chapter 18. Homeless Trust Fund

§1801. Definitions

A. In this Chapter:

DSS—the Department of Social Services (Office of Community Services).

Fund—the Louisiana Homeless Trust Fund established by R.S. 46:591 through 46:595.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:591 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 21:401 (April 1995), amended LR 25:708 (April 1999).

§1803. Application Requests

A. To receive an application, an organization that aids the homeless must submit a written request to DSS containing the following information:

1. name of the organization;

2. mailing address of the organization;

3. phone number of the organization;

4. contact person within the organization; and

5. proof of the organization's nonprofit and tax exempt status or of nonprofit application pending.

B. An organization that submits an application request will be added to DSS's mailing list and DSS shall mail the organization information about application requirements and deadlines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:591 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 21:401 (April 1995), amended LR 25:708 (April 1999).

§1805. Application Requirements and Deadlines

A. The application for funds must contain:

1. name and mailing address of the organization;

2. names and addresses of the organization's Board of Directors;

3. certification of the organization's nonprofit and tax exempt status or of nonprofit application pending;

4. brief history of the organization and its programs;

5. description of the proposed use of the requested funds;

6. description of the unmet needs of the homeless in the organization's community, including the source of the information;

7. itemized budget and budget justification for the Trust Fund proposal;

8. summary of organization's annual budget and sources of income;

9. documentation of the availability of matching funds for the proposal.

B. DSS will issue solicitations for grant applications after the end of the state fiscal year when the balance in the Fund is determined. The solicitation for grant applications will outline application deadlines and describe the eligible projects that DSS will fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:591 et seq.
HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 21:401 (April 1995), amended LR 25:709 (April 1999).

§1807. Review of Applications

A. DSS will review complete applications in the order the applications are received.

B. DSS shall evaluate each application according to the following factors:

1. the extent to which the proposal meets the needs of the homeless in the organization's service community, as identified by the most recent report of the Louisiana Interagency Council on the Homeless;

2. the extent to which the organization requires Homeless Trust Fund monies as an equivalent match for other homeless assistance funding;

3. the demonstrated success of the program in meeting the needs of the homeless, if the proposal concerns an existing program;

4. the extent to which the proposal provides for direct services or housing needs, rather than administrative services; and

5. other factors as identified in DSS's solicitation for grant applications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:591 et seq.
HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 21:401 (April 1995), amended LR 25:709 (April 1999).

§1809. Notification and Appeals

A. DSS shall notify applicants of award decisions no later than 30 days after the date of DSS's decision.

B. An organization shall notify DSS in writing and by mail of whether the organization accepts the award no later than 30 days after the date the organization received DSS's notification.

C. DSS shall publish in the *Louisiana Register* a list of all projects funded during the previous state fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:591 et seq.
HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 21:401 (April 1995), amended LR 25:709 (April 1999).

§1811. Emergency Grants

A. At any time, DSS may authorize an emergency grant of up to $2,000 to an organization that aids the homeless, as long as funding is available. A request for an emergency grant must state the immediate nature of the request and comply with §1805.A of this rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:591 et seq.
HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 21:401 (April 1995), amended LR 25:709 (April 1999).

Chapter 19. Traumatic Head and Spinal Cord Injury

Editor's Note: This Chapter, formerly LAC 67:VII.Chapter 19, was moved to LAC 48:I.Chapter 19.

§1901. Program Profile [Formerly LAC 67:VII.1901]

A. Mission—to provide services in a flexible, individualized manner to Louisiana citizens who survive traumatic head or spinal cord injuries enabling them to return to a reasonable level of functioning and independent living in their communities.

B. Program Administration

1. The Department of Health, Office of Aging and Adult Services (OAAS), shall be responsible for administration of the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund.

2. OAAS has the responsibility of:

a. promulgating rules and regulations;

b. establishing priorities and criteria for disbursement of the fund;

c. evaluating the needs of head injured and spinal cord injured individuals to identify service gaps and needs;

d. submitting an annual report with recommendations to the legislature and governor 60 calendar days prior to each Regular Session of the Legislature; and

e. monitoring, evaluating, and reviewing the development and quality of services funded through the trust fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).
HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1252 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:84 (January

2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1905 (October 2018).

§1903. Enabling Legislation [Formerly LAC 67:VII.1903]

A. House bill number 591, Act 269 of the 2012 Regular Session, chapter 48 of title 46 of R.S. 46:2631-2635 and R.S. 36:259(T).

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1252 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:84 (January 2014).

§1905. Definitions [Formerly LAC 67:VII.1905]

Advisory Board—Traumatic Head and Spinal Cord Injury Trust Fund Advisory Board.

Domiciled—a resident of the state of Louisiana with intent to permanently remain within the state.

Spinal Cord Injury—an insult to the spinal cord, not of a degenerative or congenital nature but caused by an external physical force resulting in paraplegia or quadriplegia.

Traumatic Head Injury—an insult to the head, affecting the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce a diminished or altered state of consciousness which results in an impairment of cognitive abilities or physical functioning.

Trust Fund—Traumatic Head and Spinal Cord Injury Trust Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1253 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:84 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 42:1669 (October 2016), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1905 (October 2018).

§1907. General Requirements [Formerly LAC 67:VII.1907]

A. Cost-Effective Service Provision. All services shall be provided in a cost-effective manner.

B. Case Record Documentation. A case record will be maintained for each individual served.

1. The record shall contain the following:

a. documentation to support the decision to provide, deny, or amend services;

b. documentation of the amounts and dates of each service delivery;

c. service plans and progress notes;

d. proof of individual identifications; and

e. any applicable assessments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1253 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:85 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1905 (October 2018).

§1909. Individual Appeals Rights [Formerly LAC 67:VII.1911]

A. Administrative Review. The administrative review is the first level appeal process used by individuals for a timely resolution of disagreements pertaining to eligibility decisions or a denial of services.

1. All applicants/participants shall be provided written notification to inform them of their appeal rights regarding eligibility and/or the denial of services.

a. The written notification shall include:

i. the decision being reached;

ii. the basis for and effective date of the decision;

iii. the specific means for appealing the decision;

iv. the individual's right to submit additional evidence and information;

v. information about the individual's right to representation; and

vi. the name and address of the trust fund program.

2. The appeal must be requested by the individual (or their representative) and shall be:

a. made in writing; and

b. post-marked or received in the trust fund program office within 15 business days of the date on the written notification of denial.

3. The administrative review may be conducted face-to-face or via telephone with the program manager of the Traumatic Head and Spinal Cord Injury Trust Fund Program.

4. Services shall continue during the administrative review process unless the services being provided have been obtained through:

a. misrepresentation;

b. fraud; and/or

c. collusion or criminal conduct on the part of the individual.

5. The administrative review must take place, a decision reached, and written notification of the decision provided to the individual within 30 calendar days of the receipt of the individuals' appeal request.

6. The written notification of the administrative review decision shall include:

a. the decision being reached;

b. the basis for and effective date of the decision;

c. the specific means for appealing the administrative review decision;

7. If the individual fails to attend the administrative review either in person or via telephone, the appeal will be considered abandoned and the appeal process is exhausted.

B. Advisory Board Review. In the event that a disputed decision is not resolved through the administrative review process, the individual may request a second level appeal before the advisory board.

1. Requests for advisory board review shall be:

a. made in writing to the program manager of the trust fund program;

b. post-marked or received in the trust fund program office within 15 business days of the date on the administrative review decision notice.

2. The advisory board review shall take place at the time of the next regularly scheduled advisory board meeting following the receipt of the individual's written request, unless the program manager deems that it is necessary to address the situation sooner, in which case a special meeting of the advisory board could be called for the purpose of conducting the review.

3. The individual shall have the right to:

a. submit additional evidence, and

b. bring representation to the advisory board review.

4. The advisory board shall:

a. make an impartial decision;

b. provide a written notice of the decision within 10 business days of the advisory board review.

5. The decision of the advisory board is final and the appeal process is exhausted.

6. If the individual fails to attend the appeal hearing either in person or via telephone, the appeal will be considered abandoned and all appeal processes shall be exhausted.

AUTHORITY NOTE; Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1254 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:85 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1905 (October 2018).

§1911. Program Eligibility
[Formerly LAC 67:VII.1913]

A. In order for an individual to be determined eligible for services, the individual must:

1. meet the definition of spinal cord injury or traumatic brain injury as defined in §1905 above;

2. be a resident of the state of Louisiana and officially domiciled in the state of Louisiana at the time of injury and during the provision of services;

3. have a reasonable expectation to achieve improvement in functional outcome with assistance;

4. have exhausted all other Medicare and Medicaid sources;

5. be willing to accept services from an approved facility/program; and

6. complete and submit appropriate application for services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T)

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1255 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:86 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1906 (October 2018).

§1913. Ineligibility
[Formerly LAC 67:VII.1915]

A. A determination of ineligibility is made when the individual does not meet program eligibility as defined in §1911 above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1255 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:86 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1906 (October 2018).

§1915. Fiscal
[Formerly LAC 67:VII.1917]

A. Limitations. Expenditures on behalf of any one individual shall not:

1. exceed $15,000 during the 12-month period based on the participant's eligibility/anniversary date.

2. exceed the total lifetime maximum of $50,000.

B. All applicable state and departmental purchasing policies and procedures must be followed.

C. Prior Written Authorization and Encumbrance. The proper authorizing document(s) must be written before the initiation of goods or services.

1. Failure to obtain prior authorization will result in a denial of products or services.

a. The program manager may approve items to be reimbursed for situations deemed unavoidable/emergency.

D. All monies collected, but not expended, for the Traumatic Head and Spinal Cord Injury Trust Fund Program are carried forward to the following fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S.36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1255 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:86 (January 2014), amended by the Louisiana Department of Health, Office of Aging and Adult Services, LR 44:1907 (October 2018).

§1917. Service Plan
[Formerly LAC 67:VII.1919]

A. Once an individual has been determined eligible for services, an appropriate individualized assessment shall be completed in order to:

1. determine the scope of services;

2. develop, implement, and update service plans as appropriate;

B. The service plan shall:

1. be individualized:

2. be outcome oriented;

3. include (at a minimum) all of the following:

a. specific services to be delivered or rendered;

b. frequency of the service(s)

c. beginning and ending dates;

d. costs of services;

e. service provider.

4. be presented by means understandable to the individual served.

C. The individual or authorized representative must give informed written consent to the service plan and all amendments.

D. The case record shall include all updates and amendments to the service plan.

AUTHORITY NOTE: Promulgated in accordance with| R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1255 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:86 (January 2014), LR 44:1907 (October 2018).

§1919. Services
[Formerly LAC 67:VII.1921]

A. Services are authorized, coordinated and provided for eligible individuals in accordance with each person's service plan.

B. Service plans shall be written with a goal of achieving specific objectives:

1. related to the participant's injury, and

2. to improve participant's functioning in their home and community.

C. Additional documentation may be requested to justify the need for a particular good/service.

D. Services may include, but are not limited to:

1. evaluations;

2. post-acute medical care rehabilitation;

3. therapies;

4. medication and medical supplies;

5. personal care attendant services;

6. assistive technology and equipment necessary for activities of daily living;

7. durable medical equipment;

8. environmental accessibility modifications ;

9. vehicle accessibility modifications;

10. transportation for non-emergency medical appointments.

E. The trust fund will not pay for the following (this list is not all-inclusive):

1. home purchases;

2. vehicle purchases;

3. routine vehicle maintenance and repairs;

4. routine home maintenance and repairs;

5. recreational items or activities;

6. routine bills or payments;

7. funeral expenses

8. legal expenses

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1255 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:86 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1907 (October 2018).

§1921. Service Providers
[Formerly LAC 67:VII.1923]

A. All service providers must be approved by OAAS.

B. In-state programs/facilities will be given priority for approval as service providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46.2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1256 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:87 (January 2014).

§1923. Conditions for Case Closure [Formerly LAC 67:VII.1925]

A. An individual's case can be closed at any time in the process when it has been determined that the individual:

1. has shown consistent failure to cooperate with the service plan and case managers;

2. reaches the maximum $50,000 in total lifetime expenditures;

3. has less than $100 of the lifetime balance remaining for a period of 12 months or more.

4. does not meet the program's eligibility criteria;

5. resides in another state or moves to another state;

6. fails to maintain a safe and legal home environment;

7. is unable to be contacted after two phone call attempts on two separate days and does not respond to written notification within 15 business days of the date on the notice;

8. made misrepresentations in the eligibility determination process;

9. made misrepresentations to obtain goods and services;

10. is incarcerated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46.2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1256 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:87 (January 2014), amended by the Department of Health, Office of Aging and Adult Services, LR 44:1907 (October 2018).

§1925. Limitation of Liability [Formerly LAC 67:VII.1927]

A. Members of the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund Advisory Board shall have limited liability as specified in R.S. 9:2792.4.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2631-2635 and R.S. 36:259(T).

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Rehabilitation Services, LR 21:1256 (November 1995), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 40:87 (January 2014).

Chapter 21. Liability Limitation Schedule for DHH Provided Services

§2109. Services and Facilities Other than State General Hospitals

A. Long-Term Inpatients Receiving Unearned Income

1. Facilities treating patients who receive unearned income, are not eligible under Title XIX regulations and have no dependents as defined by the United States Internal Revenue Service shall arrange to have those funds paid directly to the facility.

2. The unearned income will not be applied to the cost of the first 90 days of care but will be placed into a patient account fund.

3. For any treatment received by the patient subsequently to the first 90 days of care, the treating facility shall apply any forthcoming unearned income to the cost of care, less a personal needs allowance. Any funds over the cost of care shall be placed into the patient account fund on behalf of the patient.

4. Upon discharge of the patient, the balance of the funds remaining in the patient account shall be paid to the patient or the responsible person as provided by law.

5. If the facility is unable to have the unearned income paid directly to the facility, billing shall be made in accordance with this policy.

NOTE: Items 2 and 3, above, are applicable to Psychiatric Hospitals only.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:259 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 15:92 (February 1989), repealed and repromulgated, LR 17:208 (December 1991), amended LR 20: 1295 (November 1994).

Chapter 23. Informed Consent

§2301. Disclosure of Risks/Patient Consent

A. Pursuant to R.S. 40:1299.40E, the Louisiana Medical Disclosure Panel recommends use of the following general form, or use of a substantially similar form, for disclosure of risks and hazards related to medical care and surgical procedures.

PATIENT CONSENT TO MEDICAL TREATMENT OR SURGICAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF MEDICAL INFORMATION INFORMATION ABOUT THIS DOCUMENT READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable therapeutic alternatives and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

1. Patient Name _____

2. Treatment/Procedure:

(a) Description, nature of the treatment/procedure:
_____
_____

(b) Purpose:
_____
_____

3. Patient Condition:

Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in Item Number 2 is indicated and recommended:

_____
_____

4. Material Risks of Treatment Procedure:

(a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.

[ ] See attachment for risks identified by the Louisiana Medical Disclosure Panel

[ ] See attachment for risks determined by your doctor

(b) Additional risks (if any) particular to the patient because of a complicating medical condition are:

_____
_____

(c) Risks generally associated with any surgical treatment/procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.

5. **Reasonable therapeutic alternatives and the risks associated with such alternatives are:**

_____
_____

ACKNOWLEDGMENT

AUTHORIZATION AND CONSENT

6.(a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either express or implied, as to the success or other results of the medical treatment or surgical procedure.

(b) **Additional Information**: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(c) **Particular Concerns:** I have had an opportunity to disclose to and discuss with the physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

(d) **Questions:** I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.

(e) **Authorized Physician:** The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in Item 2 is:

_____

(Name of authorized physician or group)

(f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

_____

(Signature of Physician) Date Time

CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in item 2 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in Item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

_____

Witness

_____

Patient or Person Authorized to Consent Date/Time

_____

Relationship

If consent is signed by someone other than the patient, state the reason:

_____
_____

Attachment to Consent to Medical Treatment or Surgical Procedure and Acknowledgment of Receipt of Medical Information

_____
_____
_____

_____

Patient's Signature Date/Time

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, 40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR:1581 (December 1993), amended LR 20:307 (March 1994).

§2303. Female Genital System Treatments and Procedures

A. Abdominal Hysterectomy (Removal of Womb Resulting in Sterility)

1. uncontrollable leakage of urine;

2. injury to bladder;

3. death;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. infection;

7. damage to major blood vessels, hemorrhage, need for transfusion of blood products;

8. painful intercourse;

9. ovarian failure requiring hormone administration;

10. pulmonary embolism (blood clot from pelvis or legs that moves to lungs);

11. formation of fistula (leakage of urine or bowel contents through vagina);

12. unsatisfactory sexual function;

13. bleeding;

14. failure of wound to heal;

15. permanent and disfiguring scarring.

B. Vaginal Hysterectomy (removal of womb resulting in sterility)

1. uncontrollable leakage of urine;

2. injury to bladder;

3. death;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. infection;

7. damage to major blood vessels, hemorrhage, need for transfusion of blood products;

8. painful intercourse;

9. ovarian failure requiring hormone administration;

10. pulmonary embolism (blood clot from pelvis or legs that moves to lungs);

11. formation of fistula (leakage of urine or bowel contents through vagina);

12. unsatisfactory sexual function;

13. bleeding;

14. failure of wound to heal;

15. permanent and disfiguring scarring;

16. completion of operation resulting in abdominal incision.

C. All Fallopian Tube and Ovarian Surgery with or without Hysterectomy, including Removal and Lysis of Adhesions

1. injury to the bowel and/or bladder;

2. sterility;

3. failure to obtain fertility (if applicable);

4. failure to obtain sterility (if applicable);

5. loss of ovarian functions or hormone production from ovary(ies);

6. injury to ureter;

7. injury to major blood vessels, hemorrhage, need for transfusion of blood products;

8. failure to remove entire ovary possibly requiring further surgery (ovarian remnant syndrome);

9. pulmonary embolism.

D. Abdominal Endoscopy (Peritoneoscopy, Laparoscopy)

1. puncture of the bowel or blood vessel;

2. abdominal infection and complications of infection;

3. abdominal incision and operation to correct injury;

4. injury to bladder;

5. injury to ureter;

6. possible air embolus.

E. Removing Fibroids (Uterine Myomectomy)

1. uncontrolled leakage of urine;

2. injury to bladder;

3. sterility;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. pulmonary embolism.

F. Uterine Suspension

1. uncontrollable leakage of urine;

2. injury to bladder;

3. sterility;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. painful intercourse;

7. pulmonary embolism.

G. Removal of the Nerves to the Uterus (Presacral Neurectomy)

1. uncontrollable leakage of urine;

2. injury to bladder;

3. sterility;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. hemorrhage, complications of hemorrhage with additional operation.

H. Removal of the Cervix

1. uncontrolled leakage of urine;

2. injury to bladder;

3. sterility;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. completion of operation by abdominal incision;

7. pulmonary embolism.

I. Repair of Vaginal Hernia (Anterior and/or Posterior Colporrhaphy and/or Enterocele Repair)

1. uncontrolled leakage of urine;

2. injury to bladder;

3. sterility;

4. injury to the tube (ureter) between the kidney and the bladder;

5. injury to the bowel and/or intestinal obstruction;

6. risk of hemorrhage;

7. risk of infection;

8. painful intercourse;

9. risk of formation of fistula between the urinary tract and vagina or intestinal tract and the vagina;

10. difficulty urinating;

11. pulmonary embolism;

J. Abdominal Suspension of the Bladder (Retropubic Urethropexy)

1. uncontrolled leakage of urine;

2. injury to the bladder;

3. injury to the tube (ureter) between the kidney and the bladder;

4. injury to the bowel and/or intestinal obstruction;

5. painful inflammation or destruction of pubic bone (osteitis pubis);

6. risk of infection;

7. risk of damage to urethra;

8. risk of difficulty urinating;

9. Pulmonary embolism;

K. Conization of Cervix

1. hemorrhage with possible hysterectomy to control;

2. sterility;

3. injury to bladder;

4. injury to rectum;

5. failure of procedure to remove all of cervical abnormality;

6. scar tissue formation of mouth of womb (cervical stenosis);

7. weakening of mouth of womb resulting in miscarriage with future pregnancies (incompetent cervix);

8. pulmonary embolism.

L. Dilation and Curettage of Uterus (Diagnostic)

1. hemorrhage with possible hysterectomy;

2. perforation of the uterus;

3. sterility;

4. injury to bowel and/or bladder;

5. abdominal incision and operation to correct injury;

6. formation of scar tissue in uterine cavity (Ashermann Syndrome).

M. Dilation and Curettage of Uterus (Obstetrical)

1. hemorrhage with possible hysterectomy;

2. perforation of the uterus;

3. sterility;

4. injury to bowel and/or bladder;

5. abdominal incision and operation to correct injury;

6. formation of scar tissue in uterine cavity (Ashermann Syndrome);

7. failure to remove all products of conception.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2305. Maternity and Related Cases

A. Delivery (Vaginal)

1. injury to bladder and/or rectum, including a hole (fistula) between bladder and vagina and/or rectum and vagina;

2. hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation to control;

3. sterility;

4. brain damage, injury, or even death occurring to the fetus before or during labor and/or vaginal delivery whether or not the cause is known;

5. uterine disease or injury requiring hysterectomy;

6. pulmonary embolus;

7. risk of infection;

8. possible painful intercourse.

B. Delivery (Cesarean Section)

1. infection;

2. injury to bladder and/or rectum, including a fistula (abnormal hole) between bladder and vagina and/or rectum and vagina;

3. hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation to control;

4. sterility;

5. brain damage, injury, or even death occurring to the fetus before or during labor and/or cesarean delivery whether or not the cause is known;

6. uterine disease or injury requiring hysterectomy;

7. pulmonary embolus;

8. disfiguring scarring.

Note: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended by the Department of Health and Hospitals, Office of the Secretary, LR 22:29 (January 1996), repromulgated LR 22:456 (June 1996).

§2307. Anesthesia

A. Arterial Catheterization

1. decrease in blood flow to area supplied by the artery;

2. nerve damage;

3. loss of or loss of function of the limb or portion of the limb supplied by the artery.

B. Central Venous and Pulmonary Artery Catheterization

1. hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart), the chest cavity and elsewhere;

2. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

3. cardiac arrest (heart attack);

4. stroke;

5. pneumothorax (lung collapse);

6. infection;

7. cardiac arrhythmias (irregularities of the heart rhythm);

8. shock (severe drop in blood pressure);

9. damage to blood vessels;

10. damage to trachea (windpipe) and/or pharynx (throat);

11. injury to vocal cords;

12. distal embolization (air, fat particles or blood clots which circulate in the bloodstream until becoming lodged in a vein or artery);

13. damage to nerves, the lymph ducts, the heart and the lungs;

14. infusion to fluid into the chest cavity, lungs and pericardium.

C. Transesophageal Echocardiography

1. esophageal injury;

2. damage to teeth.

D. Epidural, Spinal, Regional

1. allergic, abnormal or hypersensitivity reaction to drugs or equipment may be fatal;

2. aspiration (inhalation) into the bronchi (airway) or lungs of stomach contents, stomach acids and foreign objects;

3. leakage of cerebrospinal fluid;

4. chipped or broken teeth;

5. convulsion (seizures);

6. epidural blood clot or abscess (bleeding or infection in the space adjacent to the spinal cord which may damage the spinal cord);

7. broken needles or catheters which may lead to complications and necessitate additional treatment;

8. production of an unintended high level of anesthesia which may necessitate need for artificial respirators and insertion of a breathing tube;

9. incomplete analgesia (pain or discomfort during the procedure);

10. injury to the lips, tongue and inside of the mouth or airway injury;

11. laryngeal and vocal cord trauma or edema (injury to or swelling of the vocal cords);

12. loss of bowel or bladder function or sexual function;

13. heart attack or other heart problems;

14. decreased blood pressure;

15. shock;

16. nerve damage ranging from loss of sensation to total paralysis;

17. back pain;

18. death;

19. brain damage;

20. severe headaches.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2309. Risks and Complications of General Anesthesia

A. Allergic, abnormal or hypersensitivity reaction to drugs or equipment, which may be fatal.

B. Aspiration (inhalation) into the bronchi (airway) or lungs of stomach contents, stomach acids and foreign objects.

C. Laryngeal and/or vocal cord trauma or edema (injury to or swelling of the vocal cords).

D. Heart Attack or Other Heart Problems

E. Death

F. Brain Damage

G. Shock

H. Nerve Damage Ranging from Loss of Sensation to Total Paralysis

I. Chipped or Broken Teeth

J. Esophageal Injury

K. Burns

L. Malignant Hyperthermia (dangerously high fever which may result in death)

M. Injury to Lips, Tongue and Inside of Mouth or Airway Injury

N. Breathing Difficulties

O. Eye Injuries

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2311. Anesthesia and Pregnancy

A. List of complications which have occurred to an unborn child in association with obstetrical anesthesia includes:

1. hypoxia or anoxia (deprivation of sufficient amounts of oxygen which, if prolonged, can cause death or brain damage);

2. cardiac and/or respiratory depression (reduction of the heart and/or breathing rate which can lead to hypoxia or anoxia);

3. brain damage;

4. mental retardation;

5. injury to body organs;

6. seizure disorders;

7. quadriplegia (paralysis of both arms and both legs);

8. paraplegia (paralysis of both legs);

9. spasticity (involuntary contraction of one or more muscles with associated loss of muscle function);

10. meconium aspiration (drawing of meconium, a fetal waste product sometimes present in the fluid surrounding the fetus, into the lungs of the unborn child);

11. broken bones;

12. death.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended by the Department of Health and Hospitals, Office of Public Health, Medical Disclosure Panel, LR 23:75 (January 1997).

§2313. Endocrine System Treatments and Procedures

A. Thyroidectomy

1. injury to the nerves resulting in hoarseness or impairment of speech;

2. injury to parathyroid glands resulting in low blood calcium levels that require extensive medication to avoid serious degenerative conditions, such as cataracts, brittle bones, muscle weakness and muscle irritability;

3. lifelong requirement of thyroid medication.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2315. Nervous System Treatments and Procedures

A. Spine Operation, including Laminectomy, Decompression, Fusion, Internal Fixation, or Procedures for Nerve Root or Spinal Cord Compression; Spine Operations for: Diagnosis; Pain, Deformity; Mechanical Instability; Injury; Removal of Tumor, Abscess, or Hematoma (Excluding Coccygeal Operations)

1. pain, numbness or paralysis, or clumsiness;

2. weakness of arm(s), hand(s), leg(s) or foot (feet) [including paraplegia (paralysis of both arms or paralysis of both legs) and quadriplegia (paralysis of all four extremities)];

3. loss of function of bladder;

4. loss of function of bowel;

5. loss of sexual function;

6. unstable spine;

7. recurrence or continuation of the condition that required the operation;

8. injury to major blood vessels;

9. leakage of spinal fluid;

10. failure to relieve pain or increase in pain;

11. failure or breakage of internal fixation;

12. infection;

13. death;

14. hemorrhage, requiring transfusion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2317. Oral Surgery

A. Removal of Tooth (including Impacted Tooth) (an impacted tooth is under the gum or bone)

1. infection;

2. bleeding;

3. failure of wound to heal;

4. injuries to adjacent teeth and/or hard or soft tissues;

5. paresthesia or numbness of face and/or mouth;

6. fracture of mandible (lower jaw) or maxilla (upper jaw);

7. opening between mouth and sinus or mouth and nose;

8. tooth or fragment in maxillary sinus;

9. incomplete removal of tooth;

10. dry socket;

11. possible injury to tmj (temporomandibular joint dysfunction or jaw joint).

B. Repair or Removal of Damaged Teeth

1. infection;

2. bleeding;

3. failure of wound to heal;

4. paresthesia or numbness of face and/or mouth;

5. loss of teeth;

6. loss of bone.

C. Removal of Exostosis, Tori, Tuberosities (Excess Bone)

1. infection;

2. bleeding;

3. failure of wound to heal;

4. slough (unanticipated loss of hard and/or soft tissue);

5. paresthesia or numbness of face and/or mouth;

6. opening between mouth and sinus or mouth and nose;

7. injury to adjacent structures.

D. Dental Implants

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. premature loss of implant(s) and attachment(s);

6. loss of bone;

7. mobility of implant (failure of implant to attach);

8. paresthesia or numbness of face and/or mouth;

9. mandibular fracture (lower jaw);

10. injury to adjacent teeth;

11. inability to place implant in intended site;

12. injury of maxillary sinus.

E. Maxillary and Mandibular Osteotomies (Cutting and Movement of Jawbones)

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. difficulty in mastication (chewing);

6. malocclusion (improper bite);

7. continued muscle pain and headaches;

8. impaired or obstructed airway (difficulty in breathing) which might cause death;

9. undesirable facial appearance;

10. new or continued temporomandibular joint symptoms (tmj);

11. nerve injury;

12. failure of bone to heal;

13. loss of teeth, bone or soft tissue;

14. damage to teeth requiring additional treatment (root canal);

15. relapse or shift of jaw structures;

16. opening between mouth and sinus or mouth and nose.

F. Genioplasty (Chin Reconstruction), Sliding Osteotomy (Cutting and Moving the Bone), Bone Graft, Alloplast (Synthetic Implant)

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. undesirable chin contour;

6. failure of bone to heal;

7. paresthesia or numbness of face and/or mouth;

8. resorption of hard and/or soft tissues secondary to alloplast implant (synthetic);

9. injury to dental structures;

10. rejection of implant material;

11. lip incompetence (droop of lip).

G. Surgery for Cleft Lip/Palate and Craniofacial Deformities (Repair of Defects from Birth Injury, Prior Surgery, and/or Disease)

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. impaired chewing or swallowing;

6. unstable or inadequate function of dental occlusion (bite);

7. residual speech problems or impairment;

8. unfavorable facial symmetry;

9. airway impairment (difficulty in breathing) which might cause death;

10. nerve injuryXsensory or motor (feeling and function);

11. loss of grafted or implanted materials;

12. blood supply compromise to tissues, hard and soft, resulting in loss of tissues;

13. failure of bone to heal;

14. failure to correct deformity;

15. opening between mouth and sinus or mouth and nose.

H. Removal of Cyst, Benign Tumors or Malignant Tumors from Jaws

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. recurrence of lesion;

6. loss of bone which would result in facial deformity;

7. unanticipated loss of teeth or adjacent vital structures;

8. facial bone fracture;

9. paresthesia or numbness of face and/or mouth;

10. metastasis (spread of cancer if tumor is cancerous).

I. Surgical Treatment of Facial Infection Including Drainage

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. loss or damage to teeth and adjacent structures including bone;

6. persistence and/or spread of infection to other parts of body;

7. airway impairment (difficulty in breathing) which might cause death.

J. Surgical Removal of Cysts, Benign Tumors and Stones of the Salivary Gland

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. recurrence of original problem;

6. metastasis (spread of cancer if tumor is cancerous);

7. damage or loss of adjacent vital structures (salivary);

8. persistent problem requiring removal of gland.

K. Temporomandibular Joint Disease (Surgery and/or Manipulation)

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. failure to relieve pain;

6. inability to chew properly;

7. restriction of jaw movement;

8. locking of jaw joint (open or closed);

9. failure of alloplast (synthetic implant) to function requiring removal;

10. malocclusion (improper bite);

11. motor or sensory nerve damage (function or feeling);

12. damage to ear canal, cartilage, or middle ear;

13. development of arthritis condition.

L. Surgical Repair of Mandible (Lower Jaw) Fractures

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. failure of bones to heal properly;

6. malocclusion (improper bite);

7. damage to teeth or loss of teeth;

8. motor or sensory nerve damage (function and feeling).

M. Surgical Repair of Maxilla (Upper Jaw) Fractures

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. failure of bones to heal properly;

6. malocclusion (improper bite);

7. opening between mouth and sinus or mouth and nose;

8. loss of bone or teeth;

9. chronic sinusitis or sinus infection;

10. motor or sensory nerve damage (function and feeling);

11. telecanthus (widening of the space between the eyes);

12. abnormal eye movements;

13. abnormal vision;

14. difficulty breathing;

15. overflow of tears;

16. inability to smell.

N. Surgical Correction of Soft Tissue Injuries of Face

1. infection;

2. bleeding;

3. failure of wound to heal;

4. permanent and disfiguring scarring;

5. failure to restore appearance;

6. motor or sensory nerve damage (function and feeling);

7. salivary gland duct damage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended by the Department of Health and Hospitals, Office of Public Health, Medical Disclosure Panel, LR 23:75 (January 1997), LR 24:1304 (July 1998).

§2319. Digestive System Treatment and Procedures

A. Cholecystectomy (Removal of the Gallbladder) with or without Common Bile Duct Exploration

1. pancreatitis (inflammation of the gland that produces insulin);

2. injury to the tube (common bile duct) between the liver and the bowel;

3. retained stones in the tube (common bile duct) between the liver and the bowel;

4. narrowing or obstruction of the tube (common bile duct) between the liver and the bowel;

5. injury to the bowel and/or intestinal obstruction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2321. Hematic and Lymphatic System

A. Transfusion of Blood and Blood Components

1. fever;

2. transfusion reaction which may include kidney failure or anemia;

3. heart failure;

4. hepatitis;

5. AIDS (acquired immune deficiency syndrome);

6. other infections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2323. Integumentary System Treatment and Procedures

A. Radical or Modified Radical Mastectomy (Simple Mastectomy Excluded)

1. limitation of movement of shoulder and arm;

2. swelling of the arm;

3. loss of the skin of the chest requiring skin graft;

4. failure to completely eradicate the malignancy;

5. decreased sensation or numbness of the inner aspect of the arm and chest wall;

6. injury to major blood vessels.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2325. Radiology

A. Cerebral Angiography

1. injury to the artery entered or studied;

2. swelling, pain, tenderness or bleeding at the blood vessel entrance by catheter or needle;

3. stroke;

4. death;

5. blindness;

6. brain damage;

7. aggravation of the condition that necessitated the procedure;

8. emboli to the brain;

9. allergic sensitivity reaction to the injected contrast medium;

10. bleeding requiring transfusion or surgery.

B. Coronary Angiography

1. injury to artery entered or studied;

2. damage to heart (including occlusion of coronary artery or perforation);

3. myocardial infarction (heart attack);

4. possible need for open heart surgery to correct complication of procedure or deterioration of the patient's medical condition;

5. arrhythmia (irregular heartbeat);

6. cardiac arrest;

7. death;

8. swelling, pain, tenderness or bleeding at the blood vessel entrance by catheter or needle;

9. aggravation of the condition that necessitated the procedure;

10. allergic sensitivity reaction to injected contrast media;

11. bleeding requiring transfusion or surgery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2327. Repair of Coarctation of Aorta

A. Quadriplegia

B. Paraplegia (Paralysis of Both Legs or Both Arms)

C. Permanent Hoarseness

D. Chylothorax (Leakage of Chyle, the White Body Fluid from Intestines Carried by the Lymphatic Vessels, into the Chest Cavity)

E. Loss of Bowel and/or Bladder Function

F. Impotence in a Male

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2329. Repair of Aortic Dissection

A. Stroke

B. Renal Failure

C. Bowel Infarction

D. Paraplegia (Paralysis of Both Legs or Both Arms)

E. Death

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2331. Lung Resection

A. Prolonged Air Leak

B. Empyema (Collection of Pus)

C. Need for Additional Surgery to Control Infection, Bleeding or Air Leak.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2333. Any Procedure Requiring Cardiopulmonary Bypass

A. Stroke

B. Respiratory Complications (Including Need for Prolonged Ventilatory Support)

C. Kidney Failure

D. Death

E. Bleeding Requiring Reoperation

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2335. Insertion of Intra-Aortic Augmentation Balloon

A. Paraplegia (Paralysis of Both Legs or Both Arms)

B. Loss of Extremity

C. Bowel Infarction

D. Renal Failure

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993).

§2337. Radiation Therapy (Radiation Oncology)

A. Head and Neck

1. Early Reactions

a. reduced and sticky saliva, loss of taste and appetite, altered sense of smell, nausea;

b. sore throat, difficulty swallowing, weight loss, fatigue;

c. skin changes; redness, irritation, scaliness, blistering or ulceration, color change, thickening, hair loss;

d. hoarseness, cough, loss of voice and swelling of airway;

e. blockage and crusting of nasal passages;

f. inflammation of ear canal, feeling of "stopped-up" ear, hearing loss, dizziness;

g. dry and irritable eye(s), if the eyes or tear glands are in the radiation beam;

h. depression of blood count leading to increased risk of infection and/or bleeding;

i. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

2. Late Reaction(s)

a. dry mouth and altered, or loss sense of, taste;

b. tooth decay and gum changes;

c. bone damage, especially in jaws;

d. stiffness and limitation of jaw movement;

e. changes in skin texture and/or coloration, permanent hair loss, scarring of skin, poor healing of surgical wounds, and death of normal tissue;

f. swelling of tissues, particularly under the chin;

g. throat damage causing hoarseness, pain, or difficulty breathing or swallowing;

h. eye damage causing dry eye(s), cataract, loss of vision, or loss of eye(s), if the eye is in the radiation beam;

i. ear damage causing dryness of ear canal, fluid collection in middle ear, hearing loss;

j. brain, spinal cord, or nerve damage causing alteration of thinking ability;

k. pituitary or thyroid gland damage requiring long-term hormone replacement therapy;

l. in children, there may be additional late reactions as follows:

i. disturbances of bone and tissue growth;

ii. abnormal development of facial bones;

iii. brain damage causing a loss of intellectual ability, learning capacity, and reduced intelligence quotient (I.Q.);

iv. second cancers developing in the irradiated area.

B. Central Nervous System

1. Early Reactions

a. skin and scalp reaction with redness, irritation, scaliness, blistering, ulceration, change in color, thickening, hair loss;

b. nausea, vomiting, headaches;

c. fatigue, drowsiness;

d. altered sense of taste or smell;

e. inflammation of ear canal, feeling of "stopped-up" ear, hearing loss, dizziness;

f. depression of blood count leading to increased risk of infection and/or bleeding;

g. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

2. Late Reactions

a. permanent hair loss of variable degrees, altered regrowth, texture, and color of hair;

b. persistent drowsiness and tiredness.

c. brain damage causing a loss of some degree of thinking ability, memory or personality changes, loss of sensation or balance, seizures, hemorrhage, or steroid dependency due to brain swelling, rarely, severe damage may produce paralysis or death;

d. scarring of skin;

e. spinal cord or nerve damage causing paralysis, loss of strength, feeling, or coordination in any part of the body;

f. damage to eye(s) or optic nerve(s) causing loss of vision;

g. ear damage causing dryness of ear canal, fluid collection in middle ear, hearing loss;

h. pituitary gland damage requiring long-term hormone replacement therapy;

i. in children, there may be additional late reactions as follows:

i. disturbances of bone and tissue growth;

ii. bone damage to spine, causing stunting of growth, curvature, and/or reduction in height;

iii. abnormal bone growth in the face or pelvis;

iv. brain damage causing a loss of intellectual ability, learning capacity, and reduced intelligence quotient (I.Q.);

v. second cancers developing in the irradiated area.

C. Thorax

1. Early Reactions

a. skin changes: redness, irritation, scaliness, ulceration, change in color, thickening; hair loss on the chest;

b. inflammation of esophagus causing pain on swallowing, heartburn, or sense of obstruction;

c. loss of appetite, nausea, vomiting, weight loss, and weakness;

d. inflammation of the lung with pain, fever, and cough;

e. inflammation of the heart sac with chest pain and possible decreased heart function;

f. bleeding or creation of a fistula resulting from tumor destruction;

g. depression of blood count leading to increased risk of infection and/or bleeding;

h. intermittent electric shock-like feelings in the lower spine or legs on bending the neck;

i. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

2. Late Reactions

a. changes in skin texture and/or coloration, permanent hair loss and scarring of skin;

b. lung scarring or shrinkage causing shortness of breath;

c. narrowing of esophagus causing swallowing problems;

d. constriction of heart sac which may require surgical correction;

e. damage to heart muscle or arteries leading to heart failure or heart attack;

f. fracture of ribs;

g. nerve damage causing pain, loss of strength or feeling in arms;

h. spinal cord damage causing paralysis, loss of strength or feeling in arms and legs and/or loss of control of bladder and rectum;

i. liver damage;

j. loss of thyroid function;

k. in children, there may be additional late reactions as follows:

i. disturbances of bone and tissue growth;

ii. bone damage to spine, causing stunting of growth, curvature, and/or reduction in height;

iii. underdevelopment or absence of development of female breast;

iv. second cancers developing in the irradiated area.

D. Breast

1. Early Reactions

a. skin changes: redness (sunburn-like), irritation, scaliness, blistering, ulceration, coloration, thickening; hair loss;

b. breast changes, including swelling, tightness, tenderness or pain;

c. inflammation of the esophagus causing pain on swallowing, heartburn, or sense of obstruction;

d. lung inflammation with cough;

e. inflammation of heart sac with chest pain and possible decreased heart functions;

2. Late Reactions

a. changes in skin texture and/or coloration, permanent hair loss and scarring of skin;

b. breast changes, including thickening, firmness, tenderness, shrinkage, or edema (swelling);

c. swelling of arm;

d. stiffness and discomfort in shoulder joint;

e. rib damage causing pain or fracture;

f. nerve damage causing pain, loss of strength or feeling in arm;

g. damage to heart muscle or heart sac leading to heart failure;

h. permanent scarring of the lung producing shortness of breath, cough, or susceptibility to infection;

i. loss of thyroid functions;

j. if there is a cancer recurrence, mastectomy may be required.

E. Abdomen

1. Early Reactions

a. skin changes: redness, irritation, scaliness, ulceration, change in color, thickening; hair loss;

b. loss of appetite, nausea, vomiting;

c. weight loss, weakness, fatigue;

d. inflammation of stomach causing indigestion, heartburn, and ulcers;

e. inflammation of bowel causing cramping and diarrhea;

f. depression of blood count leading to increased risk of infections and/or bleeding;

g. these reactions are likely to be intensified by chemotherapy before, during, and/or after radiation therapy.

2. Late Reactions

a. changes in skin texture and/or coloration, permanent hair loss and scarring of skin;

b. stomach damage causing persistent indigestion, pain, and bleeding;

c. bowel damage causing narrowing or adhesions of bowel with obstruction, ulceration or bleeding which may require surgical correction, chronic diarrhea, or poor absorption of food elements;

d. kidney damage leading to kidney failure and/or high blood pressure;

e. liver damage leading to liver failure;

f. spinal cord or nerve damage causing paralysis, loss of strength or feeling in legs and/or loss of control of bladder and/or rectum;

g. these reactions are likely to be intensified by chemotherapy in a patient who is receiving, has received, or will receive radiation therapy:

F. Female Pelvis

1. Early Reactions

a. inflammation of bowel causing cramping, diarrhea, nausea, vomiting, and/or decreased appetite;

b. inflammation of rectum and anus causing pain, spasm, discharge, bleeding;

c. bladder inflammation causing burning, frequency, spasm, pain, bleeding;

d. skin changes: redness, irritation, scaliness, blistering or ulceration, coloration, thickening; hair loss;

e. disturbance of menstrual cycle;

f. vaginal discharge, pain, irritation, bleeding;

g. depression of blood count leading to increased risk of infection and/or bleeding;

h. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

2. Late Reactions

a. bowel damage causing narrowing or adhesions of the bowel with obstruction, ulceration, bleeding, chronic diarrhea, or poor absorption of food elements and may require surgical correction or colostomy;

b. bladder damage with loss of capacity, frequency of urination, blood in urine, recurrent urinary infections, pain, or spasm which may require urinary diversion and/or removal of bladder;

c. changes in skin texture and/or coloration, permanent hair loss, scarring of skin;

d. bone damage leading to fractures;

e. ovarian damage causing infertility, sterility, premature menopause, or genetic damage to future offspring;

f. vaginal damage leading to dryness, shrinkage, pain, bleeding, or sexual dysfunction;

g. swelling of the genitals or legs;

h. nerve damage causing pain, loss of strength or feeling in legs, and/or loss of control of bladder or rectum;

i. fistula between the bladder and/or bowel and/or vagina;

j. pelvic fibrosis producing obstruction of bowel or ureters;

k. in children, there may be additional late reactions as follows:

i. disturbances of bone and tissue growth;

ii. bone damage to pelvis and hips causing stunting of bone growth and/or abnormal development;

iii. second cancers developing in the irradiated area.

G. Male Pelvis

1. Early Reactions

a. inflammation of bowel causing cramping, diarrhea, nausea, vomiting, and/or decreased appetite;

b. inflammation of rectum and anus causing pain, spasm, discharge, bleeding;

c. bladder inflammation causing burning, frequency, spasm, pain and/or bleeding;

d. skin changes: redness, irritation, scaliness, blistering or ulceration, coloration, thickening; hair loss.

e. depression of blood count leading to increased risk of infection and/or bleeding;

f. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

2. Late Reactions

a. bowel damage causing narrowing or adhesions of the bowel with obstruction, ulceration, bleeding, chronic diarrhea, or poor absorption of food elements and may require surgical correction or colostomy;

b. bladder damage with loss of capacity, frequency of urination, blood in urine, recurrent urinary infections, pain, or spasm which may require urinary diversion and/or removal of bladder;

c. changes in skin texture and/or coloration, permanent hair loss, scarring of skin;

d. bone damage leading to fractures;

e. testicular damage causing reduced sperm counts, infertility, sterility, or risk of birth defects;

f. impotence (loss of erection) or sexual dysfunction;

g. swelling of the genitalia or legs;

h. nerve damage causing pain, loss of strength or feeling in legs, and/or loss of control of bladder or rectum;

i. fistula between the bowel and other organs;

j. pelvic fibrosis producing obstruction of bowel or ureters;

k. in children, there may be additional late reactions as follows:

i. disturbances of bone and tissue growth;

ii. bone damage to pelvis and hips causing stunting of bone growth and/or abnormal development;

iii. second cancers developing in the irradiated area.

H. Skin

1. Early Reactions

a. redness, irritation, or soreness;

b. scaliness, ulceration, crusting, oozing, discharge;

c. hair loss;

d. these reactions are likely to be intensified by chemotherapy.

2. Late Reaction(s)

a. changes in skin texture causing scaly or shiny smooth skin, thickening, with contracture, puckering, scarring of skin;

b. changes in skin color or overall appearance;

c. prominently dilated small blood vessels;

d. loss of sweating in treated area;

e. permanent hair loss;

f. chronic or recurrent ulcerations, severe damage may require skin grafting or plastic surgery;

g. damage to adjacent tissues, including underlying bone or cartilage;

h. possible injury may occur from trauma, sun, or frostbite unless the treated area is forever protected;

i. in children, second cancers may develop in the irradiated area.

I. Extremities

1. Early Reactions

a. skin changes: redness, irritation, scaliness, ulceration, coloration, thickening; hair loss;

b. inflammation of soft tissues causing tenderness, swelling, and interference with movement;

c. inflammation of joints causing pain, swelling and limitation of joint motion;

d. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy;

e. depression of blood counts leading to increased risk of infection and/or bleeding.

2. Late Reactions

a. changes in skin reaction and/or coloration, permanent hair loss, and scarring of the skin;

b. scarring or shrinkage of soft tissues and muscle causing loss of flexibility and movement, swelling of the limb;

c. nerve damage causing loss of strength, feeling, or coordination;

d. bone damage causing fracture;

e. joint damage causing permanent stiffness, pain, and arthritis;

f. swelling of limb below the area treated;

g. in children, there may be additional late reactions as follows:

i. disturbances of bone and tissue growth;

ii. bone damage to limbs causing stunting of bone growth and/or abnormal development;

iii. second cancers developing in the irradiated area.

J. Total Body Irradiation

1. Early Reactions

a. loss of appetite, nausea, vomiting;

b. diarrhea;

c. reduced and sticky saliva, swelling of the salivary gland(s), loss of taste;

d. hair loss;

e. sore mouth and throat, difficulty swallowing;

f. permanent destruction of bone marrow leading to infection, bleeding, and possible fatal lung failure;

g. inflammation of the lung with fever, dry cough and difficulty breathing with possible fatal lung failure;

h. damage to liver with possible fatal liver failure;

i. depression of blood counts leading to increased risk of infection and/or bleeding;

j. these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

2. Late Reactions

a. lung scarring causing shortness of breath, infection, and fatal lung failure;

b. cataract formation in the eyes, possible loss of vision;

c. testicular damage in males causing sterility;

d. ovarian damage in females causing premature menopause and sterility;

e. increased risk of second cancer;

f. decreased ability to give further chemotherapy or other cancer treatment.

K. Endobronchial Radiation

1. Early Reactions

a. a mild sore throat;

b. some difficulty in swallowing;

c. bleeding;

d. infection or pneumonia.

2. Late Reactions

a. damage to spinal cord possibly producing paralysis;

b. lung scarring;

c. hemorrhage (possibly fatal);

d. inflammation of heart sac;

e. fistula (opening between bronchial tree and lung and/or esophagus);

f. pneumothorax (collapse of lung);

g. abscess formation;

h. death.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, 40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended by the Department of Health and Hospitals, Office of Public Health, Medical Disclosure Panel, LR 23:75 (January 1997).

§2339. Musculo-Skeletal Procedures in the Extremities

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. A surgical procedure upon, or even a closed manipulation of an extremity, entails risk to a greater or lesser degree, to all major systems of that limb, and can result in varying degrees of weaknesses, deformity, paralysis, pain, numbness, limitation of motion of the joints, and amputation. Furthermore, the goals of the procedures may not be obtained, and other therapy may be found necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 21:469 (May 1995).

§2340. Peripheral Nerve Procedures

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Failure to improve the condition or symptoms.

B. Injury to underlying nerve(s) of plexus with resultant weakness, numbness, pain including complete anesthesia of the extremity.

C. Recurrent symptoms which might require further surgery or continuation of condition for which surgery was performed.

D. Development of chronic pain problem in the area of the nerve, for example, anesthesia dolorosa (painful numbness).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 21:469 (May 1995).

§2341. Vascular Surgery

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Carotid Endarterectomy

1. thrombosis of repair (clotting);

2. bleeding/hematoma (accumulation of blood), requiring reoperation;

3. infection;

4. transient or permanent stroke;

5. nerve injury causing asymmetry of mouth, swallowing difficulty, hoarseness, weakness/atrophy and numbness of the tongue;

6. myocardial infarction (heart attack);

7. death.

B. Aortic Graft for Abdominal Aortic Aneurysm or Occlusive Disease

1. bleeding/hematoma (accumulation of blood), requiring reoperation;

2. infection of graft;

3. thrombosis or emboli;

4. limb loss;

5. kidney failure requiring dialysis;

6. ischemia of bowel (inadequate blood supply) with resulting loss of bowel;

7. ischemia of spinal cord (inadequate blood supply) with resulting paraplegia (paralysis of both legs);

8. myocardial infarction (heart attack);

9. death;

10. sexual dysfunction in male, including infertility;

11. temporary dependency on a breathing machine (ventilator).

C. Arteriovenous Shunt for Hemodialysis (Artery Vein Fistula or Synthetic Graft)

1. bleeding/hematoma (accumulation of blood), requiring reoperation;

2. infection;

3. false aneurysm (damaged blood vessel with swelling and risk of rupture);

4. recurrent thrombosis (clot);

5. severe edema of extremity (swelling);

6. inadequate blood supply to extremity;

7. inadequate blood supply to nerves with resulting paralysis.

D. Femoral, Popliteal or Tibial Bypass Grafts

1. bleeding/hematoma (accumulation of blood), requiring reoperation;

2. necrosis (death) of skin around the incision with delayed healing;

3. thrombi (clot);

4. emboli (moving clot)Xearly or late;

5. limb loss;

6. nerve damage with permanent numbness/weakness;

7. early or late thrombosis (late clotting) requiring reoperation;

8. infection;

9. myocardial infarction (heart attack);

10. death.

E. Lumbar Sympathectomy

1. injury to major artery/vein;

2. bleeding/hematoma (accumulation of blood), requiring reoperation;

3. injury to nerves (genitofemoral) with resulting numbness in groin and genital area;

4. sexual dysfunction in male with resulting numbness, impotence and infertility;

5. emboli (moving clots).

F. Thoracic Sympathectomy by Thoracotomy or Thoracoscopy or Cervical Dorsal Sympathectomy

1. Horner's Syndrome (drooping eyelids and constricted pupil).

2. Injury to blood vessel.

3. Pneumothorax (collapsed lung) with bleeding.

4. Infection/empyema (pus collection in chest).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 21:469 (May 1995).

§2343. Craniotomy

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Death

B. Paralysis or Stroke

C. Infection or Meningitis

D. Seizure or Epilepsy

E. Loss of Bone Flap

F. Personality Change

G. Loss of Memory

H Hemorrhage

I. Blindness

J. Loss of Sense of Smell or Taste

K Ringing in The Ears or Hearing Loss

L Problems with Balance

M. Double or Blurred Vision

N. Numbness or Sensory Loss at the Operative Site or Remote from the Operative Site

O. Blood Clots

P. Continuation of Condition for which Surgery was Performed

Q. Incontinence

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, 40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 21:470 (May 1995), amended by the Department of Health and Hospitals, Office of Public Health, Medical Disclosure Panel, LR 23:75 (January 1997), amended LR 21:470 (May 1995).

§2345. Anterior or Posterior Diskectomy (with or without Fusion)

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Death

B. Quadriplegia

C. Paraplegia

D. Increased Pain and Numbness

E. Hoarseness

F. Failure of Fusion (Bone Graft Fails to Stabilize)

G. Infection

H. Need for Additional Surgery

I. Continuation of Condition for which Surgery was Performed

J. Difficulty Swallowing

K. Injury to Esophagus

L. Bowel and Bladder Dysfunction

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, 40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 21:470 (May 1995).

§2347. Plastic Surgery

A. Facelift and Coronal Lift

1. bleeding or hematoma (blood clot) that may need to be evaluated;

2. infection, skin loss, poor healing that may require prolonged treatment;

3. hypertrophic (thick) scars that may need to be revised and injected to soften them;

4. discoloration and swelling in face and neck;

5. numbness and/or pain in face, neck, ears, scalp may be permanent;

6. seroma (accumulation of fluid) under skin may require a second surgery or drainage;

7. facial nerve damage that can cause facial paralysis;

8. loss of hair around incisions may be permanent;

9. facial asymmetry (unequal appearance);

10. contour irregularities (rippled and uneven) effects of skin surface.

B. Abdominoplasty

1. bleeding and hematoma (blood clot) requiring evacuation;

2. infection that may require treatment and dressing changes for a prolonged period;

3. poor healing, necrosis (tissue loss), and dehiscence (wound opening) and may require a graft or secondary surgical procedure;

4. permanent scars that can become hypertrophic (thick) that may need revision or injections to soften the scars;

5. numbness or altered sensation in abdomen may be permanent;

6. swelling, tightness, discomfort and pain in abdominal area may be temporary, but can also be permanent;

7. blood transfusion reaction with adverse risk of hepatitis, aids, and other complications;

8. loss of umbilicus (naval/"bellybutton");

9. seroma—accumulation of fluid under skin may require evacuation or drainage.

C. Breast Reduction

1. bleeding or hematoma (blood clot) which may require secondary surgery;

2. blood transfusion may be necessary;

3. infection or open wound (dehiscence) that may require treatment and dressing changes or secondary surgery;

4. poor healing and necrosis of skin (tissue loss);

5. permanent hypertrophic (thick) scars around nipple, down to the breast crease, and under breast crease;

6. asymmetry (uneven) of breasts and nipples;

7. nipple and breast sensation can be altered (numbness) or permanently lost;

8. loss of all or part of the nipple/areola;

9. unexpected malignancies (cancer) may be found requiring more extensive surgery;

10. alteration of appearance of breast tissue during mammograms;

11. interference with ability to breast feed in future;

12. contour/firmness of breast nipple and/or breasts may not be symmetrical and the breasts may sag.

D. Augmentation Mammaplasty with Implant Use or Breast Reconstruction Following Mastectomy with Implant Use

NOTE: When silicone gel implants are used, FDA consent is required. Risks specific to this product have, therefore, been excluded from this list.

1. capsule formation (scar formation around implant resulting in hard breasts and/or pain);

2. deflation of implant;

3. loss of sensation to the nipple and breast;

4. persistent pain in breast;

5. distortion of breast mound at rest and with activities;

6. palpable implant;

7. infection possibly requiring removal of implants;

8. leakage of implant contents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, 40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 21:700 (July 1995), amended by the Department of Health and Hospitals, Office of Public Health, Medical Disclosure Panel, LR 23:75 (January 1997).

§2349. Cardiology Procedures

A. Arterial Line Insertion

1. swelling, pain, tenderness or bleeding at blood vessel entrance by catheter or needle;

2. injury to artery or vein entered or studied;

3. decrease in blood flow to area supplied by the artery;

4. nerve damage;

5. loss or loss of function of an arm or leg supplied by the artery;

6. possible need for surgery due to complications.

B. Cardiac Catheterization

1. death;

2. myocardial infarction (cardiac arrest/heart attack);

3. cerebrovascular complication (stroke);

4. injury to artery or vein entered or studied;

5. local, vascular complication (groin or arm);

6. bleeding, thrombosis, distal embolization, pseudoaneurysm, arteriovenous (AV) fistula (abnormal communication between an artery and a vein), hematomas, nerve damage, injury to the artery, delayed hemorrhage;

7. loss or loss of function of an arm or leg;

8. perforation of heart or great vessels;

9. vasovagal reaction (hypotension, slow heart rate);

10. arrhythmias and conduction disturbances (irregular heart beat);

11. kidney failure (partial or complete; may necessitate hemodialysis);

12. contrast related anaphylactoid reactions (allergies);

13. congestive heart failure;

14. pulmonary embolism;

15. bleeding requiring blood transfusion or surgery;

16. possible need for surgery due to complications;

17. scar formation at the site of entrance into the artery.

C. General Angiography

1. contrast related anaphylactoid reactions (allergies);

2. injury to artery or vein entered or studied;

3. loss or loss of function of an arm or leg;

4. kidney failure (partial or complete; may necessitate hemodialysis).

D. Percutaneous Coronary Angioplasty/Stent Placement

1. death;

2. brain damage (stroke);

3. quadriplegia;

4. paraplegia;

5. injury to artery or vein entered or studied;

6. loss or loss of function of an arm or leg;

7. disfigurement (including scars);

8. kidney failure (partial or complete; may necessitate hemodialysis);

9. loss of bowel and/or bladder function;

10. myocardial infarction (cardiac arrest/heart attack);

11. restenosis (subsequent recurrence of narrowing of blood vessel);

12. possible need for surgery due to complications;

13. contrast related anaphylactoid reactions (allergies);

14. hypotension (abnormally low blood pressure);

15. arrhythmias and conduction disturbances (irregular heart beat);

16. bleeding requiring blood transfusion or surgery;

17. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

18. stent thrombosis;

19. displacement of stent or instrument requiring retrieval.

E. Thrombolysis—Regional or Systemic

1. death;

2. brain damage (stroke);

3. injury to artery or vein entered or studied;

4. loss or loss of function of an arm or leg;

5. bleeding requiring blood transfusion or surgery;

6. hematoma;

7. arrhythmias and conduction disturbances (irregular heart beat);

8. hypotension (abnormally low blood pressure);

9. contrast related anaphylactoid reactions (allergies).

F. Coronary Intervention (Stents and Atherectomy)/Directional Coronary Arthrectomy (DCA), Transluminal Extraction Catheter Arthrectomy (TEC) and Rotational Atherectomy

1. death;

2. brain damage (stroke);

3. quadriplegia;

4. paraplegia;

5. injury to artery or vein entered or studied;

6. loss or loss of function of an arm or leg;

7. disfigurement (including scars);

8. kidney failure (partial or complete; may necessitate hemodialysis);

9. loss of bowel and/or bladder function;

10. myocardial infarction (cardiac arrest/heart attack);

11. restenosis (subsequent recurrence of narrowing of blood vessel);

12. possible need for surgery due to complications;

13. contrast related anaphylactoid reactions (allergies);

14. hypotension (abnormally low blood pressure);

15. arrhythmias and conduction disturbances (irregular heart beat);

16. bleeding requiring blood transfusion or surgery;

17. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

18. side branch occlusion;

19. severe bradycardia (severe slowing of the heart);

20. stent thrombosis;

21. displacement of stent or instrument requiring retrieval;

22. perforation of heart or great vessels;

23. coronary vasospasm related to the instrument used.

G. Electrophysiologic Study Including Programmed Electrical Stimulation (EPS) (Stimulating the heart to search for abnormal heart beat)

1. perforation of heart or great vessels;

2. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

3. bleeding requiring blood transfusion or surgery;

4. injury to artery or vein entered or studied;

5. arrhythmia and conduction disturbances (irregular heart beat);

6. pneumothorax (collapse of lung);

7. death;

8. myocardial infarction (cardiac arrest/heart attack);

9. bleeding, thrombosis, distal embolization, pseudoaneurysm, arteriovenous (AV) fistula (abnormal communication between an artery and a vein), hematomas, nerve damage, injury to the artery, delayed hemorrhage;

10. thrombophlebitis (inflamation of the vein);

11. pulmonary embolism (blood clot from pelvis or legs that moves to lungs);

12. brain damage (stroke);

13. loss or loss of function of a leg or arm;

14. electrical burns to the chest.

H. Radiofrequency Catheter Ablation

1. perforation of heart or great vessels;

2. injury to artery or vein entered or studied;

3. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

4. bleeding requiring blood transfusion or surgery;

5. pneumothorax (collapse of lung);

6. death;

7. myocardial infarction (cardiac arrest/heart attack);

8. arrhythmia and conduction disturbances (irregular heartbeat);

9. bleeding, thrombosis, distal embolization, pseudoaneurysm, arteriovenous (AV) fistula (abnormal communication between an artery and a vein), hematomas, nerve damage, injury to the artery, delayed hemorrhage;

10. thrombophlebitis (inflamation of the vein);

11. pulmonary embolism (blood clot from pelvis or legs that moves to lungs);

12. brain damage (stroke);

13. loss or loss of function of a leg or arm;

14. electrical burns to the chest;

15. possible need for surgery due to complications;

16. damage to heart valve;

17. interruption of the normal electrical conduction system of the heart, requiring permanent pacemaker placement;

18. recurrence of arrhythmia after initially successful ablation.

I. Transesophageal Echocardiography

1. arrhythmias and conduction disturbances (irregular heartbeat);

2. myocardial infarction (cardiac arrest/heart attack);

3. aspiration pneumonia;

4. respiratory failure which may require ventilation;

5. trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair;

6. injury to artery or vein entered or studied;

7. injury to teeth, gums, or throat, esophageal bleeding, laceration or perforation which may require surgical repair.

J. Exercise Treadmill and Bicycle Stress Testing

1. death;

2. myocardial infarction (cardiac arrest/heart attack);

3. arrhythmias and conduction disturbances (irregular heartbeat);

4. prolonged angina (chest pain);

5. hypotension/hypertension (abnormally low blood pressure/high blood pressure);

6. brain damage (stroke);

7. syncope (fainting);

8. musculoskeletal injuries (injuries to bones, muscles, and/or joints).

K. Dobutamine Stress Testing

1. death;

2. myocardial infarction (cardiac arrest/heart attack);

3. prolonged angina (chest pain);

4. hypotension/hypertension (abnormally low blood pressure/high blood pressure);

5. brain damage (stroke);

6. arrhythmias and conduction disturbances (irregular heartbeat);

7. syncope (fainting);

8. injury to artery or vein entered or studied.

L. Automatic Implantable Cardioverter Defibrillator Implantation (Permanent Pacemaker)

1. bleeding requiring blood transfusion or surgery;

2. hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart), and the chest cavity;

3. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

4. myocardial infarction (cardiac arrest/heart attack);

5. brain damage (stroke);

6. pneumothorax (collapse of lung);

7. perforation of heart or great vessels;

8. injury to artery or vein entered or studied;

9. possible need for surgery due to complications;

10. arrhythmia and conduction disturbances (irregular heart beat);

11. damage to trachea (windpipe) and/or pharynx (throat);

12. trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair.

M. Pericardiocentesis

1. perforation of heart or great vessels;

2. damage to coronary arteries including laceration;

3. possible need for surgery due to complications;

4. arrhythmia or conduction disturbances (irregular heart beat);

5. myocardial infarction (cardiac arrest/heart attack);

6. pneumothorax (collapse of lung);

7. death;

8. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart).

N. Electrical Cardioversion

1. electrical burns to the chest;

2. myocardial infarction (cardiac arrest/heart attack);

3. embolic event to any portion of the body (e.g., brain, bowel, kidney, eyes, arm, leg) which may lead to loss of, or loss of function of, affected portion of body;

4. injury to artery or vein entered or studied;

5. death;

6. brain damage (stroke);

7. arrhythmia and conduction disturbances (irregular heartbeat).

O. Endomyocardial Biopsy

1. injury to artery or vein entered or studied;

2. hemorrhage (bleeding) into the lungs, the pericardium sac which surrounds the heart and the chest cavity;

3. pericardial tamponade (compression of the heart due to accumulation of blood in the sac around the heart);

4. myocardial infarction (cardiac arrest/heart attack);

5. arrhythmias and conduction disturbances (irregular heartbeat);

6. pneumothorax (collapse of lung);

7. perforation of heart or great vessels;

8. possible need for surgery due to complications;

9. damage to trachea (windpipe) and/or pharynx (throat);

10. trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair;

11. displacement of stent or instrument requiring retrieval;

12. brain damage (stroke);

13. bleeding requiring blood transfusion or surgery.

P. Temporary Pacemaker Placement

1. injury to artery or vein entered or studied;

2. hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart), the chest cavity and elsewhere;

3. pericardial tamponade (compression of the heart due to accumulation of blood or fluid in the sac around the heart);

4. brain damage (stroke);

5. myocardial infarction (cardiac arrest/heart attack);

6. pneumothorax (collapse of lung);

7. perforation of heart or great vessels;

8. possible need for surgery due to complications;

9. arrhythmia and conduction disturbances (irregular heartbeat);

10. trauma to vocal cords which may result in temporary or permanent vocal cord injury that may require surgical repair;

11. displacement of stent or instrument requiring retrieval.

Q. Pulmonary Angiogram and/or Right Heart Catherization

1. injury to artery or vein entered or studied;

2. hemorrhage (bleeding) into the lungs, the pericardium (sac which surrounds the heart) and the chest cavity;

3. brain damage (stroke);

4. pneumothorax (collapse of lung);

5. myocardial infarction (cardiac arrest/heart attack);

6. perforation of heart or great vessels;

7. possible need for surgery due to complications;

8. arrhythmia and conduction disturbances (irregular heart beat);

9. shock;

10. infusion of fluid into the chest cavity, lungs, and pericardium;

11. contrast related anaphylactoid reactions (allergies);

12. death;

13. aggravation of the condition that necessitated the procedure;

14. bleeding requiring transfusion or surgery;

15. kidney failure (partial or complete; may necessitate hemodialysis);

16. respiratory complications (including need for prolonged ventilator (mechanical) support);

17. loss or loss of function of an arm or leg.

R. Cardiac Rehabilitation

1. death;

2. arrhythmias and conduction disturbances (irregular heartbeat);

3. myocardial infarction (cardiac arrest/heart attack);

4. prolonged angina (chest pain);

5. hypotension/hypertension (low blood pressure/high blood pressure);

6. brain damage (stroke);

7. syncope (fainting);

8. musculoskeletal injuries (injuries to bones, muscles and/or joints);

9. drowning (if involving water activities).

S. Head up Tilt Test (Including vasoactive drugs)

1. syncope (fainting);

2. seizure (convulsions);

3. hypotension/hypertension (low blood pressure/high blood pressure);

4. arrhythmia and conduction disturbances (irregular heartbeat);

5. myocardial infarction (cardiac arrest/heart attack)

6. brain damage (stroke).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40.E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, amended LR 25:1651 (September 1999).

§2351. Cataract Surgery with or without Implantation of Intraocular Lens (placement of lens into eye)

A. Loss of Vision or Decrease in Vision

B. Loss of Eye

C. Infection

D. Bleeding inside or behind the Eye

E. Uncomfortable or Painful Eye

F. Continued Need for Glasses

G. Less Attractive Appearance, i.e., Droopy Eyelid

H. Need for Laser Surgery to Correct Clouding of Vision

I. Need for Additional Treatment and/or Surgery

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:193 (February 1994).

§2353. Glaucoma Surgery

A. Loss of Vision or Decrease in Vision

B. Loss of Eye

C. Infection

D. Bleeding inside or behind the Eye

E. Uncomfortable or Painful Eye

F. Less Attractive Eye

G. Unsuccessful or Temporary Control of Glaucoma or Worsening of Glaucoma

H. Cataract Formation or Progression

I. Need for Additional Treatment and/or Surgery

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:193 (February 1994).

§2355. Corneal Surgery: Corneal Transplant, Pterygium, or Other

A. Loss of Vision or Decrease in Vision

B. Loss of Eye

C. Infection

D. Bleeding inside or behind the Eye

E. Uncomfortable or Painful Eye

F. Increased Eye Pressure

G. Less Attractive Eye

H. Need for Additional Treatment and/or Surgery

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:193 (February 1994).

§2357. Laser Capsulotomy (creation of opening in lens membrane)

A. Loss of Vision or Decrease in Vision

B. Failure to Improve Vision

C. Glaucoma (increased eye pressure)

D. Retinal Detachment (separation of nerve layers of eye)

E. Dislocation of Lens Implant

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:193 (February 1994).

§2359. Enucleation or Evisceration (removal of eye or its contents)

A. Bleeding

B. Infection

C. Chronic Discomfort or Pain

D. Less Attractive Appearance

E. Need for Additional Treatment and/or Surgery

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299, 40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:194 (February 1994).

§2361. Radial Keratotomy (reshape cornea by multiple cuts)

A. Loss of Vision or Decrease in Vision

B. Loss of Eye

C. Infection

D. Variable Vision

E. Radiating Images around Lights

F. Over Correction, under Correction or Distortion of Vision

G. Cataract Formation or Progression

H. Retained Need for Glasses

I. Inability to Wear Contact Lenses

J. Glare Problems Causing Loss of Ability to Drive

K. Need for Additional Treatment and/or Surgery

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:194 (February 1994).

§2363. Eye Muscle Surgery

A. Loss of Vision or Decrease in Vision

B. Loss of Eye

C. Double Vision

D. Need for Additional Eye Muscle Surgery

E. Infection

F. Less Attractive Appearance

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:194 (February 1994).

§2365. Laser Treatment of Eye (glaucoma or retina problems)

A. Loss of Vision or Decrease in Vision

B. Increase in Eye Pressure (Glaucoma)

C. Visual Distortion

D. Need for Surgery Inside of the Eye

E. Need for Additional Repeat Laser Treatment to Correct Clouding of Vision

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:194 (February 1994).

§2367. Retina (nerve layer of eye)/Vitreous (central gel-like substance in eye) Surgery

A. Loss of Vision

B. Loss of Eye

C. Infection

D. Bleeding

E. Uncomfortable or Painful Eye

F. Double Vision

G. Cataract Formation or Progression

H. Need for Additional Treatment and/or Surgery

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40E et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:194 (February 1994).

§2371. Tubes in Ears

A. Persistent Infection

B. Perforation of Eardrum or Cyst behind the Eardrum Requiring Surgical Repair

C. Need to Surgically Remove Tubes

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:669 (June 1994).

§2373. Adenoidectomy

A. Bleeding

B. Nasal Speech

C. Nasal Regurgitation of Food or Liquids

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:669 (June 1994).

§2375. Tonsillectomy

A. Bleeding

B. Injury to Nerves to Tongue

C. Nasal Speech

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:669 (June 1994).

§2377. Septoplasty

A. Bleeding

B. Infection

C. Injury to Nerve(s) of Upper Teeth

D. Septal Perforation

E. Spinal Fluid Leak

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994), amended LR 21:700 (July 1995), amended by the Office of Public Health, Medical Disclosure Panel, LR 23:75 (January 1997).

§2379. Cauterization of Tissue in the Nose

A. Infection

B. Scarring with Obstruction of Breathing

C. Dryness of Nose

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2381. Rhinoplasty

A. Bleeding

B. Infection

C. Disappointing Cosmetic Result or Failure to Achieve Desired Result

D. Impaired Breathing through Nose

E. Septal Perforation

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2383. Endoscopic Sinus Surgery

A. Bleeding

B. Infection

C. Scar Formation

D. Spinal Fluid Leak with Possible Infection of Brain Tissue

E. Injury to Eye, Including Blindness

F. Injury to Sense of Smell

G. Injury to Tear Duct Drainage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2385. Radical Neck (Extensive Neck Surgery)

A. Bleeding Requiring Transfusion

B. Injury to Nerves of Shoulder Resulting in Numbness, Pain or Loss of Function

C. Injury to Voice Box Resulting in Hoarseness or Speech Impairment

D. Injury to Nerve of Diaphragm with Possible Impairment of Breathing

E. Injury to Nerve of Tongue Resulting in Loss of Sensation, Loss or Alteration of Sense of Taste or Possible Impairment of Speech

F. Injury to Mandibular Branch of Facial Nerve Resulting in Loss of Function of Lip or Cheek.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2387. Submandibular Gland Surgery

A. Bleeding

B. Infection

C. Injury to Nerve of Lip or Tongue

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2389. Tympanoplasty (Operation on Eardrum)

A. Infection

B. Injury to Nerve of Tongue Causing Loss of Taste

C. Loss of Hearing

D. Perforation (Non-Healing)

E. Ringing in Ears

F. Dizziness

G. Graft Failure

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2391. Tympanoplasty with Mastoidectomy (Operation on Eardrum and Removal of Bone behind Ear)

A. Infection

B. Injury to Nerves of Tongue Causing Loss of Taste

C. Injury to Nerves of Face Causing Paralysis

D. Loss of Hearing

E. Ringing in Ears

F. Dizziness

G. Hole in Eardrum

H. Graft Failure

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2393. Direct Laryngoscopy (Passage of Lighted Tube into the Voice Box)

A. Persistent Hoarseness

B. Broken Teeth

C. Perforation of Throat

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2395. Parotidectomy (Removal of Salivary Gland near the Ear)

A. Bleeding

B. Infection

C. Facial Nerve Palsy

D. Numbness of Ear

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:670 (June 1994).

§2400. Esophageal Dilation/ Esophagogastroduodenoscopy

A. Infection

B. Bleeding which May Require Transfusion and/or Surgery

C. Perforation of Esophagus, Stomach, Intestinal Wall which may Require Surgery

D. Respiratory Arrest

E. Cardiac Arrhythmias (Irregular Heartbeats)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:895 (August 1994).

§2404. Diagnostic and Therapeutic ERCP (Endoscopic Retrograde Cholangio Pancreatogram)

A. Infection

B. Bleeding which may Require Transfusion

C. Perforation of Esophagus, Stomach, Intestinal Wall or Ducts which May Require Surgery

D. Cardiac Arrhythmias (Irregular Heartbeats)

E. Pancreatic Inflammation

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2406. Colonoscopy

A. Infection

B. Bleeding which may Require Transfusion and/or Surgery

C. Perforation of Colon or Rectal Wall which may Require Surgery

D. Cardiac Arrhythmias (Irregular Heartbeats)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896(August 1994).

§2408. Sigmoidoscopy/Proctoscopy

A. Infection

B. Bleeding which may Require Transfusion and/or Surgery

C. Perforation of Colon or Rectal Wall which may Require Surgery

D. Cardiac Arrhythmias (Irregular Heartbeats)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2410. Esophageal Manometry

A. Esophageal Perforation which may Require Surgery

B. Aspiration Pneumonia

C. Cardiac Arrhythmias (irregular heartbeats)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2412. Percutaneous Needle Biopsy of the Liver

A. Bleeding Requiring Transfusion and/or Surgery

B. Lung Collapse which may Require Surgery

C. Internal Leakage of Bile which may Require Surgery

D. Puncture of other Organs which may Require Surgery

E. Aspiration Pneumonia

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2414. 24-Hour PH Monitoring

A. Aspiration Pneumonia

B. Cardiac Arrhythmias (Irregular Heartbeats)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2416. Gastrectomy or Vagotomy and Pyloroplasty

A. Infection in Incision or Inside Abdomen

B. Bleeding which may Require Transfusion

C. Leakage from Stomach (Fistula)

D. Inability to Maintain Weight

E. "Dumping Syndrome" (Chronic Vomiting after Eating)

F. Inability to eat Large Amount of Food, Especially Early after Surgery

G. Diarrhea

H. Need for Vitamin B-12 Injections for Life if Total Gastrectomy is Needed

I. Recurrence of Condition for which Surgery was Originally Done

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2418. Colon Resection

A. Infection in the Incision

B. Intra-Abdominal Infection (Abscess) Requiring Additional Surgery and Prolonged Hospitalization

C. Leakage from Colon (Fistula) Requiring Additional Surgery and Possible Colostomy (Colon Empties into Bag Worn on the Abdomen)

D. Injury to other Organ or Blood Vessel Requiring Additional Surgery or Blood Transfusion

E. Diarrhea, Sometimes Permanent

F. Hernia in Incision Requiring Additional Surgery for Repair

G. Recurrence of Cancer (if Surgery is done for Cancer)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2420. Appendectomy

A. Infection in the Incision

B. Bleeding from or into Incision

C. Intra-Abdominal Infection (Abscess) Requiring Additional Surgery and Prolonged Hospitalization

D. Leakage from the Colon (Fistula) Requiring Additional Surgery and/or Colostomy (Colon Empties into Bag Worn on the Abdomen)

E. Hernia in the Incision

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:896 (August 1994).

§2422. Hernia Repair

A. Infection in the Incision, Possibly Requiring Additional Surgery to Remove Mesh if used for Repair

B. Bleeding into Incision or Scrotum Resulting in Marked Swelling with Pain, Possibly Requiring Additional Surgery

C. Recurrence of Hernia

D. Injury to or Loss of Testicle(s) or Spermatic Cords(s), Possibly Causing Sterility

E. Nerve Injury Resulting in Numbness or Chronic Pain in Groin Area

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:897 (August 1994).

§2424. Hemorrhoidectomy or Excision of Anal Fistula or Fissure

A. Bleeding at Operative Site

B. Post-Operative Pain, Especially with Bowel Movements

C. Temporary/Permanent Difficulty Controlling Bowel Movements or Passage of Gas

D. Recurrence of Hemorrhoids or Fistula or Fissure

E. Narrowing of Anal Opening Requiring Additional Surgery or Repeated anal Dilatations

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:897 (August 1994).

§2426. Excisional Breast Biopsy

A. Infection;

B. Blood clot (hematoma);

C. Failure to obtain accurate diagnosis;

D. Disfiguring scar;

E. Failure to locate and remove abnormality.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:897 (August 1994).

§2428. Lumpectomy (partial excision of breast) with Axillary Dissection

A. Infection

B. Blood Clot (Hematoma)

C. Disfiguring Scar

D. Fluid Collection in Axilla (Arm Pit)

E. Numbness to Arm

F. Swelling of Arm on Side of Surgery

G. Damage to nerves of Arm or Chest Wall, Resulting in Pain, Numbness, Weakness

H. Local Recurrence of Cancer

I. Complication of Irradication

AUTHORITY NOTE : Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 20:897 (August 1994).

§2430. Intravenous Injection of Radiopaque Contrast Media (both ionic and nonionic)

A. This procedure has been identified by the Louisiana Medical Disclosure Panel as having no risks that are required to be disclosed. Absence of required disclosure of risks does not mean that consent for the treatment or procedure is not necessary. Furthermore, it may be necessary to disclose risks if a complicating medical condition is present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E), et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 10:1126 (October 1994), repromulgated LR 20:1126 (October 1994).

§2432. Ventriculoperitoneal Shunt Placement

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Malfunction of Shunt Due to Infection

B. Collection of Blood or Fluid between Brain and Skull (Subdural Hematoma/Hygroma)

C. Headaches (Low Pressure Syndrome)

D. Development of Condition Requiring another Shunt (e.g., Isolated Ventricle)

E. Weakness or Loss of Sensation or other Function Due to Placement of Catheter

F. Blood Clot in Brain (Intracerebral Hematoma)

G. Failure to Absorb Fluid from Peritoneal Cavity (Fluid in Abdomen)

H. Blindness, Seizures or Epilepsy

I. Leaks in Catheter And Its Connections

J. Injury to Abdominal Organs

K. Mechanical Failure

L. Separation or Migration of Catheter

M. Infection with or without Malfunction of Shunt

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 21:471 (May 1995).

§2434. Ventricular Atrial Shunt Placement

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. All of the Material Risks for Ventriculoperitoneal Shunt Placement

B. Heart Failure

C. Infection in Blood Stream

D. Occlusion of Large Veins in Chest

E. Blood or Fluid Collection around Heart

F. Blood Clots in the Lung

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 21:471 (May 1995).

§2436. Lumboperitoneal Shunt Placement

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Inflammation Reaction in Nerves of Spinal Canal

B. Curvature of Spine

C. Shifting/Movement of Brain with Neurological Impairment

D. Headaches

E. Spasticity

F. Difficulty Swallowing

G. Other Neurological Difficulties

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 21:471 (May 1995).

§2438. Hemodialysis

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Hypotension (Abnormally Low Blood Pressure)

B. Blood Vessel Access Problems

C. Anticoagulant Complications such as Hemorrhage

D. Sepsis (Infection in Blood Stream)

E. Cardiac Arrhythmias (Irregular Heartbeats)

F. Allergic Reactions To Tubing And Dialyzer

G. Abdominal Pain

H. Pulmonary Edema (Excess Fluid in Lungs)

I. Hypertension (High Blood Pressure)

J. Systemic Poisoning from Accumulation of Toxic Levels of Metabolic By-Products

K. Air Bubbles in the Bloodstream

L. Abnormal Levels of Minerals in the Blood

M. Acute Hemolysis

N. Seizure

O. Blood Loss

P. Hypothermia (Lowered Body Temperature)

Q. Hyperthermia (Fever)

R. Transfusion Complications, such as Allergic Reaction to Blood Products

S. Metabolic Disorders (Protein Loss, Malnutrition, Elevated Blood Sugar)

T. Acquisition of Viral Infection such as Hepatitis or HIV

U. Cardiac Arrest (Heart Stoppage)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, in consultation with the Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 22:30 (January 1996).

§2440. Peritoneal Dialysis

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Peritonitis (Infection within the Abdominal Cavity)

B. Catheter Complications (Perforation of an Organ In the Abdomen)

C. Hypotension (Abnormally Low Blood Pressure)

D. Metabolic Disorders (Protein Loss, Malnutrition, Elevated Blood Sugar)

E. Hypertension (High Blood Pressure)

F. Pulmonary Edema (Excess Fluid in Lungs)

G. Cardiac Arrhythmias (Irregular Heartbeats)

H. Cardiac Arrest (Heart Stoppage)

I. Use of Temporary Access Catheter

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, in consultation with the Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 22:30 (January 1996).

§2442. Insertion of Temporary Hemodialysis Access Catheter

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Blood Clots, Requiring Re-Operation

B. Infection

C. False Aneurysm (Damaged Blood Vessel with Swelling And Risk Of Rupture)

D. Recurrent Thrombosis (Blood Clot)

E. Severe Edema Of Extremity (Swelling)

F. Inadequate Blood Supply to Extremity (Interference with Blood Supply)

G. Inadequate Blood Supply to Nerves with Resulting Paralysis

H. Pneumothorax (Air in Chest Cavity Causing Collapse of Lung)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, in consultation with the Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 22:30 (January 1996).

§2444. Insertion of Temporary Peritoneal Dialysis Catheter

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Peritonitis (Infection inside the Abdominal Cavity)

B. Bleeding

C. Infection

D. Intestinal Perforation (Piercing of an Organ Within the Abdominal Cavity)

E. Ileus (Sluggishness and Distention of Intestines)

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, in consultation with the Louisiana Medical Disclosure Panel, LR 18:1391 (December 1992), repromulgated LR 19:1581 (December 1993), amended LR 22:30 (January 1996).

§2446. Percutaneous Renal Biopsy Complications

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Injury to Adjacent Organs, such as Spleen or Liver

B. Infection

C. Hypotension (Abnormally Low Blood Pressure)

D. Bleeding from the Kidney

E. Internal Bleeding

F. Intestinal Perforation

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 22:31 (January 1996).

§2449. Urology

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Nephrectomy (complete or partial removal of kidney)

1. bleeding;

2. infection;

3. injury to adjacent organs such as lung, spleen, liver, bowel, adrenal gland (if not removed);

4. incomplete removal of tumor, if present.

B. Extracorporeal Shock Wave Lithotripsy (using shock waves to break up kidney or ureteral stones)

1. bleeding in or around kidney;

2. obstruction of kidney by stone particles;

3. failure to completely fragment stone requiring repeat treatment or other form of treatment;

4. high blood pressure (transient or permanent);

5. loss of kidney.

C. Cystectomy with Urinary Diversion (removal of bladder with use of bowel to drain urine)

1. bleeding requiring blood transfusion;

2. infection;

3. injury to adjacent organs (bowel, blood vessels, nerves, etc.);

4. impotence (loss of erection functions);

5. ostomy problems (scarring, infection) which might necessitate re-operation.

D. Transurethral Prostatectomy (use of lighted scope and cautery to internally remove portion of prostate causing blockage)

1. bleeding requiring transfusion or re-operation;

2. infection;

3. injury to bladder or urethra or rectum;

4. impotence;

5. retrograde ejaculation ("dry ejaculation"Xbackward flow of ejaculate fluid into bladder) producing infertility;

6. bladder neck contractureXformation of scar tissue causing bladder blockage requiring repeat surgery or treatment;

7. incontinence (urinary leakage).

E. Radical Prostatectomy (total removal of prostate gland)

1. bleeding;

2. infection;

3. injury to adjacent organs (blood vessels, bowel, nerves);

4. blockage of ureters (kidney drainage tubes);

5. erectile dysfunction (impotence, i.e., loss of erection/ejaculation);

6. incontinence (urinary leakage).

F. Bladder Suspension (MMK, PereryaXProcedure, Cystocele Repair, etc.)

1. bleeding;

2. infection;

3. blockage of ureters (kidney drainage tubes);

4. persistent leakage;

5. urinary fistula (abnormal hole in connection between bladder, vagina, etc.);

6. inability to void.

G. Vasectomy

1. bleeding;

2. infection;

3. testicular swelling or pain/possible loss of testicular function;

4. spermatic granuloma (nodule in cord at site of surgery);

5. recanalization ("re-connection" of vas tube resulting in becoming fertile again).

H. Penile Implant

1. bleeding;

2. infection (with possible loss of implant);

3. penile pain or numbness;

4. injury to bladder or urethra;

5. problems with implantable prosthetic.

I. Orchiectomy (removal of testicle)

1. bleeding;

2. infection;

3. loss of hormone (testosterone) resulting in erection problems, decreased energy, etc.;

4. loss of fertility (ability to have children).

J. Varicocele Repair (ligation/tying of spermatic veins)

1. bleeding;

2. infection;

3. injury to spermatic cord (vas deferens), testicular artery, nerves;

4. testicular swelling or pain;

5. possible loss of testicle due to blood vessel injury or infection (rare).

K. Transurethral Resection of Bladder Tumor

1. bleeding;

2. infection;

3. perforation of bladder;

4. obstruction of ureter (kidney drainage tube).

L. Circumcision (removal of penile foreskin)

1. ulceration and scarring of urine hole at tip of penis (meatal stenosis);

2. bleeding;

3. infection (minor or serious);

4. removal of too much or too little skin;

5. skin bridge;

6. fistula (abnormal hole in urine tube);

7. buried penis.

M. Hernia/Hydrocele (removal of fluid filled sac)

1. injury to sperm duct (vas deferens);

2. injury to blood vessels of testis;

3. atrophy (shriveling) of the testicle with loss of function;

4. reaccumulation of hernia or fluid in scrotum.

N. Hypospadias Repair (Correction of Penile Curvature/Urethroplasty) (Construction/reconstruction of drainage tube from bladder)

1. leakage of urine at surgical site;

2. stricture formation;

3. residual curvature of penis;

4. disfiguring scars;

5. injury to glans (head of penis);

6. additional operations.

O. Ureteral Reimplantation (Reinserting ureter, tube between kidney and bladder, into the bladder)

1. leakage of urine at surgical site;

2. obstruction to urine flow;

3. damage to or loss of ureter (kidney drainage tube);

4. backward flow of urine from bladder into ureter (kidney drainage tube);

5. damage to other adjacent organs;

6. damage to kidney.

P. Pyeloplasty (pyeloureteroplastyXreconstruction of kidney drainage system)

1. obstruction of urinary flow;

2. leakage of urine at surgical site;

3. injury to or loss of kidney;

4. damage to adjacent organs;

5. decrease in kidney functionXtemporary/ permanent;

6. infection with resultant failure of surgery and/or loss of kidney function.

Q. Orchiopexy (surgically placing an undescended testicle into the scrotum)

1. atrophy (shriveling) of the testicle with loss of function;

2. removal of the testicle;

3. injury to the vas deferens;

4. inability to completely bring the testicle into the scrotum in a single surgical procedure;

5. recurrent hernia formation;

6. infection with possible loss of testicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 22:31 (January 1996), repromulgated LR 22:285 (April 1996), LR 22:712 (August 1996).

§2451. Gastric Lap Band for Obesity

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for the particular procedure.

A. Risks of Surgery

1. Damage to surrounding organs:

a. bowel, pancreas, liver, requiring more surgery;

b. blood vessels and/or spleen with bleeding requiring transfusion;

c. with removal of spleen.

B. Risks of Recovery Period

1. Abdominal wound problems:

a. infection, failure to heal, severe scarring, hernia.

2. Blood clots in the legs and/or pulmonary embolism (clots moving to lungs).

3. Pneumonia or other breathing problems requiring prolonged need for ventilator (breathing machine).

C. Need for additional surgery due to:

1. gallstones with possible inflammation of the liver and/or pancreas;

2. stomach or intestinal blockage from trapped food or scarring;

3. abdominal infection with abscess;

4. bleeding.

D. Other long term risks:

1. extreme weight loss;

2. failure to lose weight;

3. large folds of loose skin;

4. depression as a result of weight loss, required diet change, or complications of surgery;

5. failure of the procedure;

6. vitamin and/or mineral deficiency, possibly requiring lifelong injections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 24:1304 (July 1998).

§2453. Gastric Bypass with or without Liver Biopsy for Obesity

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for the particular procedure.

A. Risks of Surgery:

1. damage to surrounding organs:

a. bowel, pancreas, liver, requiring more surgery;

b. blood vessels and/or spleen with bleeding requiring transfusion;

c. with removal of spleen.

B. Risks of Recovery Period:

1. abdominal wound problems:

a. infection, failure to heal, severe scarring, hernia;

2. blood clots in the legs and/or pulmonary embolism (clots moving to lungs);

3. Pneumonia or other breathing problems requiring prolonged need for ventilator (breathing machine);

C. Need for additional surgery due to:

1. gallstones with possible inflammation of the liver and/or pancreas;

2. stomach or intestinal blockage from trapped food or scarring;

3. abdominal infection with abscess;

4. bleeding.

D. Other long term risks:

1. extreme weight loss;

2. failure to lose weight;

3. large folds of loose skin;

4. depression as a result of weight loss, required diet change, or complications of surgery;

5. failure of the procedure;

6. excessive flatulence (passing bowel gas);

7. severe, persistent diarrhea;

8. vitamin and/or mineral deficiency, possibly requiring lifelong injections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 24:1305 (July 1998).

§2455. Thoracentesis (insertion of needle or tube for drainage of chest cavity fluid)

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for the particular procedure.

A. Bleeding

B. Pneumothorax (Lung Collapse)

C. Infection

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 24:1305 (July 1998).

§2457. Cancer Chemotherapy (treatment of cancer using anti-cancer medications)

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for the particular procedure.

A. Hair Loss

B. Damage to Blood Forming Organ (Bone Marrow) which May Result in Bleeding, Infection, Anemia, and Possible Need for Transfusion

C. Damage to Brain, Heart, Kidneys, Liver, Lungs, Nervous System, and Skin

D. Serious Allergic Reaction Including Shock

E. Sterility

F. Nausea and/or Vomiting

G. Constipation or Diarrhea

H. Sores on Lips and/or Ulcers in the Lips, Mouth, Throat, Stomach, Rectum

I. Loss of Lining of Intestinal Tract from Mouth to Anus

J. Secondary Cancer (Cancers in the Future Caused by Chemotherapy)

K. Local Damage at Injection Site

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Medical Disclosure Panel, LR 24:1305 (July 1998).

§2459. Intravenous Conscious Sedation

NOTE: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for the particular procedure.

A. The risks for Intravenous Conscious Sedation will be covered by 4 (c), as stated in the main consent form [death, brain damage, disfiguring scars, quadriplegia (paralysis for neck down), paraplegia (paralysis from waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain].

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Medical Disclosure Panel, LR 24:1305 (July 1998).

§2461. Cervical Manipulation/Adjustment

NOTE: This Section was originally promulgated as §2440 but was moved as that number was in use.

Note: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Stroke

B. Disc Herniation

C. Soft Tissue Injury

D. Rib Fracture

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 21:701 (July 1995).

§2463. Thoracic or Lumbar Manipulation/Adjustment

NOTE: This Section was originally promulgated as §2442 but was moved as that number was in use.

Note: Itemization of the procedures and risks under a particular specialty does not preclude other qualified practitioners from using those risks identified for that particular procedure.

A. Disc Herniation

B. Soft Tissue Injury

C. Rib Fractures

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1299.40(E) et seq.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Medical Disclosure Panel, LR 21:701 (July 1995).

Chapter 25. Departmental Research

§2501. Purpose

A. These policies are designed to assure the protection of the rights of human subjects of research conducted in programs or facilities operated or funded by the Department of Health and Hospitals (DHH).

AUTHORITY NOTE: Promulgated in accordance with 56 FR 28002.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:449 (March 1998).

§2503. Applicability

A. These policies apply to all research conducted in programs/facilities operated or funded by the DHH.

AUTHORITY NOTE: Promulgated in accordance with 56 FR 28002.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:449 (March 1998).

§2505. Definitions

Cognitively Impaired—having either a psychiatric disorder (e.g., psychosis, neurosis, personality or behavior disorders), an organic impairment (e.g., dementia) or a developmental disorder (e.g., mental retardation) that affects cognitive or emotional functions to the extent that capacity for judgement and reasoning is significantly diminished. Others, including persons under the influence of or dependent on drugs or alcohol, those suffering from

degenerative diseases affecting the brain, terminally ill patients, and persons with severely disabling physical handicaps may also be compromised in their ability to make decisions in their best interests.

Competence—technically, a legal term used to denote capacity to act on one's own behalf; the ability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a choice. (See also: Incompetence, Incapacity.) Competence may fluctuate as a function of the natural course of a mental illness, response to treatment, effects of medication, general physical health, and other factors. Therefore, mental status should be re-evaluated periodically. As a designation of legal status, competence or incompetence pertains to an adjudication in court proceedings that a person's abilities are so diminished that his or her decisions or actions should have no legal effect. Such adjudications are often determined by inability to manage business or monetary affairs and do not necessarily reflect a person's ability to function in other situations.

DHH—Department of Health and Hospitals (Louisiana).

DHHS—U.S. Department of Health and Human Services. This federal agency promulgated 45 CFR, Part 46, Protection of Human Subjects, revised June 18, 1991, effective August 19, 1991. DHH's research policies are based upon 45 CFR, Part 46.

Human Subject—a living individual about whom an investigator (whether professional or student) conducting research obtains:

1. data through intervention or interaction with the individual; or

2. identifiable private information.

Identifiable Private Information—private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (e.g., a medical record). Private information must be individually identifiable (i.e., the identification of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

Incapacity—a person's mental status and means inability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a choice. Often used as a synonym for incompetence.

Incompetence—technically, a legal term meaning inability to manage one's affairs. Often used as a synonym for incapacity.

IRB Approval—the determination of the IRB that the research has been reviewed and may be conducted within the constraints set forth by the IRB and by other state and federal requirements.

Institutional Review Board (IRB)—the DHH committee with responsibility for reviewing and recommending approval/disapproval of all research proposals.

Interaction—includes communication or interpersonal contact between investigator and subject.

Intervention—includes both physical procedures by which data are gathered (e.g., venipuncture) and manipulations of the subject or his/her environment that are performed for research purposes.

Investigator—the person conducting research.

Minimal Risk—the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during performance of routine physical or psychological examinations or tests.

Programmatic Offices—the major programmatic offices in DHH are:

Bureau of Health Services Financing (BHSF), Office of Alcohol and Drug Abuse (OADA), Office for Citizens with Developmental Disabilities (OCDD), Office of Mental Health (OMH), and Office of Public Health (OPH).

Research—systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

AUTHORITY NOTE: Promulgated in accordance with 56 FR 28002.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:449 (March 1998).

§2507. Statement of Principles

A. The DHH believes that research involving human subjects must be based upon the principles of respect for persons, beneficence, and justice.

1. Respect for persons involves a recognition of personal dignity and autonomy of individuals, and special protection of those persons with diminished autonomy.

2. Beneficence entails an obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risks of harm.

3. Justice requires that benefits and burdens of research be distributed fairly.

B. DHH also recognizes that many consumers of its services may be cognitively impaired and therefore deserve special consideration as potential research subjects. The predominant ethical concern in research involving persons with psychiatric, cognitive, developmental, or chemical dependency disorders is that their conditions may compromise their capacity to understand the information presented and their ability to make a reasoned decision about participation. Consequently, approval of proposals to use

these individuals as research subjects will be conditioned upon the researcher demonstrating that:

1. such individuals comprise the only appropriate subject population;

2. the research question focuses on an issue unique to these subjects;

3. the research involves no more than minimal risk, except when the purpose of the research is therapeutic for these individual subjects and the risk is commensurate with the degree of expected benefit.

AUTHORITY NOTE: Promulgated in accordance with 56 FR 28002.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:450 (March 1998).

§2509. Policies and Procedures

A. Policy Basis. Research conducted and authorized by the DHH will meet all applicable federal and state laws and regulations, accreditation standards, and professional codes of ethics. These policies derive primarily from 45 CFR, Part 46, Protection of Human Subjects and are also consonant with 21 CFR, Parts 50 and 56, adopted by the Food and Drug Administration. (Both sets of regulations were effective on August 19, 1991.) 45 CFR, Part 46 is applicable to other DHHS components, including the Health Care Financing Authority (Medical Assistance Programs).

B. Establishment of Institutional Review Board (IRB). There is hereby established a DHH IRB to review and evaluate all proposed research projects.

1. Twenty-four hour facilities may either utilize these policies as written or amend them to provide for an in-house IRB for initial assessment of research projects prior to submission to the DHH IRB for final review.

2. All research involving DHH consumers, employees, or services in the community and in institutions will be reviewed by the DHH IRB before it is submitted to the secretary or designee for final approval.

3. The IRB is a permanent standing committee which meets quarterly or as needed.

4. The membership shall consist of at least seven members, appointed by the secretary, partly from recommendations by the assistant secretaries and the director of the BHSF:

a. the director of research and development or his/her designee shall serve as permanent chairperson of the IRB. In the event of an extended absence from duty of the permanent chair, the secretary shall appoint a temporary replacement to serve during that period;

b. each office and the BHSF shall have at least one member;

c. relevant professional disciplines shall be represented in the membership;

d. at least one member shall be a direct service provider;

e. one member shall not be employed by the DHH. If possible, this member should be an ethicist (specialist in ethics) or an attorney;

f. at least one member shall be either a primary consumer, or a family member, or an advocate;

g. at least one member's primary concerns shall be in science areas and at least one member's primary concerns shall be in nonscientific areas. If not selected under §2509.B.4.e, an attorney or ethicist should fill the latter slot;

5. The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available to the IRB. Such individuals shall not vote with the IRB.

6. IRB members should have appropriate research training, experience or interest. Membership should also sufficiently represent the cultural, ethnic, and gender diversity of the state and be sensitive to diverse community attitudes.

7. Except for the chair, members shall be appointed for one-year terms and may be reappointed.

8. No IRB member may participate in the initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

9. Once constituted, the IRB shall adopt written bylaws and guidelines/application materials for conducting research in DHH operated/funded programs or facilities.

10. Research approved by the Office of Public Health's (OPH) IRB prior to the adoption of these policies does not require DHH IRB approval. However, copies of proposals approved by the OPH IRB shall be provided to the chair of the DHH IRB.

C. IRB Review Process. Prior to authorization and initiation of research, an IRB meeting shall be convened to conduct a detailed review of the project in order to determine that all of the following requirements are met.

1. Proposal incorporates procedures designed to minimize the risk to participants. Risks to subjects are minimized by using procedures which are consistent with sound research design and do not unnecessarily expose subjects to risk and, whenever appropriate, by using procedures already being performed on subjects for diagnostic or treatment purposes.

2. Risks to subjects are reasonable in relation to anticipated benefits and the importance of any knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research, as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research. The IRB should not consider possible long-range effects of applying knowledge

gained in the research (e.g., possible effects of research on public policy) as among those research risks that fall within its purview.

3. Selection of subjects is equitable. In making this assessment, the IRB should take into account the purposes and setting of the research. It should be particularly cognizant of special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.

4. Research design minimizes possible disruptive effects of project on organizational operation.

5. Research design is in compliance with accepted ethical standards.

6. Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with and to the extent required in §2509.E.

7. Informed consent will be appropriately documented, in accordance with and to the extent required by §2509.E.1-5 of these rules.

8. When appropriate, the research plan provides monitoring of the data collected to ensure subjects' safety.

9. Research proposal contains requisite safeguards to protect the privacy of subjects and to maintain the confidentiality of data.

10. Research proposal has been approved at the appropriate program administrative level, beginning with the program/facility.

D. IRB Recommendations and Notification

1. Researchers should be either present at the IRB meeting which considers their proposals or available for questioning at an indicated phone number during that time.

2. Following detailed review, the IRB by majority vote approves (fully or provisionally) or disapproves the research proposal.

a. Provisional approval means that minor modifications, specified in writing by the IRB, must be received by the chair within 30 days in order to recommend full approval.

b. Proposals receiving full approval are sent to the secretary or designee for authorization to begin research.

3. The secretary or the director of research and development will notify the researcher in writing of the IRB's decision to approve or disapprove the proposed research within 10 working days.

a. If the proposal is not approved, the letter will indicate reasons for disapproval and give the researcher an opportunity to respond in writing to the IRB.

b. There are no appeals for research proposals disapproved on the basis of ethical shortcomings or potential harm to subjects.

c. No research, subject to IRB review, can begin until written authorization from the secretary or designee is received.

d. Research approved by the IRB may be subject to further administrative review and approval or disapproval. However, no administrator can approve research which has not been approved by the IRB.

e. After approval, the IRB shall review the research in progress at appropriate intervals, but not less than once per year.

f. The IRB has the authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected harm to subjects. Any suspension or termination of approval shall be in writing, include the reasons for this action, and be reported promptly to the investigator, appropriate agency officials, and the secretary.

g. Cooperative research refers to those projects covered by this Chapter which involve more than one institution or agency. In the conduct of cooperative research projects, each institution or agency is responsible for safeguarding the rights and welfare of human subjects and for complying with 45 CFR, Part 46. With the approval of the DHH or agency head, an institution participating in a cooperative project may enter into a joint review arrangement, rely upon the review of another qualified IRB, or make similar arrangements for avoiding duplication of effort.

4. Expedited Review Procedure

a. Research that involves no more than minimal risk and in which the only involvement of human subjects will be in one or more of the following categories (carried out through standard methods) may be reviewed by the IRB through an expedited review procedure. Under this procedure, the review may be carried out by the IRB chairperson or by one or more experienced reviewers designated by the chair from among IRB members. In reviewing the research, the reviewers may exercise all of the authority of the IRB except that they may not disapprove the research. Research may be disapproved only after review in accordance with the nonexpedited procedures set forth in §2509.C. A report of all research approved by expedited review will be presented by the chair to the full IRB at its next regularly scheduled meeting. Categories of research which may qualify for expedited review include:

i. research conducted in established or commonly accepted educational settings, involving normal educational practices (e.g., research on special education instructional strategies);

ii. research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior if such research does not record information or identifiers which can be linked to individual human subjects;

iii. research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens;

iv. research and demonstration projects which are conducted by or subject to the approval of the secretary or heads of programmatic offices and are designed to study, evaluate, or otherwise examine public benefit of services or programs;

v. research conducted by faculty or students at colleges/universities if all of the following conditions are met:

(a). a copy of the university's IRB policies is on file with the DHH IRB;

(b). university IRB's approval of the research is documented;

(c). a copy of the full research proposal is included;

(d). for student research, written approval of the project by both a faculty advisor and a DHH staff sponsor must be provided;

vi. research approved by an IRB in 24-hour facilities if requested via the chief executive officer of the facility to the DHH IRB chair;

vii. requests from investigators for minor changes in research approved less than one year prior to such request;

viii. cooperative research which has been approved by the IRB and head of an agency outside of DHH.

b. The secretary or agency heads may restrict, suspend, terminate, or choose not to authorize use of the expedited review procedure.

E. Informed Consent of Research Subjects. Except as provided elsewhere in Chapter 25, no investigator may involve a human being as a subject in research unless the investigator obtains the legally effective informed consent of the subject or the subject's authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The information that is given to the subject or representative shall be in language easily understandable to the subject or representative. No informed consent document may include any exculpatory language through which the subject or representative is made to waive or appear to waive any of the subject's legal rights or the investigator, the sponsor, or the agency and its agents are/appear to be released from liability for negligence.

1. Basic Elements of Informed Consent. Except as provided below, the investigator shall provide each subject the following information:

a. a statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;

b. a description of any reasonably foreseeable risks or discomforts to the subject;

c. a description of any benefits to the subject or to others which may reasonably be expected from the research;

d. a disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;

e. a statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

f. for research involving more than minimal risk, explanations as to whether any compensation and medical treatment are available if injury occurs and, if so, what they consist of, or where further information may be obtained;

g. an explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research related injury to the subject;

h. a statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

2. Additional Elements of Informed Consent. When appropriate, one or more of the following elements of information shall also be provided to each subject:

a. a statement that the particular treatment or procedure may involve risk that is currently unforeseeable;

b. anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent;

c. any additional costs to the subject that may result from research participation;

d. the consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;

e. a statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject;

f. the approximate number of subjects involved in the study.

3. Waiver of Informed Consent. The IRB may waive the requirement to obtain informed consent provided that the IRB finds and documents that:

a. the research or demonstration project is to be conducted by or subject to the approval of state government officials and is designed to study or evaluate public benefit of services provided or funded by DHH;

b. such project deals with improving procedures for obtaining benefits/services under those programs and/or suggesting possible changes in or alternatives to those programs/procedures or in the methods/levels of payment for benefits or services under those programs; and

c. such research or projects shall not involve identifying individual recipients of services/benefits.

4. Documentation of Informed Consent

a. Informed consent shall be documented by the use of a written consent form approved by the IRB and signed by the subject or the subject's legally authorized representative. A copy shall be given to the person signing the form.

b. The written consent document must embody the elements of informed consent required in §2509.E.1. This form may be read to the subject or the subject's legally authorized representative but, in any event, the investigator shall give either the subject or the representative adequate opportunity to read it before it is signed. An IRB recommended informed consent document will be included in the guidelines/application materials for conducting research in DHH operated/funded programs or facilities.

c. The IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either:

i. that the only record linking the subject and the research would be the consent document and the principal risk would be the potential harm resulting from a breach of confidentiality. Each subject will be asked if he/she wants documentation linking him/her with the research, and the subject's wish shall govern; or

ii. that the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

d. In cases in which the documentation requirement is waived, the IRB may require the investigator to provide subjects with a written statement regarding the research.

5. The IRB shall demand additional protection and informed consent rights if the research involves fetuses, pregnant women and human in-vitro fertilization (45 CFR46:201-211), prisoners (45 CFR 46:301-306), or children (45 CFR 46:401-409).

F. Responsibilities of Research Investigators. In addition to all of the requirements detailed in §2509, researchers shall be responsible for the following.

1. Research investigators shall prepare and submit a protocol giving a complete description of the proposed research.

a. The protocol shall include provisions for adequate protection of the rights and welfare of prospective research subjects and ensure that pertinent laws and regulations are observed.

b. Samples of proposed informed consent forms shall be included with the protocol.

c. A completed DHH Application to Conduct Research must be submitted with the protocol.

2. Research investigators shall obtain and document appropriate administrative approval (beginning at the program/facility level) to conduct research before the proposal is submitted to the DHH IRB.

3. Prior to the beginning of the research, the investigator shall communicate to impacted staff the purpose and nature of the research.

4. Upon completion of the research, the principal investigator shall attempt to remove any confusion, misinformation, stress, physical discomfort, or other harmful consequences, however unlikely, that may have arisen with respect to subjects as a result of the research.

5. Within 30 working days of the completion of the research, the principal investigator shall communicate the outcome(s) and practical or theoretical implications of the research project to the program administrator and, when appropriate, program staff in a manner that they can understand.

6. The researcher shall submit progress reports as requested by the IRB (at least annually). As soon as practicable after completion of the research, but in no case longer than 90 working days later, the research investigator shall submit to the IRB a written report, which, at a minimum, shall include:

a. a firm date on which a full, final report of research findings will be submitted;

b. a succinct exposition of the hypotheses of the research, the research design and methodologies, and main findings of the research;

c. an estimate of the validity of conclusions reached and some indication of areas requiring additional research; and

d. specific plans for publishing results of the research.

7. A final report of the research as well as copies of any publications based upon the research will be submitted to the IRB as soon as possible. The state owns the final report, but prior permission of the IRB for the investigator to publish results of the research is not required. The publication is the property of the researcher and/or the medium in which it is published. However, failure to provide the IRB with required periodic and final reports or publications based on the research shall negatively impact that researchers's future research shall negatively impact that researcher's future requests to conduct research in DHH operated/funded programs or facilities.

G. Initiation of the Research Review Process

1. The first contact in the process should be by the research investigator with the manager of the program or facility from which subjects will be drawn.

2. If the manager agrees that the research is feasible and desirable, the researcher will obtain his/her written authorization and send the protocol to appropriate staff at headquarters for consideration and approval by the assistant secretaries or the director of BHSF.

3. The assistant secretaries or the director of BHSF, in approving the research proposal, will certify that:

a. the research design is adequate and meets acceptable scientific standards;

b. appropriate ethical considerations have been identified and discussed;

c. the proposal contains provisions to minimize possible disruptive effects of the project on organization's operation;

d. the research will potentially benefit the participants directly or improve the service system; and

e. the research topic is compatible with the agency's research agenda.

4. The assistant secretaries or the director of BHSF, after approval of the research, will submit the proposal to the IRB for further consideration.

H. IRB Records

1. The IRB shall prepare and maintain adequate documentation of IRB activities, including the following:

a. copies of all research proposals reviewed, scientific evaluations, if any, that accompany the proposals, approved sample consent documents, progress reports submitted by investigators, and reports of injuries to subjects;

b. minutes of IRB meetings in sufficient detail to show attendance at the meeting; actions taken by the IRB; the vote on these actions, including the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution;

c. records of continuing review activities;

d. copies of all correspondence between the IRB and investigators;

e. a list of IRB members identified by name; earned degrees; representative capacity; indications of experience sufficient to describe each member's chief anticipated contributions to IRB deliberations; and any employment or other relationship between each member and the DHH;

f. written procedures for the IRB and statements of significant new findings provided to subjects.

2. The records required by §2509.H shall be retained for at least three years, and records relating to research which is conducted shall be retained for at least three years after completion of the research. All records shall be accessible for inspection and copying by authorized representatives of DHHS or the agency at reasonable times and in a reasonable manner.

AUTHORITY NOTE: Promulgated in accordance with 56 FR 28002.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:450 (March 1998).

Chapter 27. Capital Area Human Services District

§2701. Introduction

A. This agreement is entered into by and between Department of Health and Hospitals, hereinafter referred to as DHH, and Capital Area Human Services District, hereinafter referred to as CAHSD, in compliance with R.S. 46:2661 through 46:2666 as well as any subsequent legislation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:948 (May 1998), amended LR 25:666 (April 1999), LR 28:1593 (July 2002), LR 29:1092 (July 2003).

§2703. Purpose and General Agreement

A. The Department of Health and Hospitals is authorized by law to provide for the direction, operation, development and management of programs of community-based mental health, mental retardation/developmental disabilities, addictive disorders, public health and related activities for eligible consumers in Louisiana.

B. The legislation authorizes CAHSD to provide services of community-based mental health, developmental disabilities, addictive disorders, public health and related activities for eligible consumers in CAHSD, which includes East Baton Rouge, West Baton Rouge, Ascension, Iberville, East Feliciana, West Feliciana and Pointe Coupee parishes; and to assure that services meet all relevant federal and state regulations; and to provide the functions necessary for the administration of such services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:948 (May 1998), amended LR 25:666 (April 1999), LR 28:1593 (July 2002), LR 29:1092 (July 2003).

§2705. Designation of Liaisons

A. The primary liaison persons under this agreement are:

1. for DHHXdeputy secretary;

2. for CAHSDXchairperson.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:949 (May

1998), amended LR 25:667 (April 1999), LR 28:1593 (July 2002), LR 29:1093 (July 2003).

§2709. Services to be Delivered

A. In order to provide a broad spectrum of coordinated public services to consumers of the Office of Mental Health, hereinafter referred to as OMH, the Office for Citizens with Developmental Disabilities, hereinafter referred to as OCDD, the Office for Addictive Disorders hereinafter referred to as OAD, the Office of Public Health, hereinafter referred to as OPH and for the District Administration, CAHSD will assume programmatic, administrative and fiscal responsibilities for including, but not limited to, the following:

1. OCDD community services;

2. mental health services consistent with the State Mental Health Plan, as required under the annual Mental Health Block Grant Plan;

3. outpatient treatment (non-intensive)XOAD;

4. community-based servicesXOAD;

5. intensive outpatient treatment/day treatmentXOAD;

6. non-medical/social detoxificationXOAD;

7. primary preventionXOAD;

8. adult inpatient treatment servicesXOAD;

9. transition to recovery homes (when funds and placements are available);

10. residential board and care (when funds and placements are available)XOAD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:949 (May 1998), amended LR 25:667 (April 1999), LR 28:1593 (July 2002), LR 29:1093 (July 2003).

§2711. Responsibilities of Each Party

A. CAHSD accepts the following responsibilities:

1. to perform the functions which provide community-based services and continuity of care for the diagnosis, prevention, detection, treatment, rehabilitation and follow-up care of mental and emotional illness;

2. to be responsible for community-based programs and functions relating to the care, diagnosis, eligibility determination, training, treatment, and case management of developmentally disabled and autistic persons as defined by the MRDD law, and to follow the rules or policies governing admissions to OCDD Developmental Centers;

3. to be responsible for the delivery and supervision of OCDD transition services and case management, where appropriate, and provide supports to person waiting for Waiver Services when an individual transitions to the community;

4. to provide for the gradual assumption of community-based public health services which will be determined to be feasible through consultation with the Office of Public Health;

5. to provide services related to the care, diagnosis, training, treatment, and education of, and primary prevention of addiction. The criteria for admission and treatment must be parallel to OAD state operated programs;

6. to maintain services in community-based mental health, developmental disabilities, and substance abuse at least at the same level as the state maintains similar programs;

7. to ensure that the quality of services delivered is equal to or higher than the quality of services previously delivered by the state;

8. to perform human resources functions necessary for the operation of CAHSD;

9. to be responsible for the provision of any function/service, reporting or monitoring, mandated by the Block Grant Plan of each respective program office;

10. to provide systems management and services data/reports in a format, and content, and frequency content as that required of all regions by each DHH program office. Specific content of required information sets will be negotiated and issued annually through program office directives;

11. to utilize ARAMIS, MIS, Mental Health's SPOE, CMIS and any other required DHH/program office systems to meet state and federal reporting requirements. CAHSD will use the OCDD Individual Tracking System and/or other designated MIS system. OCDD will allow CAHSD to electronically upload and download information at prescribed intervals. No information will be uploaded by OCDD without prior notification of CAHSD;

12. to make available human resource staffing data for on-site review;

13. to maintain and support Single Point of Entry (SPOE) state standard;

14. to provide for successful delivery of services to persons discharged from state facilities into CAHSD service area by collaborative discharge planning;

15. to provide in-kind or hard match resources as required for acceptance of federal grant or entitlement funds utilized for services in CAHSD as appropriately and collaboratively applied for consistent with other regions in the state;

16. to make available a list of all social and professional services available to children and adults through contractual agreement with local providers. The list shall include names of contractors, dollar figures and brief description of services;

17. to work with OAD to assure that all requirements and set asides of the Substance Abuse Block Grant are adhered to in the delivery of services;

18. to develop and utilize a five-year strategic plan as required by Act 1465;

19. to monitor the quality of supports delivered to developmentally disabled individuals in state funded supported living arrangements;

20. to report to OMH on a monthly basis data consistent with that reported in DHH operated regions in order to assure statewide data integrity and comparability across all 64 parishes. The format for reporting this information must comply with OMH data transmission requirements as specified by the assistant secretary for OMH;

21. to continue to make available through all CAHSD sites, materials available from OPH, based on availability of current funding from state and federal resources. Availability of materials shall also be based on the incidence rate of HIV in Region II and throughout the state;

22. to comply with OAD movement toward research-proven best practices and adhere to the established standard of care.

B. DHH retains/accepts the following responsibilities:

1. operation and management of any inpatient facility under the jurisdiction of DHH except that CAHSD shall have the authority and responsibility for determination of eligibility for receipt of such inpatient services (OMH's SPOE function) which were determined at the regional level prior to the initiation of this agreement;

2. operation, management and performance of functions and services for environmental health;

3. operation, management and performance of functions related to the Louisiana Vital Records Registry and the collection of vital statistics;

4. operation, management and performance of functions and services related to laboratory analysis in the area of personal and environmental health;

5. operation, management and performance of functions and services related to education provided by or authorized by any state or local educational agency;

6. monitoring this service agreement, assuring corrective action through coordination with CAHSD and reporting failures to comply to the Governor's Office;

7. operation, management and performance of functions for pre-admission screening and resident review process for nursing home reform;

8. sharing with CAHSD information regarding but not limited to program data, statistical data, and planning documents that pertain to the CAHSD. Statewide information provided on a regional basis to providers, consumers and advocates shall either include accurate data for CAHSD, as confirmed by CAHSD, or shall include a statement that information for Region II (CAHSD) is available on request. This is necessary to make community stakeholders aware that CAHSD is participating in the submission of the same data reports as are required of the other regions;

9. communicating to CAHSD Executive Director any planned amendments to current law establishing CAHSD, or new legislation that is primarily directed to impacting CAHSD funding or administration or programs, prior to submission to the Governor's Office or to a legislative author;

10. reporting of statewide performance or comparisons, which are circulated outside of the DHH Program Offices, which include data submitted directly by CAHSD, or which are generated from data transmission programs in which CAHSD participates will be provided to CAHSD;

11. providing fair and equal access to all DHH facilities and to all appropriately referred citizens residing in the parishes served by CAHSD;

12. inviting the CAHSD Community Services Regional Manager (CSRM) to OCDD meetings that include the CSRMs of the eight regions under OCDD administration, when discussions or presentations impact citizens and/or administration of duties within CAHSD;

13. meeting with CAHSD to discuss and plan for any necessary upgrades in hardware, software or other devices necessary for the electronic submission of data which is required of CAHSD;

14. including CAHSD's Executive Director in discussions that specifically relate to changes in CAHSD programming or financing, prior to final decision-making;

15. planning, managing and delivering services funded under this agreement as required in order to be consistent with the priorities, policies and strategic plans of DHH, its program offices, and related local initiatives. DHH shall include CAHSD as appropriate in the development of these plans and priorities and notify the executive director within at least the same time period as other regional managers;

16. determining if community-based mental health, developmental disabilities, addictive disorders, and public health services are delivered at least at the same level by CAHSD as the state provides for similar programs in other areas. Performance indicators shall be established and will be consistent with those collected in other regions. Such indicators will measure extensiveness of services, accessibility of services, availability of services and, most importantly, quality of services. CAHSD will not be required to meet performance indicators which are not mandated for state-operated programs in these service areas;

17. any requests by program offices for new and expanded regional funds requested statewide will include the appropriate proportionate amount of funding for CAHSD.

C. Joint Responsibilities

1. CAHSD shall work closely with OCDD in transitioning individuals from all Developmental Centers to the district and will be responsible for the case management oversight, when appropriate, of the service providers to ensure that their recipients receive appropriate services and outcomes as designated in the comprehensive plan of care.

2. CAHSD will work with OAD to assure that the key performance indicators sent to the Division of Administration (DOA) are the same for CAHSD and OAD.

3. CAHSD will work with OAD to assure that there is a clear audit trail for linking alcohol and drug abuse funding and staffing to alcohol and drug abuse services.

4. CAHSD will collaborate with Region II OPH managers when appropriate to assist clients in accessing community-based services and ensure continuity of care for education, prevention, detection, treatment, rehabilitation and follow up care related to personal health.

5. CAHSD shall notify the DHH Bureau of Legal Services and relative program offices in a timely manner to assure proper representation in all judicial commitments and court events involving placement in DHH programs. CAHSD shall also provide program staff as representatives to assist DHH in all judicial commitments and court events involving placement in DHH programs. DHH will provide legal support and representation in judicial commitments to the department.

6. Budget requests for new and expanded programs or requests for additional funding for existing programs will be discussed between CAHSD Executive Director and appropriate program office personnel in a timely manner to avoid incongruous requests for new funding prior to submission to DOA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:949 (May 1998), amended LR 25:667 (April 1999), LR 28:1593 (July 2002), LR 29:1093 (July 2003).

§2713. Reallocation of Resources/Staff and Financial Agreements

A. For FY02/03, DHH agrees to transfer financial resources in accordance with the Memorandum of Understanding (MOU) to the direction and management of CAHSD. The financial resources will be adjusted based upon the final appropriation for CAHSD.

B. CAHSD will submit to DHH an annual budget request for funding of the cost for providing the services and programs for which CAHSD is responsible. The format for such request shall be consistent with that required by the DOA and DHH. The request shall conform with the time frame established by DHH. The CAHSD Executive Director will submit new and expanded program requests to the Office of the Secretary prior to submission to DOA.

C. CAHSD shall operate within its budget allocation and report budget expenditures to DHH.

D. Revisions of the budget may be made upon written consent between CAHSD and DHH and, as appropriate, through the Legislative Budget Committee's BA-7 process. In the event any additional funding is appropriated and received by DHH that affects any budget categories for the direction, operation, and management of the programs of mental health, mental retardation/developmental disabilities, addictive disorders services, and public health, and related activities for any other such DHH entities or regions, CAHSD will receive additional funds on the same basis as other program offices. In the event of a budget reduction, CAHSD will receive a proportionate reduction in its budget.

E. CAHSD shall bill DHH agencies for services they provide in a timely manner.

F. CAHSD shall not bill any DHH agency more than is shown in Attachment 1 of the MOU.

G. CAHSD shall assume all financial assets and/or liabilities associated with the programs transferred.

H. CAHSD shall be responsible for repayment of any funds received which are determined ineligible and subsequently disallowed.

I. DHH shall continue to provide to CAHSD certain support services from the Office of the Secretary and from the Office of Management and Finance which are available to the regional program offices of OCDD, OMH, OAD, and OPH. The services CAHSD will continue to receive, at the level provided to other regions are: Communications and Inquiry; Internal Audit; Fiscal Management; Information Services; Facility Management; Lease Management; and Research and Development.

J. Any increases from OAD must comply with the resource allocation law and CAHSD will participate in cost benefit analysis and outcome.

K. CAHSD will comply with the resource allocation formula and adjustments in the funding for CAHSD may be made according to this formula.

L. If the implementation of the area structure changes the means of financing in a way that would negatively impact total funds received by CAHSD for mental health services, OMH will structurally guarantee the ability to bill for/collect funds for the services provided, or fund the district in the amount the total CAHSD/OMH portion of its budget will not be decreased from what would be allocated or collected by the other regions.

M. Funding for all medications needed by OMH forensic clients, (except those originally residing within the CAHSD region) who are released from the hospital into forensic community-based beds within CAHSD, shall be provided to CAHSD through this MOU. Funds will be based on average cost for annual number of clients, and OMH Forensic and CAHSD staff shall coordinate the verification of clients served and the cost of medications provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:950 (May 1998), amended LR 25:668 (April 1999), LR 28:1595 (July 2002), LR 29:1095 (July 2003).

§2715. Joint Training and Meetings

A. CAHSD, through its staff, will participate in DHH and other programmatic trainings, meetings and other activities as agreed upon by CAHSD and DHH. In a reciprocal manner, CAHSD will provide meetings, training sessions, and other activities that will be available for participation by DHH staff as mutually agreed upon by CAHSD and DHH. All program office meetings (trainings, information dissemination, policy development, etc.) discussing/presenting information with statewide implications shall include CAHSD staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:950 (May 1998), amended LR 25:669 (April 1999), LR 28:1595 (July 2002), LR 29:1095 (July 2003).

§2717. Special Provisions

A. CAHSD agrees to abide by all applicable Federal, State, and Parish laws regarding nondiscrimination in service delivery and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status or any other non-merit factor.

B. CAHSD shall maintain a property control system of all movable property in the possession of CAHSD that was formally under the control of DHH, and of all additional property acquired.

C. For purposes of purchasing, travel reimbursement, and securing of social service/professional contracts, CAHSD shall utilize established written bid/RFP policies and procedures. Such policies and procedures shall be developed in adherence to applicable statutory and administrative requirements. CAHSD shall provide informational copies of such policies and procedures to DHH as requested.

D. CAHSD shall abide by all court rulings and orders that affect DHH and impact entities under CAHSD's control, and shall make reports to DHH's Bureau of Protective Services of all applicable cases of alleged abuse, neglect, exploitation or extortion of individuals in need of protection in a format prescribed by DHH.

E. In the event of a departmental budget reduction in state general funds, or federal funds equivalent, CAHSD shall share in that reduction consistent with other DHH agencies. If reductions occur through Executive Order, DOA, or legislative action in the appropriation Schedule 09, and CAHSD is included in these reductions, then these same reductions shall not be reassessed to CAHSD by DHH agencies.

F. CAHSD shall have membership on the Region II Planning Group and the Statewide Planning Group for the HIV/AIDS Prevention Program. CAHSD shall be a voting member of the Region II Planning Group (RPG). CAHSD shall be a non-voting member of the Statewide Planning Group (SPG) unless the CAHSD member is also elected by the Region II RPG as its official delegate to the SPG. In such case, the CAHSD representative shall vote as the representative of the Region II RPG.

G. CAHSD can obtain a copy of all requests for funding, solicitation of offers, notices of funding availability and other such comparable documents sent out by OPH relative to community-based HIV Prevention and Treatment Services for Region II as well as any such notices received by OPH and not chosen for application by them.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:950 (May 1998), amended LR 25:669 (April 1999), LR 28:1596 (July 2002), LR 29:1095 (July 2003).

§2719. Renewal/Termination

A. This agreement will cover the period of time from July 1, 2002 to June 30, 2003.

B. This agreement will be revised on an annual basis, as required by law, and will be promulgated through the Administrative Procedure Act. The annual agreement shall be published in the state register each year in order for significant changes to be considered in the budget process for the ensuing fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2661.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 24:951 (May 1998), amended LR 25:669 (April 1999), LR 28:1596 (July 2002), LR 29:1096 (July 2003).

Chapter 29. Organ Procurement

§2901. Definitions

A Designated Requestor—an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ and tissue donation.

Department—the Department of Health and Hospitals.

Hospital—a hospital licensed, accredited, or approved under the laws of any state and includes a hospital operated by the U.S. government, a state, or subdivision thereof, although not required to be licensed under state laws.

Louisiana/Designated Organ Procurement Organization—the organ procurement organization designated by CMS and recognized by the secretary of the Department of Health and Hospitals of Louisiana under R.S.17:2354.4(J).

Organ Procurement Organization (OPO)—an organization that is designated by the U.S. Department of Health and Human Services, Centers for Medicare and

Medicaid Services (CMS), formerly Health Care Financing Administration, or its successor, to perform or coordinate the performance of surgical recovery, preservation, and transportation of organs, and that maintains a system for locating perspective recipients for available organ transplantation.

Tissue Bank or Storage Facility—a nonprofit facility licensed or approved under the laws of any state for storage of human bodies or parts thereof for use in transplantation to individuals, medical education, research, or therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2354.4(J), and 42 CFR Part 482.45.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 28:834 (April 2002), repromulgated LR 32:405 (March 2006).

§2903. Conditions for Participation

A. In order to insure that the family of each potential donor is informed of its options to donate organs, tissues, or eyes or to decline to donate, the department adopts the procedures specified in the federally approved Medicare Conditions for Participation for Hospitals (42 CFR Part 482.45) to be followed by all hospitals in Louisiana. The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor.

B. The Department of Health and Hospitals shall recognize the federally designated organ procurement organization. A letter by the CMS shall be presented to the Secretary of the Department of Health and Hospitals upon certification of the organ procurement organization. Any changes between certification periods shall be reported to the secretary within 30 working days.

C. The secretary shall compile and disseminate a list of those nonprofit organ and tissue banks that, in addition to the Louisiana designated OPO, shall be authorized to receive donations under this Section. The organ procurement organization shall be authorized upon designation by the Health Care Finance Administration. The nonprofit tissue bank or eye bank must submit copies of the following to the secretary for authorization:

1. proof that a nonprofit tissue bank or eye bank registered in this state or any state as a 501-C-3 charitable organization with no direct ties to any for-profit tissue processor unless an approved nonprofit vehicle is unavailable;

2. a copy of the current accreditation letter by the American Association of Tissue Banking for those nonprofit tissue banks, and a current accreditation letter by the Eye Banks of America Association for the nonprofit eye banks.

D. Under the Medicare Conditions for Participation for Hospitals, the following procedures are to be implemented to facilitate proper coordination among hospitals, Louisiana designated OPO, and tissue and eye banks.

1. All hospitals will incorporate an agreement with the Louisiana designated OPO, under which it must notify in a timely manner, the OPO of individuals whose death is imminent or who have died in the hospital.

2. The OPO will determine medical suitability for organ donation under this agreement.

3. The hospital will incorporate an agreement with at least one nonprofit tissue bank and at least one non-profit eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes, as may be appropriate to assure that all useful tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement.

4. The Louisiana designated OPO will refer all appropriate referrals to the appropriate nonprofit tissue or eye bank which the OPO and hospital have incorporated an agreement with for those purposes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:2354.4(J), and 42 CFR Part 482.45.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 28:834 (April 2002), repromulgated LR 32:405 (March 2006).

Chapter 39. Controlled Dangerous Substances

Subchapter A. Training and Monitoring Requirements

§3901. Opioid Antagonist Administration and Training

A. Purpose and Applicability

1. Pursuant to R.S. 40:978.2, to protect public health and safety, the Department of Health and Hospitals sets forth the following training and monitoring requirements for a licensed medical practitioner who prescribes, dispenses, or administers naloxone or another opioid antagonist to a person reasonably believed to be undergoing an opioid-related drug overdose.

2. Training and monitoring requirements of this Rule shall apply to licensed medical practitioners when dispensing or distributing opioid antagonists to third parties who will be administering the medication. Training shall include how to recognize signs of overdose indicating when it is appropriate to utilize naloxone or another opioid antagonist, standards for storage and administration of the medication, and instructions for emergency follow-up procedures.

3. First responders as defined in R.S. 40:978.1 are exempt from the training requirements as detailed in this Rule.

4. Prescribers are strongly encouraged to co-prescribe naloxone or another opioid antagonist once in a given year to persons receiving opioid therapy for greater than 14 days.

B. Definitions

Department—the Department of Health and Hospitals.

Licensed Medical Practitioner—a physician or other healthcare practitioner licensed, certified, registered, or otherwise authorized to perform specified healthcare services consistent with state law.

Opioid Antagonist—agents such as naloxone that have high affinity and bind to opiate receptors but do not activate these receptors. This effectively blocks the receptor, preventing the body from responding to opioids and endorphins. These drugs block the effects of externally administered opioids.

Opioid-Related Overdose—a condition including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or the ceasing of respiratory or circulatory function resulting from the consumption or use of an opioid, or another substance with which an opioid was combined.

SAMHSA—the Substance Abuse and Mental Health Services Administration.

Toolkit—the SAMHSA opioid overdose toolkit. Reference available online through SAMHSA's website.

C. Training Requirements

1. At minimum, licensed medical practitioners shall provide the following information and training regarding signs of overdose when prescribing, distributing, or dispensing an opioid antagonist.

a. Signs of overdose, which often results in death if not treated, include:

i. face is extremely pale and/or clammy to the touch;

ii. body is limp;

iii. fingernails or lips have a blue or purple cast;

iv. the patient is vomiting or making gurgling noises;

v. he or she cannot be awakened from sleep or is unable to speak;

vi. breathing is very slow or stopped;

vii. heartbeat is very slow or stopped.

b. Signs of overmedication, which may progress to overdose, include:

i. unusual sleepiness or drowsiness;

ii. mental confusion, slurred speech, intoxicated behavior;

iii. slow or shallow breathing;

iv. pinpoint pupils;

v. slow heartbeat, low blood pressure; and

vi. difficulty waking the person from sleep.

c. For additional guidance and information, please reference the most recent version of the SAMHSA opioid overdose toolkit.

2. At minimum, licensed medical practitioners shall provide the following information and training regarding storage and administration when prescribing, distributing, or dispensing an opioid antagonist:

a. instructions on storage of the opioid antagonist in accordance with the manufacturer instructions;

b. instructions on administration of the opioid antagonist in accordance with the instructions printed on or distributed with the device by the manufacturer.

3. At minimum, licensed medical practitioners shall provide the following information and training regarding emergency and follow-up procedures when dispensing or prescribing an opioid antagonist.

a. Prior to administration, the person administering the opioid antagonist shall immediately call 9-1-1 for emergency medical services if medical assistance has not yet been sought or is not yet present.

b. After calling for emergency services and administering the opioid antagonist, emergency follow-up procedures shall be conducted in accordance with the guidelines set forth in the SAMHSA opioid overdose toolkit.

c. Upon stabilization by emergency medical services, the treating practitioner shall refer the patient to and offer information regarding substance use treatment services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:978.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Behavioral Health, LR 42:64 (January 2016).

Subchapter B. Drug Testing

§3991. Applicability

A. To assure maintenance of a drug-free workforce, it shall be the policy of DHH to implement a program of drug testing, in accordance with Executive Order No. MJF 98-38, R.S. 49:1001, et seq., and all other applicable federal and state laws, as set forth below. This policy shall apply to all employees of DHH including appointees and all other persons having an employment relationship with this agency. Each prospective employee shall be required to submit to drug screening. Pursuant to R.S. 49:1008, a prospective employee who tests positive for the presence of drugs in the initial screening shall be eliminated from consideration for employment.

B. Drug testing pursuant to this policy shall be conducted for the presence of cannabinoids (marijuana metabolites), cocaine metabolites, opiate metabolites, phencyclidine, and amphetamines in accordance with the provisions of R.S. 49:1001, et seq. DHH reserves the right to test its employees for the presence of any other illegal drug

or controlled substance when there is reasonable suspicion to do so.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1015.

HISTORICAL NOTE: Promulgated by Department of Health and Hospitals, Office of the Secretary, LR 26:1058 (May 2000).

§3993. Definitions

Controlled Substance—a drug, chemical substance or immediate precursor in Schedules I through V of R.S. 40:964 or Section 202 of the Controlled Substances Act (21 U.S.C. 812).

Designer (Synthetic) Drugs—those chemical substances that are made in clandestine laboratories where the molecular structure of both legal and illegal drugs is altered to create a drug that is not explicitly banned by federal law.

Employee—unclassified, classified, and student employees, student interns, and any other person having an employment relationship with the agency, regardless of the appointment type (e.g. full time, part time, temporary, etc.).

Illegal Drug—any drug which is not legally obtainable or which has not been legally obtained, to include prescribed drugs not legally obtained and prescribed drugs not being used for prescribed purposes or being used by one other than the person for whom prescribed.

Reasonable Suspicion—belief based upon reliable, objective and articulable facts derived from direct observation of specific physical, behavioral, odorous presence, or performance indicators and being of sufficient import and quantity to lead a prudent person to suspect that an employee is in violation of this policy.

Safety-Sensitive or Security-Sensitive Position—a position determined by the Appointing Authority to contain duties of such nature that the compelling State interest to keep the incumbent drug-free outweighs the employee's privacy interests. A list of such positions within DHH is maintained by the DHH Human Resource Director. The list was determined with consideration of statutory law, jurisprudence, the practices of this agency and the examples of safety-sensitive and security-sensitive positions provided in the model policy document issued by the Division of Administration.

Under the Influence—for the purposes of this policy, a drug, chemical substance, or the combination of a drug, chemical substance that affects an employee in any detectable manner. The symptoms or influence are not confined to that consistent with misbehavior, nor to obvious impairment of physical or mental ability, such as slurred speech or difficulty in maintaining balance. A determination of influence can be established by a professional opinion or a scientifically valid test.

Workplace—any location on agency property including all property, offices and facilities (including all vehicles and equipment) whether owned, leased or otherwise used by the agency or by an employee on behalf of the agency in the conduct of its business in addition to any location from which an individual conducts agency business while such business is being conducted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1015.

HISTORICAL NOTE: Promulgated by Department of Health and Hospitals, Office of the Secretary, LR 26:1058 (May 2000).

§3995. Policy Provisions

A. General Provisions. It shall be the policy of DHH to maintain a drug-free workplace and a workforce free of substance abuse. Employees are prohibited from reporting for work or performing work for DHH with the presence in their bodies of illegal drugs, controlled substances, or designer (synthetic) drugs at or above the initial testing levels and confirmatory testing levels as established in the contract between the State of Louisiana and the official provider of drug testing services. Employees are further prohibited from the illegal use, possession, dispensation, distribution, manufacture, or sale of controlled substances, designer (synthetic) drugs, and illegal drugs at the work site and while on official state business, on duty or on call for duty.

B. Conditions Requiring Drug Tests

1. DHH shall require drug testing under the following conditions. The Human Resource Director shall be involved in any determination that one of the above-named conditions requiring drug-testing exists.

a. Reasonable Suspicion. Any employee shall be required to submit to a drug test if there is reasonable suspicion (as defined in this policy) that the employee is using drugs.

b. Post-accident. Each employee involved in an accident that occurs during the course and scope of employment shall be required to submit to a drug test if the accident:

i. involves circumstances leading to a reasonable suspicion of the employee's drug use;

ii. results in a fatality; or

iii. results in or causes the release of hazardous waste as defined in R.S. 30:2173(2) or hazardous materials as defined in R.S. 32:1502(5).

c. Rehabilitation Monitoring. Any employee who is participating in a substance abuse after-treatment program or who has a rehabilitation agreement with the agency following an incident involving substance abuse shall be required to submit to random drug testing.

d. Pre-employment. Each prospective employee shall be required to submit to drug screening at the time and place designated by the DHH Security Coordinator, (the person within DHH responsible for administering the drug testing program) following a job offer contingent upon a negative drug-testing result. Pursuant to R.S. 49:1008, a prospective employee who tests positive for the presence of drugs in the initial screening shall be eliminated from consideration for employment.

e. Safety-Sensitive and Security-Sensitive Positions—Appointments and Promotions. Each employee who is offered a safety-sensitive or security-sensitive position (as defined in this policy) shall be required to pass a drug test before being placed in such position, whether through appointment or promotion.

f. Safety-Sensitive and Security-Sensitive Positions—Random Testing. Every employee in a safety-sensitive or security-sensitive position shall be required to submit to drug testing as required by the Appointing Authority, who shall periodically call for a sample of such employees, selected at random by a computer-generated random selection process, and require them to report for testing. All such testing shall, if practicable, occur during the selected employee's work schedule.

C. Confidentiality. All information, interviews, reports, statements, memoranda, and/or test results received by DHH through its drug testing program are confidential communications, pursuant to R.S. 49:1012, and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in an administrative or disciplinary proceeding or hearing, or civil litigation where drug use by the tested individual is relevant.

D. Responsibility. The Secretary is responsible for the overall compliance with this policy and shall submit to the Office of the Governor, through the Commissioner of Administration, a report on this policy and drug testing program, describing progress, the number of employees affected, the categories of testing being conducted, the associated costs of testing, and the effectiveness of the program by November 1 of each year.

E. Violations. Violation of this policy, including refusal to submit to drug testing when properly ordered to do so, may result in disciplinary actions up to and including termination of employment. Each violation and alleged violation of this policy will be handled on an individual basis, taking into account all data, including the risk to self, fellow employees, and the general public.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1015.

HISTORICAL NOTE: Promulgated by Department of Health and Hospitals, Office of the Secretary, LR 26:1059 (May 2000).

Chapter 40. Provider Fees

§4001. Specific Fees

A. Definitions

*Emergency Ground Ambulance Service Provide*r—a non-public, non-federal provider of emergency and non-emergency ground ambulance services.

Quarter—for purposes of this Chapter, quarters shall be constituted as follows.

First Quarter	December, January, February
Second Quarter	March, April, May
Third Quarter	June, July, August
Fourth Quarter	September, October, November

a. Exception. For purposes of hospital and emergency ground ambulance services, quarters shall be constituted as follows.

First Quarter	July, August, September
Second Quarter	October, November, December
Third Quarter	January, February, March
Fourth Quarter	April, May, June

B. Nursing Facility Services

1. A fee shall be paid by each facility licensed as a nursing home in accordance with R.S. 40:2009.3 et seq., for each occupied bed on a per day basis. A bed shall be considered occupied, regardless of physical occupancy, based upon payment for nursing facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed reserved and paid for during a temporary absence from a nursing facility shall be subject to the fee. Likewise, any bed or beds under contract to a Hospice shall be subject to the fee for each day payment is made by the Hospice. Contracts, agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for nursing services available or provided. Nursing facilities subject to the fee shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fee imposed for nursing facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of services and shall not exceed $12.08 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

C. Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD) Services

1. A fee shall be paid by each facility licensed as an intermediate care facility for individuals with developmental disabilities in accordance with R.S. 46:2625 et seq., for each occupied bed per day. A bed shall be considered occupied, regardless of physical occupancy, based on payment for ICF/DD facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed reserved and paid for during a temporary absence from a facility shall be subject to the fee. Likewise, any bed or beds under contract to a hospice shall be subject to the fee for each day payment is made by the hospice. Contracts, agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for ICF/DD facility services available or provided. ICF/DD facilities subject to fees shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fees imposed for ICF/DD facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of service and shall not exceed $30 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

D. Pharmacy Services. A fee shall be paid by each pharmacy and dispensing physician for each out-patient prescription dispensed. The fee shall be $0.10 per prescription dispensed by a pharmacist or dispensing physician. Where a prescription is filled outside of Louisiana and not shipped or delivered in any form or manner to a patient in the state, no fee shall be imposed. However, out-of-state pharmacies or dispensing physicians dispensing prescriptions which are shipped, mailed or delivered in any manner inside the state of Louisiana shall be subject to the $0.10 fee per prescription. The fee only applies to prescriptions which are dispensed for human use. Pharmacies and dispensing physicians subject to the fees shall provide documentation quarterly, on a form provided by the department, in conjunction with payment of fees.

E. Emergency and Non-Emergency Ground Ambulance Services. Effective August 1, 2016, a fee shall be imposed on emergency ground ambulance service providers for emergency ground ambulance services in accordance with R.S. 46:2626. Effective July 1, 2019, this fee shall also include non-emergency ambulance services.

1. The total assessment for the initial state fiscal year in which the assessment is charged shall not exceed the lesser of the following:

a. the state portion of the cost, excluding any federal financial participation, of the reimbursement enhancements provided for in R.S. 46:2626 that are directly attributable to payments to emergency ground ambulance services providers; or

b. 1 1/2 percent of the net operating revenue of all emergency ground ambulance service providers assessed relating to the provision of emergency and non-emergency ground ambulance transportation.

2. Except for the first year maximum fee of 1 1/2 percent of the net operating revenue, the department shall not impose any new fee or increase any fee on any emergency ground ambulance service provider on or after July 1, 2016, without first obtaining either of the following:

a. prior approval of the specific fee amount by record vote of two-thirds of the elected members of each house of the legislature while in regular session;

b. written agreement of those providers subject to the fee which provide a minimum of 65 percent of the emergency and non-emergency ground ambulance transports.

3. After the initial year of assessment, the assessment shall be a percentage fee, determined at the discretion of the secretary and subject to the provisions below in collaboration with the express and written mutual agreement of the emergency ground ambulance service providers subject to the assessment and which make up a minimum of 65 percent of all emergency and non-emergency ground ambulance transports in the state of Louisiana.

a. the maximum fee allowable in any year shall not exceed the percentage of net patient service revenues permitted by federal regulation pursuant to 42 CFR 433.68 as determined by the department, as reported by the provider and subject to audit for the previous fiscal year of the provider. The department will arrive at net patient services revenue by using net operating revenue as defined in R.S. 46:2626.

F. Hospital Services

1. Effective January 1, 2017, a hospital stabilization assessment fee shall be levied and collected in accordance with article VII, section 10.13 of the Constitution of Louisiana and any legislation setting forth the hospital stabilization formula.

a. The total assessment for each state fiscal year shall be equal to, but shall not exceed, the lesser of the following:

i. the state portion of the cost, excluding any federal financial participation and any costs associated with full Medicaid pricing, of payments for healthcare services through the implementation of a health coverage expansion of the Louisiana Medical Assistance Program that meets all the necessary requirements necessary for the state to maximize federal matching funds as set forth in 42 U.S.C. 1396(d)y of title XIX of the Social Security Act, which are directly attributable to payments to hospitals; or

ii. one percent of the total inpatient and outpatient net patient revenue of all hospitals included in the assessment, as reported in the Medicare cost report ending in state fiscal year 2015.

2. The assessment shall be allocated to each assessed hospital on a pro rata basis by calculating the quotient of the total assessment divided by the total inpatient and outpatient hospital net patient revenue of all assessed hospitals, as reported in the Medicare cost report ending in state fiscal year (SFY) 2015, and multiplying the quotient by each assessed hospital's total inpatient and outpatient hospital net patient revenue. If a hospital was not required to file a Medicare cost report or did not file a Medicare cost report ending in SFY 2015, the hospital shall submit to the department its most applicable calendar year total of inpatient and outpatient hospital net patient revenue in a form prescribed by the department.

3. The assessment will be levied and collected on a quarterly basis and at the beginning of each quarter that the assessment is due. Prior to levying or collecting the assessment for the applicable quarterly period, the department shall publish in the *Louisiana Register* the total

amount of the quarterly assessment and the corresponding percentage of total inpatient and outpatient hospital net patient revenue that will be applied to the assessed hospitals.

4. Hospitals meeting the definition of a rural hospital, as defined in R.S. 40:1189.3, shall be excluded from this assessment.

5. No licensed facility, which is prohibited from participating in the Medicare Program set forth in 42 U.S.C. 1396, shall be assessed or levied any fee for the hospital stabilization authorized in Article VII, Section 10.13 of the Constitution of Louisiana. This provision is specifically subject to the approval of any waiver required by the Centers for Medicare and Medicaid Services and approval by the Department of Health.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and P.L. 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:51 (January 1994), LR 26:1478 (July 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:100 (January 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887, 1888 (November 2016), LR 43:73 (January 2017), repromulgated LR 43:323 (February 2017), amended LR 44:1015 (June 2018), LR 44:1894 (October 2018), LR 45:1597 (November 2019).

§4003. Due Date for Submission of Reports and Payment

A. Quarterly reports and fees shall be submitted to the department and shall be due on the twentieth calendar day of the month following the close of the quarter and shall be deemed delinquent on the thirtieth calendar day of that month. Even if no fee is due, submission of the report is still mandatory.

B. For hospital and emergency ground ambulance services, payment is due 30 days from the notification of the amount owed.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887 (November 2016), LR 44:1017 (June 2018).

§4005. Delinquent and/or Unfiled Reports

A. Penalty Assessment. In the case a report has been determined delinquent, the specific penalty shall be 5 percent of the total fee due on the report for every 30 days that the report is not filed, not to exceed 180 days. When a report is not received within 180 days from the due date, the report shall be deemed not filed and there shall be cause for an audit, investigation or examination to be made by the department.

B. Estimation of Provider Fee Due. In those cases in which a health care provider fails to file the quarterly report, the department will estimate the provider fee due. The department will, by certified mail, notify the provider of the estimated fee due, the method used to calculate the estimated fee and the department's intent to collect the delinquent fee. The provider shall have 15 days from the date of the notice to file a provider fee report with the department. Any provider who fails to file the quarterly report within 15 days of the date of the department's estimated provider fee notice shall waive any and all rights to appeal the department's action and to contest payment of the estimated fee.

C. Incorrect Reporting. If a provider submits a quarterly report required by the provisions of this Chapter and the report made and filed does not correctly compute the amount of the fee owed, there shall be cause for an audit, investigation or examination to be made by the department.

D. False or Fraudulent Reporting. When a provider files a quarterly report that is false or fraudulent or grossly incorrect, there shall be imposed, in addition to any other sanctions allowed under rule or law, a specific penalty of 50 percent of the fee due.

E. Reimbursement of Audit, Hearing, and Witness Costs. If actions by a provider cause the department to examine books, records, or documents, or undertake an audit thereof, and/or conduct a hearing, and/or subpoena witnesses, then the provider shall be assessed an amount as itemized by the department to compensate for all costs incurred in making such examination or audit, and/or in holding such hearing, and/or in subpoenaing and compensating witnesses.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1017 (June 2018).

§4007. Delinquent and/or Unpaid Fees

A. When the provider fails to pay the fee due, or any portion thereof, on or before the date it becomes delinquent, interest at the rate of 1 1/2 percent per month compounded daily shall be assessed on the unpaid balance until paid.

B. Collection of Delinquent Fees

1. For those health care providers enrolled in the Louisiana Medical Assistance Program (Medicaid), collection of delinquent provider fees will be as follows.

a. The department will withhold from the provider's Medicaid reimbursement, an amount equal to 50 percent of the reimbursement or the actual amount of the delinquent provider fee, including interest and penalty, whichever is less.

b. By enrolling and participating in the Louisiana Medical Assistance Program (Medicaid) a provider agrees that during the period of time delinquent provider fees are

being collected, no additional provider fee delinquency will occur. If the provider becomes further delinquent, the department will withhold 100 percent of the Medicaid reimbursement or the actual amount of the delinquent provider fees, including interest and penalty, whichever is less.

2. For those health care providers not enrolled in the Louisiana Medical Assistance Program (Medicaid), the department will avail itself of any and all appropriate legal and judicial remedies in the collection of delinquent provider fees.

C. Nonsufficient Fund (NSF) Checks in Payment of Fee. A specific service charge, in accordance with R.S. 9:2782(B) as it may be amended from time to time, shall be imposed on all NSF checks. The tender of three NSF checks shall be cause for an audit, investigation or examination to be made by the department, and the provider will be required to make payment thereafter by certified check or money order.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:1114 (October 1994), LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887 (November 2016), LR 44:1017 (June 2018).

§4009. Appeals

A. Any provider aggrieved pursuant to the provisions determined herein shall have the right to administrative appeal as specified in R.S. 46:107.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), repromulgated LR 26:1480 (July 2000).

§4011. Exceptions

A. The secretary may exempt any assessment of penalty and interest described in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1480 (July 2000).

Subpart 3. Licensing

Chapter 41. Expedited Licensing Process for Healthcare Facilities and Providers Licensed by the Department of Health

§4101. Definitions

Applicant—any person, partnership, corporation, unincorporated association or other legal entity currently operating, or planning to operate, any of the health care facilities or providers licensed by the Department of Health.

Applicant Representative—the person specified by the applicant on the application form authorized to respond to inquiries from the Department of Health regarding the expedited licensing process and to whom written notifications are sent relative to the status of the expedited licensing application.

Approval—a determination by the Department of Health that an application meets the criteria of the expedited licensing process.

Department—the Louisiana Department of Health (LDH).

Health Standards Section (HSS)—the section in the Department of Health responsible for licensing health care facilities and agencies, certifying facilities and agencies that apply for participation in the Medicaid (titles XIX and XXI) and Medicare (title XVIII) programs, and conducting surveys and inspections.

Licensing—deemed to include initial licensing of a provider or facility, licensure upon a change of ownership, licensing due to relocation or replacement facility, or licensing due to adding locations, off-sites, satellites, beds, units, fleet additions or services.

Notification—deemed to be given on the date on which an applicant representative receives notice from LDH of the expedited license determination, either electronically or by certified mail to the last known address of the applicant representative.

Readiness Date—the date that the applicant indicates to the HSS field office assigned scheduler that the facility or provider is ready for the licensing survey to be conducted by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 44:2159 (December 2018).

§4103. General Provisions

A. Any person, partnership, corporation, unincorporated association or other legal entity currently operating, or planning to operate, any of the health care facilities or providers licensed by the department may seek an expedited licensing process as provided for in this Chapter.

B. The provisions of this Chapter shall apply to an applicant provider or facility for any of the health care facility or provider types licensed by the department.

C. The expedited licensing process provided for in this Chapter is at the discretion of the applicant provider or facility requesting such expedited process.

1. A request for the expedited licensing process is voluntary.

2. An applicant provider or facility shall not be delayed from the usual licensing and/or survey scheduling process and timeframe, if the expedited licensing process is not requested.

D. The department shall ensure that no applicant provider or facility seeking approval to apply for licensure pursuant to a pre-licensing facility need review approval process is affected by another provider of the same license type choosing the expedited licensing process instead of the regular licensing process.

E. The department shall not utilize existing employees who conduct regular licensing surveys to conduct any expedited licensing survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2160 (December 2018).

§4105. Expedited Licensing Applications and Fees

A. Requests for expedited licensing applications shall be submitted to the LDH Health Standards Section (HSS) on the forms indicated for that purpose, containing such information as the department may require, and shall be accompanied by the specified fee as established in Paragraph E of this Section.

B. The applicant shall designate a representative on the expedited licensing process application.

1. The designated applicant representative shall be the only person to whom HSS will send written notification in matters relative to the status of the expedited licensing process.

2. If the applicant representative or his/her address changes at any time during the licensing process, it is the responsibility of the applicant to notify HSS in writing of such change.

C. Documentation and correspondence related to the expedited licensing process may be submitted and received via electronic transmission to shorten the timeframe of the process.

D. The expedited licensing process fee is required at the time that the application is submitted to the department. The expedited licensing process fee shall be:

1. made payable to the Louisiana Department of Health; and

2. made in the manner required by the department on the expedited licensing process application.

E. The expedited licensing process fee shall be determined by the complexity and acuity of the requested licensing process and shall be assessed on a tiered basis pursuant to §4107 of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2160 (December 2018).

§4107. Expedited Licensing Survey Types and Tiers

A. The fees associated with the expedited licensing process shall be assessed according to the following tiers.

1. Tier 1. Expedited licensing fee is set at $7,000.

2. Tier 2. Expedited licensing fee is set at $6,000.

3. Tier 3. Expedited licensing fee is set at $5,000.

B. Tier 1 expedited licensing processes include, but are not limited to, the following:

1. initial licensing of a hospital or off-site location of a hospital;

2. licensing of a replacement facility or location (or relocation) of the main campus of a hospital;

3. licensing of a replacement facility or location (or relocation) of an off-site campus of a hospital that has any of the following:

a. licensed beds;

b. surgical services; or

c. an emergency department; and

4. initial licensing of the following:

a. an ambulatory surgical center (ASC);

b. an end stage renal disease (ESRD) facility;

c. a rural health clinic (RHC);

d. a nursing facility (NF); or

e. a home and community-based services (HCBS) provider or an off-site or satellite location of the provider.

C. Tier 2 expedited licensing processes include, but are not limited to, the following:

1. initial licensing of the following:

a. an adult residential care provider (ARCP) level 1, 2, 3 or 4;

b. a crisis receiving center (CRC);

c. an intermediate care facility for people with developmental disabilities (ICF/DD);

d. a pediatric day health care (PDHC) facility;

e. a home health agency (HHA) or an off-site or satellite location of a HHA;

f. a hospice agency, an off-site or satellite location of a hospice agency or an inpatient hospice facility;

g. a psychiatric residential treatment facility (PRTF);

h. a therapeutic group home (TGH);

i. a behavioral health services provider (BHSP);

j. an adult day health care (ADHC) facility;

k. a forensic supervised transitional residential and aftercare (FSTRA) facility;

l. a pain management clinic (PMC);

m. an adult brain injury (ABI) facility;

n. an emergency medical transportation services (EMTS) provider; or

o. any other provider or facility licensed by LDH;

2. licensing of a replacement facility or location (or relocation) of the following:

a. an ASC;

b. an ESRD facility;

c. an RHC;

d. a CRC;

e. a NF; or

f. an HCBS provider or an off-site or satellite location of the provider; and

3. licensing of additional units, services or beds, or other action at an existing licensed hospital, ASC, ESRD facility or NF that requires a physical environment survey.

D. Tier 3 expedited licensing processes include, but are not limited to, the following:

1. licensing of a replacement facility (or relocation) for the following:

a. an ICF/DD;

b. a PDHC;

c. an ADHC facility;

d. an ARCP level 1, 2, 3 or 4;

e. an HHA or an off-site or satellite location of a HHA;

f. a hospice agency or an off-site or satellite location of hospice agency or an inpatient hospice facility;

g. a PRTF;

h. a TGH;

i. a BHSP;

j. a FSTRA facility;

k. a PMC;

l. an ABI facility; or

m. any other provider or facility licensed by LDH; and

2. licensing additional units, services, beds, or other action an existing licensed ICF/DD, PDHC, HCBS provider, ADHC center, ARCP (levels 1, 2, 3 and 4), PRTF, TGH, BHSP, CRC, FSTRA facility, ABI facility, or other provider or facility licensed by the department that requires a physical environment survey, or a fleet addition for an EMTS provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2160 (December 2018).

§4109. Expedited Licensing Application Review Process

A. If an applicant provider or facility submits an expedited licensing process application and pays all applicable fees in the required manner, the department shall prioritize the application. After priority review of the application, the department shall:

1. notify the applicant provider or facility of any missing documentation or information; or

2. notify the applicant of the approval of the completed expedited licensing application packet.

B. The department shall notify the applicant representative, upon approval of the completed expedited licensing application packet, that the applicant shall provide a readiness date for the expedited survey to the appropriate HSS field office.

C. The applicant shall not contact the HSS field office to schedule the expedited survey until notified of approval as provided for in Paragraphs A and B of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2161 (December 2018).

§4111. Expedited Licensing Survey Process

A. Once the expedited licensing application packet has been approved, the department shall conduct the expedited licensing survey within 10 working days of the readiness date indicated by the applicant provider or facility, or such other time period to which the provider has agreed.

B. The expedited licensing survey shall be conducted in accordance with this Subchapter and applicable published licensing statutes, rules and regulations for the particular health care provider or facility type for which the applicant has applied.

C. The expedited licensing survey shall be scheduled and conducted in an expedited manner pursuant to the usual survey process, protocols and procedure.

D. The department shall provide written notification to the applicant representative of the results of the expedited licensing survey within 10 working days of the survey exit

date. This notification may be made by electronic transmission.

1. The written notification of the expedited survey results shall include any licensing deficiencies, requirements for a plan of correction, and review and/or appeal rights as to the deficiencies, if applicable, pursuant to applicable licensing statutes, rules and regulations.

2. If deficiencies are cited at the expedited licensing survey, the department may, at its option:

a. require a plan of correction and conduct a follow-up licensing survey;

b. issue a provisional license, pursuant to applicable licensing regulations; or

c. issue a license denial, including appeal rights, pursuant to applicable licensing regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2161 (December 2018).

§4113. Expedited Licensing Survey Refunds

A. The department shall refund the expedited licensing process fee amount paid by an applicant provider or facility if the survey is not conducted within the time periods specified in §4111.A, unless such failure to conduct the survey is due to the unavailability of the facility or provider.

B. If the applicant facility or provider fails to be ready when the department begins to conduct the expedited licensing survey, the survey will be ended, no refund of the expedited licensing fee will be due, and the applicant facility or provider shall have the choice to:

1. re-submit a new expedited licensing process application and applicable fee; or

2. submit a regular licensing process application and applicable fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2162 (December 2018).

Chapter 42. Adult Day Health Care

Subchapter A. General Provisions

§4201. Introduction

A. The purpose of Adult Day Health Care (ADHC) services is to provide an alternative to or a possible prevention or delay of 24-hour institutional care by furnishing direct care for a portion of the day to adults who have physical, mental, or functional impairments. An ADHC shall be operational for at least five hours each day of operation. An ADHC center shall be operational for at least five days per week. An ADHC center shall protect the health, safety, welfare, and well-being of participants attending ADHC centers.

B. An ADHC center shall have a written statement describing its philosophy as well as long-term and short-term goals. The ADHC center program statement shall include goals that:

1. promote the participant's maximum level of independence;

2. maintain the participant's present level of functioning as long as possible, while preventing or delaying further deterioration;

3. restore and rehabilitate the participant to the highest level of functioning;

4. provide support and education for families and other caregivers;

5. foster participation, socialization and peer interaction; and

6. serve as an integral part of the community services network and the long-term care continuum of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2177 (October 2008), repromulgated LR 34:2622 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1964 (October 2017).

§4203. Definitions

Accreditation—process by which an ADHC that is owned and operated by a PACE organization with an executed program agreement with CMS/LDH is deemed to meet ADHC licensing requirements.

Activities of Daily Living (ADL)—the functions or tasks which are performed either independently or with supervision, or assistance for mobility (i.e., transferring, walking, grooming, bathing, dressing and undressing, eating and toileting).

Adult Day Health Care (ADHC)—a medical model adult day health care program designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community based nursing center.

Adult Day Health Care Center—any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more functionally impaired adults who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day.

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

Change of Ownership (*CHOW*)—a change in the legal center/entity responsible for the operation of the ADHC center.

Chemical Restraint—any drug that is used for discipline or convenience and when it is not required to treat medical symptoms.

Complaints—allegations of noncompliance with regulations filed by someone other than the center.

Department—the Louisiana Department of Health (LDH) and its representatives.

Direct Care Staff—unlicensed staff who provide personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Director—the person designated by the governing body of the ADHC to:

1. manage the center;

2. insure that all services provided are consistent with accepted standards of practice; and

3. ensure that center policies are executed.

Direct Service Worker—an unlicensed staff person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the participant.

Elopement—to slip away or run away.

Employee—person who performs a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is hired for a staff position.

Full-Time Equivalent—40 hours of employment per week or the number of hours the center is open per week, whichever is less.

Functionally Impaired Adults—persons 17 years of age or older who are physically and/or mentally impaired and require services and supervision for medical, nursing, social, and personal care needs.

Governing Body—the person or group of persons that assumes full legal responsibility for determining, implementing and monitoring policies governing the ADHC's total operation, and who is responsible for the day-to-day management of the ADHC program, and shall also insure that all services provided are consistent with accepted standards of practice.

Individualized Service Plan (*ISP*)—an individualized written program of action for each participant's care and services to be provided by the ADHC center based upon an assessment of the participant.

Involuntary Discharge/Transfer—a discharge or transfer of the participant from the ADHC center that is initiated by the center.

Key Staff—the designated program manager(s), social worker(s) or social services designee(s), and nurse(s) employed by the ADHC. A key staff person may also serve as the ADHC director.

Licensed Practical Nurse (LPN)—an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

Line of Credit—a credit arrangement with a federally insured, licensed lending institution which is established to assure that the center has available funds as needed to continue the operations of the agency and the provision of services to participants. The line of credit shall be issued to the licensed entity and shall be specific to the geographic location shown on the license. For purposes of ADHC licensure, the line of credit shall not be a loan, credit card or a bank balance.

Minimal Harm—negative impact of injury causing the least possible physical or mental damage.

Non-Operational—the ADHC center is not open for business operations on designated days and hours as stated on the licensing application and business location signage.

Participant—an individual who attends an adult day health care center.

Personal Representative—an adult relative, friend or guardian of a participant who has an interest or responsibility in the participant's welfare. This individual may be designated by the participant to act on his/her behalf and should be notified in case of emergency and/or any change in the condition or care of the participant.

Physical Restraint—any manual method (ex: therapeutic or basket holds and prone or supine containment) or physical or mechanical device material (ex: arm splints, leg restraints, lap trays that the participant cannot remove easily, posey belts, posey mittens, helmets), or equipment attached or adjacent to the participant's body that interferes or restricts freedom of movement or normal access to one’s body and cannot be easily removed by the participant.

Primary Care Physician—a physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the participant or his personal representative as responsible for the direction of the participant's overall medical care.

Program Manager—a designated staff person, who is responsible for carrying out the center’s individualized program for each participant.

Program of All-Inclusive Care for the Elderly (*PACE*)—an organization that provides prepaid, capitated, comprehensive health care services.

Progress Notes—ongoing assessments of the participant which enable the staff to update the individualized service plan in a timely, effective manner.

Registered Nurse (RN)—an individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Revocation—action taken by the department to terminate an ADHC center's license.

Social Service Designee/Social Worker—an individual responsible for arranging medical and/or social services needed by the participant.

Voluntary Discharge/Transfer—a discharge or transfer of the participant from the ADHC center that is initiated by the participant or a legal or personal representative.

Volunteer—a person who provides services at an adult day health care center without compensation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2177 (October 2008), repromulgated LR 34:2622 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2373 (September 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1964 (October 2017).

§4205. Licensure Requirements

A. All ADHC centers shall be licensed by the Department of Health (LDH). LDH is the only licensing authority for ADHC centers in the State of Louisiana. It shall be unlawful to operate an ADHC center without possessing a current, valid license issued by LDH. The license shall:

1. be issued only to the person/entity named in the license application;

2. be valid only for the ADHC center to which it is issued and only for the specific geographic address of the center;

3. be valid for one year from the date of issuance, unless revoked prior to that date;

4. expire on the last day of the twelfth month after the date of issuance, unless otherwise renewed;

5. not be subject to sale, assignment, or other transfer, voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

B. In order for an ADHC center to be considered operational and retain licensed status, the center shall meet the following conditions.

1. The center shall always have at least one employee on duty at the business location during the days and hours of operation. Once a participant is admitted, all staff that are required to provide services shall be on duty during operational hours to assure adequate coverage and care to participants.

2. There shall be sufficient numbers of trained direct care and professional services staff either employed or contracted and available to be assigned to provide care and services to persons receiving services at all times.

3. The center shall have admitted or has provided services to at least two participants in the past 12 months prior to their licensure resurvey.

C. The licensed center is required to abide by and adhere to any state laws, rules, policy and procedure manuals or memorandums pertaining to ADHC centers issued by LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2178 (October 2008), repromulgated LR 34:2623 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1965 (October 2017).

§4207. Initial License Application Process

A. Each ADHC applicant shall obtain facility need review approval (FNR) prior to submission of an initial application for licensing.

B. After FNR approval is received, an initial application for licensing as an ADHC center shall be obtained from the department. A completed initial license application packet for an ADHC center shall be submitted to and approved by the department prior to an applicant providing ADHC services. An applicant shall submit a completed initial licensing packet to the department, which shall include:

1. a completed ADHC licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural center plans from the Office of the State Fire Marshal;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy report of the center from the Office of Public Health;

5. a copy of state-wide criminal background checks conducted by the Louisiana State Police, or its authorized agent, on all owners;

6. proof of financial viability including:

a. line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000; and

b. general and professional liability insurance of at least $300,000;

7. if applicable, clinical laboratory improvement amendments (CLIA) certificate or CLIA certificate of waiver;

8. a completed disclosure of ownership and control information form;

9. a floor sketch or drawing of the premises to be licensed;

10. the days and hours of operation; and

11. any other documentation or information required by the department for licensure.

C. If the initial licensing packet is incomplete, the applicant will be notified of the missing information and will have 90 days to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ADHC center shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

D. Once the initial licensing application packet is approved by LDH, the applicant will be sent written notification with instructions for requesting the announced initial licensing survey.

E. An applicant who has received the notification with instructions for requesting the announced initial licensing survey shall notify the department of readiness for an initial licensing survey within 90 days of the date of receipt of that notification. If an applicant fails to notify the department of readiness for an initial licensing survey within 90 days, the initial licensing application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ADHC center shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

F. Applicants shall be in compliance with all appropriate federal, state, departmental, or local statutes, laws, ordinances, rules, regulations, and fees before the ADHC center will be issued an initial license to operate by LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2178 (October 2008), repromulgated LR 34:2624 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2373 (September 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1965 (October 2017).

§4209. Initial Licensing Surveys

A. Prior to the initial license being issued to the ADHC center, an initial licensing survey shall be conducted on-site at the ADHC center to assure compliance with ADHC licensing standards.

B. In the event that the initial licensing survey finds that the ADHC center is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the center. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

C. In the event that the initial licensing survey finds that the ADHC center is noncompliant with any licensing laws or regulations that are a threat to the health, safety, or welfare of the participants, the department shall deny the initial license.

D. In the event that the initial licensing survey finds that the ADHC center is noncompliant with any other required statutes, laws, ordinances, rules or regulations that are a threat to the health, safety, or welfare of the participants, the department shall deny the initial license.

E. In the event that the initial licensing survey finds that the ADHC center is noncompliant with any licensing laws, rules or regulations, but the department, in its sole discretion, determines that the noncompliance does not present a threat to the health, safety, or welfare of the participants, the department may issue a provisional initial license for a period not to exceed six months. The center shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, then a full license will be issued. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional license will expire and the center shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

F. The initial licensing survey of an ADHC center shall be an announced survey. Follow-up surveys to the initial licensing surveys are not announced surveys.

G. Once an ADHC center has been issued an initial license, the department may conduct licensing surveys at intervals deemed necessary by the department to determine compliance with licensing regulations; these licensing surveys shall be unannounced.

1. A follow-up survey shall be conducted for any licensing survey where deficiencies have been cited to ensure correction of the deficient practices.

2. The department may issue appropriate sanctions, including, but not limited to:

a. civil monetary penalties;

b. directed plans of correction; and

c. license revocations for deficiencies and noncompliance with any licensing survey.

H. LDH surveyors and staff shall be given access to all areas of the center and all relevant files during any licensing survey. LDH surveyors and staff shall be allowed to interview any center staff or participant as necessary to conduct the survey.

I. When issued, the initial ADHC license shall specify the maximum number of participants which may be served by the ADHC center.

J. Plan of Correction. A plan of correction shall be required from an ADHC center for any survey where deficiencies have been cited. The plan of correction shall be filed with HSS within 10 calendar days after the center's receipt of notification and statement of deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2179 (October 2008), repromulgated LR 34:2624 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1966 (October 2017).

§4211. Types of Licenses

A. The Department shall have the authority to issue the following types of licenses.

1. In the event that the initial licensing survey finds that the ADHC center is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the center. The license shall be valid until the expiration date shown on the license unless the license is modified, revoked, suspended, or terminated.

2. In the event that the initial licensing survey finds that the ADHC center is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, the department is authorized to issue a provisional initial license pursuant to the requirements and provisions of this §4209.

3. The department may issue a full renewal license to an existing licensed ADHC center who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. The department, in its sole discretion, may issue a provisional license to an existing licensed ADHC center for a period not to exceed six months, for the following reasons:

a. the existing ADHC center has more than five deficient practices or deficiencies cited during any one survey;

b. the existing ADHC center has more than three validated complaints in one licensed year period;

c. the existing ADHC center has been issued a deficiency that involved placing a participant at risk for serious harm or death;

d. the exiting ADHC center has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey;

e. the existing ADHC center is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations, and fees at the time of renewal of the license.

5. When the department issues a provisional license to an existing licensed ADHC center, the department shall conduct an on-site follow-up survey at the ADHC center prior to the expiration of the provisional license. If that on-site follow-up survey determines that the ADHC center has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the ADHC license.

6. If an existing licensed ADHC center has been issued a notice of license revocation, suspension, modification, or termination, and the center's license is due for annual renewal, the department shall deny a license renewal subject to the pending license revocation, suspension, modification, or termination. The denial of renewal of such a license does not affect in any manner the license revocation, suspension, modification or termination.

B. The denial of renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the center.

C. The license for an ADHC center shall be valid for one year from the date of issuance unless revoked, suspended, modified, or terminated prior to that time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2179 (October 2008), repromulgated LR 34:2625 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR:43:1966 (October 2017).

§4212. Accredited Status

A. After initial licensure, an ADHC center may request accreditation. To achieve accredited status, the ADHC shall be required to submit a copy of its current program of all-inclusive care for the elderly (PACE) program agreement to show documented proof of meeting initial and continual compliance with PACE requirements and for each annual renewal of licensure.

B. The department may accept accreditation in lieu of periodic on-site licensing surveys when the center provides documentation to the department that shows:

1. the PACE program agreement is current; and

2. the center remains in substantial compliance with all PACE program agreement requirements.

C. The department may conduct unannounced complaint investigations on all ADHCs, including those with accredited status.

D. There is no waiver of licensure fees for a center that is granted accredited status by the department. An ADHC that is granted accredited status shall pay all initial licensing fees, renewal of licensure fees pursuant to §4213, and any other required fees, to achieve or maintain accredited status. The center shall pay any civil monetary penalties imposed by LDH or may forfeit accredited status.

E. The department may rescind accredited status and may conduct a licensing survey for the following:

1. any substantiated complaint within the preceding 12 months;

2. a change of ownership;

3. issuance of a provisional license in the preceding 12-month period;

4. deficiencies identified in the preceding 12-month period that placed participants at risk for harm;

5. treatment or service resulting in death or serious injury; or

6. a change in geographic location.

F. The ADHC center shall notify HSS upon change in accredited status within two business days.

G. The department will rescind accredited status if the center's PACE Program agreement is terminated.

H. An ADHC center which receives approval for accredited status is subject to, and shall comply with, all provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1967 (October 2017).

§4213. Renewal of License

A. License Renewal Application. The ADHC center shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. the days and hours of operation;

3. a current fire inspection report;

4. a current health inspection report;

5. the required license renewal fee;

6. proof of continuous financial viability without interruption including maintenance of a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

7. proof of PACE program agreement, if accredited; and

8. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2180 (October 2008), repromulgated LR 34:2626 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1967 (October 2017).

§4215. Reporting Requirements

A. The following changes, or any combination thereof, shall be reported in writing to the department within five working days of the occurrence of the change. A change in:

1. the name of the ADHC center;

2. the geographic or mailing address;

3. contact information, i.e., telephone number, fax number, email address; or

4. key administrative staff (i.e., director, program manager, social service designee, a registered nurse (RN) and /or licensed practical nurse (LPN), etc).

B. Change of Ownership (CHOW). The license of an ADHC center is not transferable to any other ADHC or individual. A license cannot be sold. When a change of ownership occurs, the ADHC center shall notify the Health Standards Section in writing within 15 days prior to the effective date of the CHOW.

1. A signed copy of the legal document showing the transfer of ownership shall be provided to HSS.

2. Other required documents are to be submitted to HSS within five working days of the effective date of the CHOW.

3. The new owner shall submit a license application identifying all new information and, for the application to be complete, it shall be submitted with the appropriate CHOW licensing fee.

4. An ADHC center that is under license revocation, renewal of licensure or provisional licensure, may not undergo a CHOW.

C. Any change which requires a change in the license shall be accompanied by a fee. Any request for a duplicate license shall be accompanied by a fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2180 (October 2008), repromulgated LR 34:2626 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1967 (October 2017).

§4217. Denial of License, Revocation of License, Denial of License Renewal

A. The department may deny an application for a license, may deny a license renewal, or may revoke a license in accordance with the provisions of the Administrative Procedures Act.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the ADHC center is noncompliant with any licensing laws, rules, ordinances or regulations or with any other required statutes that are a threat to the health, safety, or welfare of the participants.

2. The department shall deny any initial license for any of the reasons designated in §4217.D that a license may be revoked or denied renewal.

C. Voluntary Non-Renewal of License. If a center fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the center.

D. Revocation of License or Denial of License Renewal. An ADHC license may be revoked or may be denied renewal for any of the following reasons including, but not limited to:

1. failure to be in substantial compliance with the ADHC licensing laws, rules, and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules, and regulations;

3. failure to uphold participant rights whereby deficient practices may result in harm, injury, or death of a participant;

4. failure to protect a participant from a harmful act of an employee including, but not limited to:

a. abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a participant's health and safety;

c. coercion;

d. threat or intimidation; or

e. harassment;

5. failure to notify the proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof;

6. knowingly making a false statement in any of the following areas including, but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. participant records;

d. matters under investigation by the department or the Office of the Attorney General;

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to LDH employees or to law enforcement agencies;

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

9. an owner, officer, member, manager, director, or person designated to manage or supervise participant care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court;

a. for purposes of this paragraph, conviction of a felony means a felony relating to the violence, abuse, or negligence of a person, or a felony relating to the misappropriation of property belonging to another person;

10. failure to comply with all reporting requirements in a timely manner as required by the department;

11. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview center staff or participants;

12. failure to allow, or refusal to allow, access to authorized departmental personnel to records; or

13. bribery, harassment, or intimidation of any participant designed to cause that participant to use the services of any particular ADHC center.

E. In the event an ADHC license is revoked or renewal is denied, any owner, officer, member, manager or director of such ADHC center is prohibited from owning, managing, directing or operating another ADHC center for a period of two years from the date of the final disposition of the revocation or denial action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2180 (October 2008), repromulgated LR 34:2626 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1968 (October 2017).

§4219. Notice and Appeal of License Denial, Revocation, and Denial of License Renewal

A. Notice of a license denial, license revocation, or denial of license renewal shall be given to the center in writing.

B. The ADHC center has a right to an informal reconsideration of the license denial, license revocation, or denial of license renewal.

1. The ADHC center shall request the informal reconsideration within 15 days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section.

2. The request shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request is received by HSS, an informal reconsideration shall be scheduled and the center will receive written notification.

4. The center shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or denial of license renewal, shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process and does not extend the

time limits for filing an administrative appeal of the license denial, revocation, or denial of license renewal.

C. The ADHC center has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal.

1. The ADHC center shall request the administrative appeal within 30 days of the receipt of the notice of the license denial, license revocation, or denial of license renewal or within 30 days of the receipt of the results of the informal reconsideration, if conducted. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law (DAL).

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL, the license revocation or denial of license renewal will be suspended during the pendency of the appeal. However, if the secretary of the department determines that the violations of the center pose an imminent or immediate threat to the health, safety, or welfare of a participant, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the center will receive written notification.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation, or denial of license renewal, shall not be a basis for the administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2181 (October 2008), repromulgated LR 34:2627 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1968 (October 2017).

§4220. Complaint Surveys (Formerly §4221)

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

B. Complaint surveys shall be unannounced surveys.

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

D. The department may issue appropriate sanctions including, but not limited to civil monetary penalties, directed plans of correction, and license revocations for deficiencies and noncompliance with any complaint survey.

E. LDH surveyors and staff shall be given access to all areas of the center and all relevant files during any complaint survey. LDH surveyors and staff shall be allowed to interview any ADHC center staff and participant as required to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2182 (October 2008), repromulgated LR 34:2627 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1969 (October 2017).

§4221. Statement of Deficiencies (Formerly §4223)

A. The following statements of deficiencies issued by the department to the ADHC center shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to an ADHC center shall be available for disclosure to the public 30 days after the center submits an acceptable plan of correction to the deficiencies or 90 days after the statement of deficiencies is issued to the center, whichever occurs first.

C. Unless otherwise provided in statute or in these licensing provisions, a center shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

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

2. The informal reconsideration of the deficiencies shall be requested in writing within 10 calendar days of the ADHC center's receipt of the statement of deficiencies, unless otherwise provided in these standards.

3. The request for informal reconsideration of the deficiencies shall be made to HSS and will be considered timely if received by HSS within 10 calendar days of the center's receipt of the statement deficiencies.

4. If a timely request for an informal reconsideration is received, the department will schedule and conduct the informal reconsideration.

NOTE: Informal reconsiderations of the results of a complaint investigation are conducted as desk reviews.

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

6. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided in these licensing provisions for initial license denials, revocations and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:21482 (October 2008), repromulgated LR 34:2627 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1969 (October 2017).

§4222. Cessation of Business

A. Except as provided in §4223 and §4224 of these licensing regulations, a license shall be immediately null and void if an ADHC center becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the ADHC center ceased offering or providing services to the community and/or is considered non-operational in accordance with the requirements of §4205.

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

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

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

1. give 30 days' advance written notice to:

a. each participant or participant's legal representative, if applicable;

b. each participant's physician;

c. Health Standards Section (HSS);

d. Office of Aging and Adult Services (OAAS); and

e. support coordination agency for waiver participants;

2. provide for a safe and orderly discharge and transition of all of the center's participants.

F. In addition to the advance notice, the ADHC center shall submit a written plan for the disposition of participant(s) medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

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

3. the name and contact information for the appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

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

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

H. Once any ADHC center has ceased doing business, the center shall not provide services until the ADHC center has obtained a new initial ADHC license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1969 (October 2017).

§4223. Inactivation of License due to a Declared Disaster or Emergency

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

1. the licensed center shall submit written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

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

b. the licensed ADHC center intends to resume operation as an ADHC center in the same service area;

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

d. includes an attestation that all participants have been properly discharged or transferred to another center; and

e. provides a list of each participant and where that participant is discharged or transferred to;

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

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

4. the licensed ADHC center continues to submit required documentation and information to the department.

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

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

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

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

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

2. The center resumes operating as an ADHC center in the same service area within one year.

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

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

E. No change of ownership in the ADHC center shall occur until such ADHC center has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as an ADHC center.

F. The provisions of this section shall not apply to an ADHC center which has voluntarily surrendered its license and ceased operation.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1970 (October 2017).

§4224. Inactivation of License due to a Non-Declared Disaster or Emergency

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

1. the licensed ADHC center shall submit written notification to the HSS within 30 days of the date of the non-declared emergency or disaster stating that:

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

b. the licensed ADHC center intends to resume operation as a ADHC center in the same service area;

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

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

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

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

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

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

C. Upon center's receipt of the department's approval of request to inactivate the center's license, the center shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the center, if applicable, to OSFM and OPH as required.

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

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

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

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

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall

request scheduling of a licensing or physical environment survey, where applicable; and

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

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

G. No change of ownership in the ADHC center shall occur until such ADHC center has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as an ADHC center.

H. The provisions of this subsection shall not apply to an ADHC center which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the ADHC license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1970 (October 2017).

Subchapter B. Administration and Organization

§4225. Governing Body

A. The center shall have a governing body with responsibility as an authority over the policies and activities of the center.

1. The center shall have documents identifying the following information regarding the governing body:

a. names and addresses of all members;

b. terms of membership, if applicable;

c. officers of the governing body, if applicable; and

d. terms of office of all officers, if applicable.

2. When the governing body is composed of more than one person, formal meetings shall be held at least twice a year.

3. The governing body shall have by-laws specifying frequency of meetings and quorum requirements.

4. The center shall have written minutes of all formal meetings of the governing body.

5. The governing body may be composed of a single person or owner who shall assume all responsibilities of the governing body. At least twice a year, such single person or owner shall have documentation of reviewing and meeting the requirements pursuant to §4225.B.

B. Governing Body Responsibilities. The governing body of an ADHC center shall:

1. ensure the center's continual compliance and conformity with all relevant federal, state, parish and municipal laws and regulations;

2. ensure that the center is adequately funded and fiscally sound;

3. review and approve the center's annual budget;

4. ensure that the center is housed, maintained, staffed and equipped appropriately considering the nature of the program;

5. designate a person to act as the director and delegate sufficient authority to this person to manage the center and to insure that all services provided are consistent with accepted standards of practice;

6. formulate and annually review, in consultation with the director, written policies concerning the center's philosophy, goals, current services, personnel practices and fiscal management;

7. annually evaluate the director's performance;

8. have the authority to dismiss the director;

9. meet with designated representatives of the department whenever required to do so; and

10. inform designated representatives of the department prior to initiating any substantial changes in the program, services or physical plant of the center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2182 (October 2008), repromulgated LR 34:2628 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1971 (October 2017).

§4227. Policy and Procedures

A. An ADHC center shall have a written program plan describing the services and programs that it furnishes.

B. The center shall have written policies and procedures governing all areas of care and services provided by the center that are available to staff, participants, and/or sponsors. These policies and procedures shall:

1. ensure that each participant receives the necessary care and services to promote his/her highest level of functioning and well-being;

2. reflect awareness of the medical and psychosocial needs of participants as well as provisions for meeting those needs, including admission, transfer, and discharge planning; and the range of services available to participants;

3. be developed in consultation with a group of professional personnel consisting of at least a licensed physician, the director, and a registered nurse;

4. govern access, duplication and dissemination of information from the participant's personal and medical record;

5. establish guidelines to protect any money or other personal items brought to the ADHC center by participants;

6. describe the process for participants to file a grievance with the center and/or register a complaint with the department:

a. the LDH toll-free telephone number for registering complaints shall be posted conspicuously in public areas of the ADHC center;

7. be available to the participant's physician of choice;

8. be revised as necessary, but reviewed by the professional group at least annually; and

9. be approved by the governing body.

C. The director, or his designee:

1. is responsible for the execution of ADHC center policies; and

2. shall be accessible to center staff or to any representative of the Department of Health conducting an audit, survey, monitoring activity, or research and quality assurance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2182 (October 2008), repromulgated LR 34:2628 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2373 (September 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1971 (October 2017).

§4229. Fiscal Accountability

A. A center shall establish a system of business management and staffing to assure maintenance of complete and accurate accounts, books and records.

B. A center shall demonstrate fiscal accountability through regular recording of its finances.

C. A center shall not permit funds to be paid or committed to be paid to any entity in which any member of the governing body or administrative personnel, or members of their immediate families, have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the center.

1. The center shall provide a written disclosure of any financial transaction regarding the center in which a member of the governing body, administrative personnel, or his/her immediate family is involved.

D. The center shall ensure that all entries in records are legible, signed by the person making the entry and accompanied by the date on which the entry was made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2183 (October 2008), repromulgated LR 34:2628 (December 2008).

§4231. Administrative Records

A. A center shall have administrative records that include:

1. documents identifying the governing body;

a. a list of the officers and members of the governing body, their addresses and terms of membership, if applicable;

b. by-laws of the governing body and minutes of formal meetings, if applicable;

2. documentation of the center's authority to operate under state law;

3. an organizational chart for the center;

4. all leases, contracts and purchase-of-service agreements to which the center is a party;

5. insurance policies;

6. annual budgets and audit reports; and

7. a master list of all other programs and services used by the center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2183 (October 2008), repromulgated LR 34:2629 (December 2008).

§4233. Participant Case Records

A. A center shall have an organized record system which includes a written case record for each participant. The case record shall contain administrative and treatment data from the time of admission until the time that the participant leaves the center.

B. The participant’s case record shall include:

1. identifying information such as:

a. name;

b. birth date;

c. home address;

d. Social Security number;

e. marital status;

f. gender;

g. ethnic group; and

h. religion;

2. identifying information for the participant's personal representative, if applicable, such as:

a. name;

b. address; and

c. telephone number;

3. social and medical history including:

a. a complete record of admitting diagnoses and any treatments that the participant is receiving;

b. history of serious illness, serious injury or major surgery;

c. allergies to medication;

d. a list of all prescribed medications and non-prescribed drugs currently used;

e. current use of alcohol; and

f. the name of the participant's personal physician and an alternate;

4. complete health records, when available, including physical, dental and/or vision examinations;

5. a copy of the participant’s individual service plan including:

a. any subsequent modifications; and

b. an appropriate summary to guide and assist direct care staff in implementing the participant's program;

6. the findings made in periodic reviews of the plan including:

a. a summary of the successes and failures of the participant’s program; and

b. recommendations for any modifications deemed necessary;

7. any grievances or complaints filed by the participant and the resolution or disposition of these grievances or complaints;

8. a log of the participant's attendance and absence;

9. a physician's signed and dated orders for medication, treatment, diet, and/or restorative and special medical procedures required for the safety and well-being of the participant;

10. progress notes that:

a. document the delivery of all services identified in the individualized service plan;

b. document that each staff member is carrying out the approaches identified in the individualized service plan that he/she is responsible for;

c. record the progress being made and discuss whether or not the approaches in the individualized service plan are working;

d. record any changes in the participant's medical condition, behavior or home situation which may indicate a need for a change in the individualized service plan; and

e. document the completion of incident reports, when appropriate; and

NOTE: Each individual responsible for providing direct services shall record progress notes at least weekly, but any changes to the participant's condition or normal routine should be documented on the day of the occurrence.

11. discharge planning and referral.

C. All entries made by center staff in participants' records shall be legible, signed and dated.

D. The medications and treatments administered to participants at the center shall be charted by the appropriate staff.

E. The center may produce, maintain and/or store participant case records either electronically or in paper form.

F. The center shall ensure that participant case records are available to staff who are directly involved with participant care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2183 (October 2008), repromulgated LR 34:2629 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1972 (October 2017).

§4235. Retention of Records

A. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of according to state laws. An ADHC center shall have sufficient space, facilities and supplies for providing effective record-keeping services.

B. All records concerning past or present medical conditions of participants are confidential and shall be maintained in compliance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The expressed written consent of the participant shall be obtained prior to the disclosure of medical information regarding the participant.

C. The participant's medical record shall consist of the active participant record and the ADHC center's storage files or folders. As this active record becomes bulky, the outdated information shall be removed and filed in the ADHC center's storage files or folders. The active medical records shall contain the following information:

1. the necessary admission records;

2. at least six months of current pertinent information relating to the participant's active ongoing care; and

3. if the ADHC center is aware that a participant has been interdicted, a statement to this effect shall be noted on the inside front cover of the record.

D. Upon request, the ADHC center shall make all records, including participant records, available to the applicable federal and state regulatory agencies in order to

determine the center's compliance with applicable federal and state laws, rules and regulations.

E. An ADHC center's records may be produced, maintained and/or stored in either an electronic or paper form and shall be producible upon request by the department or its employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2184 (October 2008), repromulgated LR 34:2629 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1972 (October 2017).

§4237. Confidentiality and Security of Records

A. A center shall have written procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of records, and to whom records may be released. Records shall be the property of the ADHC center and as custodian, the center shall secure records against loss, tampering or unauthorized use.

B. A center shall maintain the confidentiality of all participants' case records. Employees of the center shall not disclose or knowingly permit the disclosure of any information concerning the participant or his/her family, directly or indirectly, to any unauthorized person.

C. A center shall obtain the participant's written, informed permission prior to releasing any information from which the participant or his/her family might be identified, except for authorized federal and state agencies or another program with professional interest in the participant.

D. The ADHC center shall safeguard the confidentiality of participant information and shall release confidential information only under the following conditions:

1. by court order; or

2. by the participant's written authorization, unless contraindicated as documented in the participant's record by the attending physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2184 (October 2008), repromulgated LR 34:2630 (December 2008).

Subchapter C. Participant Rights

§4239. Statement of Rights

A. Each participant shall be informed of his/her rights and responsibilities regarding the ADHC center. The regulations of the ADHC center and all rules governing participant conduct and behavior shall be fully explained to the participant. Before or upon admission, the ADHC center shall provide a copy of the participant rights document to each participant. A signed and dated acknowledgment form shall be filed in each participant's record.

B. If the ADHC center changes its participant rights policies, a signed and dated acknowledgment form shall be filed in each participant's record.

C. The center shall have a written policy on participant civil rights. This policy shall give assurances that:

1. a participant's civil rights are not abridged or abrogated solely as a result of placement in the ADHC center's program; and

2. a participant is not denied admission, segregated into programs or otherwise subjected to discrimination on the basis of race, religion or ethnic background.

D. The participant rights document shall include at least the following items:

1. the right to be informed, in writing, of:

a. all services available at the ADHC center;

b. the charges for those services; and

c. the center's days and hours of operation;

2. the right to participate in each interdisciplinary staffing meeting and any other meeting involving the care of the participant;

3. the right to refuse any service provided in the ADHC center;

4. the right to present complaints or recommend changes regarding the center's policies and services to staff or to outside representatives without fear of restraint, interference, coercion, discrimination or reprisal;

5. the right to be free from mental, physical or verbal abuse;

6. the right to be free from coercion; and

7. the right to be free from restraints. ADHC centers are prohibited from the use of any restraints;

8. the right to privacy during the provision of personal needs services;

9. the right to communicate, associate, and meet privately with individuals of his/her choice, unless this infringes on the rights of another participant; and

10. the right not to be required to perform services for the ADHC center, except when the performance of a specific service is identified in the individualized service plan as an appropriate approach to meeting a need or resolving a problem of the participant.

E. A friendly, supportive, comfortable, and safe atmosphere shall be maintained at all times, and all participants shall be treated equitably with respect, kindness, and patience.

F. Each participant shall be encouraged and assisted to exercise his/her rights as a participant at the ADHC center and as a citizen.

G. Devolution of Participant Rights. If the participant rights have devolved to the personal representative or next of kin, that party shall receive the explanation of and sign the participant rights and any other documents described in these standards. Under the following conditions, the ADHC center shall ensure that participant rights devolve to the personal representative or next of kin.

1. The participant has been interdicted in a court of law. In such cases, the ADHC center shall ensure that the participant's rights devolve to the curator/curatrix of record. The ADHC center shall obtain an official document verifying that the participant has indeed been interdicted and the interdiction shall be documented on the inside front cover of the participant's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2184 (October 2008), repromulgated LR 34:2630 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1972 (October 2017).

Subchapter D. ADHC Center Services

§4241. Mandatory Daily Program Components

A. There shall be a planned daily program of both individual and group activities which is sufficiently varied and structured so as to directly involve the participants in a stimulated and meaningful use of time while at the center. Emphasis shall be given to maintaining and improving the participants' functional abilities.

B. Participants shall be encouraged to take part in the planning and directions of activities. Programming shall allow for active and passive participation.

C. Centers shall provide a detailed description of individual and group activities that are being provided to participants on a daily basis and shall make this information available upon request. This information shall also be made available to participants and their families.

D. When available, community resources may be used to provide educational programs, lectures, concerts and similarly stimulating activities to participants.

E. An arts and crafts activities program may be available to make use of the rehabilitative as well as the recreational values of such pastimes. A supply of materials adequate to accommodate all participants shall be on hand for this program.

F. An outdoor activities program, such as gardening or walking, may be maintained where space, weather, and participants' health permit.

G. A daily rest period may be incorporated into the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2185 (October 2008), repromulgated LR 34:2631 (December 2008).

§4243. Core Services

A. At a minimum, each center shall provide the following services:

1. individualized training or assistance with the activities of daily living (toileting, grooming, ambulation, etc.);

2. health and nutrition counseling;

3. an individualized, daily exercise program;

4. an individualized, goal-directed recreation program;

5. daily health education;

6. one nutritionally-balanced hot meal and two snacks served each day;

7. nursing services that include the following individualized health services:

a. monitoring vital signs appropriate to the diagnosis and medication regimen of each participant no less frequently than monthly;

b. administering medications and treatments in accordance with physician's orders;

c. initiating and developing a self-administration of medication plan for the ADHC center which is individualized for each participant for whom it is indicated; and

8. transportation to and from the center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2185 (October 2008), repromulgated LR 34:2631 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1972 (October 2017).

§4245. Transportation Requirements

A. The center shall provide transportation to and from the ADHC center at the beginning and end of the program day. The center shall comply with the following requirements governing transportation.

1. The center shall have liability insurance coverage and have proof of such coverage.

2. The center shall conform to all state laws and regulations pertaining to drivers, vehicles and insurance.

B. The driver, whether directly employed or provided by third-party contract, shall hold a valid chauffeur's license or commercial driver license (CDL), if applicable with passenger endorsement.

1. The driver shall meet personal and health qualifications of other staff and receive necessary and appropriate training to ensure competence to perform duties assigned.

C. The number of occupants allowed in a car, bus, station wagon, van, or any other type of transportation shall not exceed the number for which the vehicle is designed.

D. Provisions shall be made to accommodate participants who use assistive devices for ambulation.

E. The vehicle shall be maintained in operating condition.

F. There shall be at least one staff member in the vehicle who is trained in first-aid and cardio pulmonary resuscitation (CPR) whether transportation is provided by center-owned transportation or by a third-party commercial proprietor.

G. Centers shall provide transportation to any participant within their licensed region, but no participant, regardless of their region of origin, may be in transport for more than one hour on any single trip.

1. If the center develops a policy that establishes a limited mileage radius for transporting participants, that policy shall be submitted to LDH for review and approval prior to the center being allowed to limit transportation for participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2186 (October 2008), repromulgated LR 34:2631 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2373 (September 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1973 (October 2017).

Subchapter E. Participant Care

§4249. Medical Services

A. Medical services shall be provided by the participant's physician of choice.

B. The center shall have a listing of available medical services for referral. When referrals are made, the center shall follow-up to see that the participant is receiving services.

C. Appropriate staff shall immediately notify the participant's physician and the legal or personal representative of any emergency, change in condition or injury to the participant that occurs at the center.

1. In areas where 911 services are not available, the center shall have means to transport participants for medical emergencies.

2. In cities or communities that have a city or community wide ambulance service (fire department or other emergency medical service), a statement in the center files regarding available emergency transportation services and the method of contact for the service will be acceptable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2186 (October 2008), repromulgated LR 34:2632 (December 2008).

§4251. Nursing Services

A. All nursing services furnished in the ADHC center shall be provided in accordance with acceptable nursing professional practice standards.

B. A licensed registered nurse (RN) shall serve on the interdisciplinary (ID) team and shall monitor the overall health needs of the participants. The RN serves as a liaison between the participant and medical resources, including the treating physician.

1. The RN's responsibilities include medication review for each participant at least monthly and when there is a change in the medication regimen to:

a. determine the appropriateness of the medication regime;

b. evaluate contraindications;

c. evaluate the need for lab monitoring;

d. make referrals to the primary care physician for needed monitoring tests;

e. report the efficacy of the medications prescribed; and

f. determine if medications are properly being administered in the center.

C. The RN shall supervise the method of medication administration to participants (both self-administration and staff administration).

D. The RN shall approve the method of medication storage and record-keeping.

E. The RN or LPN shall document the receipt of all prescribed medications for each participant with a legible signature and will comply with all Louisiana laws and rules regarding medication control and disbursement.

F. The RN shall give in-service training to both staff and participants on health related matters at least quarterly.

G. The RN shall ensure that diagnoses are compiled into a central location in the participant's record and updated when there is a change.

H. The RN shall monitor and supervise any staff licensed practical nurse (LPN) providing care and services to participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2186 (October 2008), repromulgated LR 34:2632 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1973 (October 2017).

§4253. Nutrition Services

A. There shall be a hot, nutritious and palatable noon meal served daily which provides one-third of the

recommended dietary allowances (RDA) as established by the National Research Council and American Dietetic Association. Accommodations shall be made for participants with special diets.

1. There shall be a mid-morning snack served daily in centers where breakfast is not served.

2. There shall be a mid-afternoon snack served daily.

B. Menus shall be varied and planned and approved well in advance by a licensed registered dietitian. Any substitutions shall be of comparable nutritional value and documented.

C. All food and drinks shall be of safe quality.

D. Drinking water shall be readily available and offered to participants.

E. Food preparation areas and utensils cleaning procedures shall comply with the State Sanitary Code.

F. A licensed registered dietitian shall:

1. review all orders for special diets;

2. prepare menus as needed; and

3. provide in-service training to staff and, as appropriate, participants.

G. Documentation of these reviews and recommendations shall be available in the participant case record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2187 (October 2008), repromulgated LR 34:2632 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1973 (October 2017).

§4255. Social Work Services

A. All social work services shall be provided in accordance with acceptable professional social work practice standards.

B. A social service designee or social worker shall serve on the ID team and shall monitor the overall social needs of the participant.

C. Social services, as a part of an interdisciplinary spectrum of services, shall be provided to the participants to:

1. maximize the social functioning of each participant;

2. enhance the coping capacity of the participant and, as appropriate, his family;

3. assert and safeguarding the human and civil rights of participants; and

4. foster the human dignity and personal worth of each participant.

D. While the participant is receiving ADHC services, the social service designee or social worker shall, as appropriate, serve as a liaison between the participant and the center, their family and the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2187 (October 2008), LR 34:2632 (December 2008).

Subchapter F. Human Resources

§4259. Personnel Policies

A. An ADHC center shall have personnel policies that include:

1. a written plan for recruitment, screening, orientation, in-service training, staff development, supervision and performance evaluation of all staff members;

2. written job descriptions for each staff position, including volunteers;

3. a health assessment which includes, at a minimum, evidence that the employee is free of active tuberculosis and that staff are retested on a time schedule as mandated by the Office of Public Health:

a. policies shall be in accordance with state rules, laws and regulations for employees, either contracted or directly employed, and volunteers;

4. a written employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or neglect in accordance with state law, whether the abuse or mistreatment is committed by another staff member, a family member or any other person;

6. clarification of the center's prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media and include, at a minimum, ensuring confidentiality of participant information and preservation of participant dignity and respect, including protection of participant privacy and personal and property rights; and

7. prevention of discrimination.

B. A center shall not discriminate in recruiting or hiring on the basis of sex, race, creed, national origin or religion.

C. A center's screening procedures shall address the prospective employee's qualifications, ability, related experience, health, character, emotional stability and social skills as related to the appropriate job description.

1. A center shall obtain written references from three persons (or prepare documentation based on telephone contacts with three persons) prior to making an offer of employment. The names of the references and a signed release shall be obtained from the potential employee.

2. A center shall comply with the provisions of R.S. 40:2120.41-2120.47 and the rules regarding the direct service worker (DSW) registry prior to making an offer of employment to a direct care staff applicant.

3. A center shall obtain a state-wide criminal background check conducted by the Louisiana State Police, or its designee, prior to making an offer of employment to a direct care staff applicant in accordance with applicable state laws.

a. The center shall have documentation on the final disposition of all charges that bar employment pursuant to applicable state law.

D. Annual performance evaluations shall be completed for all staff members.

1. For any person who interacts with participants, the performance evaluation procedures shall address the quality and nature of a staff member's interactions with participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2187 (October 2008), repromulgated LR 34:2633 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1973 (October 2017).

§4261. Orientation and Training

A. A center's orientation program shall provide training for any new direct care staff, either contracted or employed, to acquaint them with the philosophy, organization, program, practices and goals of the center. The orientation shall also include instruction in safety and emergency procedures as well as the specific responsibilities of the employee's job.

B. A center shall document that all employees, either contracted or staff, receive training on an annual basis in:

1. the principles and practices of participant care;

2. the center's administrative procedures and programmatic goals;

3. emergency and safety procedures;

4. protecting the participant's rights;

5. procedures and legal requirements concerning the reporting of abuse and neglect;

6. acceptable behavior management techniques,

7. crisis management; and

8. the center’s policy on the prohibited use of social media.

C. A center shall ensure that each direct care staff completes no less than 20 hours of face-to-face training per year. Orientation and normal supervision shall not be considered for meeting this requirement.

D. A new direct care staff employee shall not be assigned to carry out a participant’s care until competency has been demonstrated and documented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2187 (October 2008), repromulgated LR 34:2633 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1974 (October 2017).

§4263. Personnel Files

A. In accordance with §4259, an ADHC center shall have a personnel file for each employee, either contracted or staff that contains:

1. the application for employment and/or resume;

2. the statewide criminal background history checks;

3. documentation of proof of DSW registry checks;

4. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

5. any required medical examinations;

6. evidence of applicable professional credentials/certifications according to state law;

7. annual performance evaluations;

8. personnel actions, other appropriate materials, reports and notes relating to the individual's employment with the center; and

9. the employee’s starting and termination dates.

B. An ADHC center shall retain an employee’s personnel file for at least three years after the employee's termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2188 (October 2008), repromulgated LR 34:2633 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1974 (October 2017).

Subchapter G. Center Responsibilities

§4265. General Provisions

A. A center shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the center's responsibilities are carried out and that the following functions are adequately performed:

1. administrative functions;

2. fiscal functions;

3. clerical functions;

4. housekeeping, maintenance and food service functions;

5. direct service functions;

6. supervisory functions;

7. record-keeping and reporting functions;

8. social services functions; and

9. ancillary service functions;

B. The center shall ensure that all staff members are properly certified and/or licensed as legally required.

C. The center shall ensure that an adequate number of qualified direct service staff is present with the participants as necessary to ensure the health, safety and well-being of participants.

1. Staff coverage shall be maintained giving consideration to the time of the day, the size and nature of the center and the needs of the participants.

D. The center shall not knowingly hire, or continue to employ, any person whose health, educational achievement, emotional or psychological makeup impairs his/her ability to properly protect the health and safety of the participants or is such that it would endanger the physical or psychological well-being of the participants.

1. This requirement is not to be interpreted to exclude the continued employment of persons undergoing temporary medical or emotional problems unless such problems pose a threat to the health or safety of any participant or staff.

E. If any required professional services are not furnished by center employees, the center shall have a written agreement with an appropriately qualified professional to perform the required service or written agreements with the state for required resources.

F. The center shall establish procedures to assure adequate communication among staff in order to provide continuity of services to the participant. This system of communication shall include:

1. a regular review of individual and aggregate problems of participants, including actions taken to resolve these problems;

2. sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and

3. the maintenance of all accidents, personal injuries and pertinent incidents records related to implementation of the participant's individual service plans.

G. Any employee who is working directly with participant care shall have access to information from participant case records that is necessary for the effective performance of the employee's assigned tasks.

H. The center shall establish procedures which facilitate participation and feedback by staff members in policy-making, planning and program development for participants.

I. At all times, there shall be a staff member in the center who has knowledge of and can apply first aid and who is certified in CPR.

J. In the absence of the director, a staff member shall be designated to supervise the center.

K. The center shall not provide service to more participants than the number specified on its license on any given day or at any given time.

L. The center shall make available to the department any information, which the center is required to have under these standards and is reasonably related to the assessment of compliance with these standards. The participant's rights shall not be considered abridged by this requirement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2188 (October 2008), repromulgated LR 34:2633 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1974 (October 2017).

§4267. Staffing Requirements

A. Staff at ADHC centers shall meet the following education and experience requirements. All college degrees shall be from a nationally accredited institution of higher education as defined in §102(b) of the Higher Education Act of 1965 as amended. The following "key" staff positions are required and subject to the provisions listed below.

1. Director. The director shall have a bachelor's degree in a human services-related field, such as social work, nursing, education or psychology. Eight years of supervisory experience working in a human services-related field may be substituted for the bachelor's degree.

2. Nurse. The center shall employ one or more RN or LPN who shall be available to provide medical care and supervision services as required by all participants. The RN or LPN shall be on the premises daily for at least 8 hours or the number of hours the center is open, or during the time participants are present at the center, whichever is less. Nurses shall have a current Louisiana state nursing license.

3. Social Service Designee/Social Worker. The center shall designate at least one staff person who shall be employed at least 10 hours a week to serve as the social services designee or social worker.

a. The social services designee shall have, at a minimum, a bachelor's degree in a human service-related field such as psychology, sociology, education, or counseling. Two years of experience in a human service-related field may be substituted for each year of college.

b. The social worker shall have a bachelor's or master's degree in social work.

4. Program Manager. The center shall designate at least one staff member who shall be employed at least 10 hours a week to be responsible for carrying out the center's individualized program for each participant.

B. The following additional staff positions are required, subject to the provisions listed below.

1. Food Service Supervisor. The center shall designate one staff member who shall be employed at least 10 hours a week who shall be responsible for meal preparation and/or

serving. The food service supervisor shall have ServSafe® certification.

2. *Direct Service Worker*—an unlicensed person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the participant.

3. Volunteers. Volunteers and student interns are considered a supplement to the required staffing component. A center which uses volunteers or student interns on a regular basis shall have a written plan for using these resources. This plan shall be given to all volunteers and interns and it shall indicate that all volunteers and interns shall be:

a. directly supervised by a paid staff member;

b. oriented and trained in the philosophy of the center and the needs of participants as well as the methods of meeting those needs;

c. subject to character and reference checks similar to those performed for employment applicants upon obtaining a signed release and the names of the references from the potential volunteer/intern student;

d. aware of and briefed on any special needs or problems of participants; and

e. provided program orientation and ongoing in-service training. The in-service training should be held at least quarterly.

C. The direct service worker to participant ratio shall be a minimum of one full-time direct service worker to every nine participants.

D. Center staffing requirements shall be based on licensed capacity; however, the center shall ensure that the following requirements are met regardless of the licensed capacity of the center.

1. The RN or LPN shall be on the premises daily for at least eight hours, the number of hours the center is open, or during the time participants are present at the center, whichever is less.

2. If the RN or LPN has been on duty at least eight hours and there are still participants present in the ADHC, the RN or LPN may be relieved of duty, however, at least one key staff person shall remain on duty at the center. The key staff person shall be the social service designee/social worker or the program manager.

3. A staff member who is certified in CPR shall be on the premises at all times while participants are present.

E. Centers with a licensed capacity of 15 or fewer participants may designate one full-time staff person or full-time equivalent person to fill up to three "key staff" positions, and shall employ at least one full-time person or full-time equivalent to fulfill key staff requirements.

F. Centers with a licensed capacity to serve 16-30 participants shall employ at least two full-time persons or full-time equivalents to fulfill key staff requirements, and may designate one full-time staff person or full-time equivalent person to fill up to, but no more than, two "key staff" positions.

G. Centers with a licensed capacity to serve more than 30 participants shall employ at least three full-time persons or full-time equivalents to fill key staff positions. Each key staff position shall be filled with a full-time person or full-time equivalent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2188 (October 2008), repromulgated LR 34:2634 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2373 (September 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1974 (October 2017).

§4269. Incident Reports

A. There shall be policies and procedures which cover the writing of and disposition of incident reports.

1. The center shall complete incident reports for each participant involved in the following occurrences:

a. accidents and injuries;

b. the involvement of any participant in any occurrence which has the potential for affecting the welfare of any other participant;

c. any elopement or attempted elopement, or when the whereabouts of a participant is unknown for any length of time; and

d. any suspected abuse, whether or not it occurred at the center.

B. Progress notes documented on the day of the incident shall indicate that an incident report was written.

C. The completed individual incident report shall be filed in a central record system.

D. Incident reports shall include, at a minimum, the following information:

1. the name of the participant or participants;

2. the date and time of the incident;

3. a detailed description of the incident;

4. the names of witnesses to the incident and their statements; and

5. a description of the action taken by the center with regard to the incident.

E. Incident reports shall be reviewed by the director, his designee or a medical professional within 24 hours of the occurrence. A qualified professional shall recommend action, in a timely manner, as indicated by the consequences of the incident.

F. ID team members shall review all incident reports quarterly, and recommend action as indicated to:

1. insure that the reports have all of the required information;

2. identify staff training needs;

3. identify patterns which may indicate a need for changes in the center policies/practices; and

4. assist in identifying those participants who may require changes in their plans of care or who may not be appropriately placed in the ADHC center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2189 (October 2008), repromulgated LR 34:2635 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1975 (October 2017).

Subchapter H. Direct Service Management

§4273. Admissions

A. A center shall have a written description of its admission policies and criteria. The admission information for individual participants shall include:

1. the participant's name, date of birth, home address and telephone number;

2. the name, address and telephone number of the participant's closest relative or friend;

3. a brief social history that includes the participant's marital status, general health status, education, former occupation, leisure-time interest and existence of supportive family members or friends;

4. the name, address and telephone number of the participant's physician and/or medical center as well as the date of participant's last physical exam;

5. a nursing assessment summary performed by the center's RN or LPN at the time of the participant's admission to the center which includes:

a. special dietary needs;

b. prescribed medication;

c. allergies;

d. any limitations on activity;

e. the degree to which the participant is ambulant;

f. visual or hearing limitations and/or other physical impairments;

g. apparent mental state or degree of confusion or alertness;

h. the ability to control bowel or bladder;

i. the ability to feed self;

j. the ability to dress self; and

k. the ability to self-administer medication.

NOTE: The Minimum Data Set Home Care (MDS/HC) can be used in place of the nursing assessment summary.

B. The center shall not refuse admission to any participant on the grounds of race, sex or ethnic origin.

C. The center shall not knowingly admit any participant into care whose presence would be seriously damaging to the ongoing functioning of the center or to participants already receiving services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2189 (October 2008), repromulgated LR 34:2635 (December 2008).

§4275. Discharge

A. The center shall have written policies and procedures governing voluntary discharges (the participant withdraws from the program on his/her own) and non-voluntary discharges (center initiated discharges).

1. The policy may include the procedures for non-voluntary discharges due to the health and safety of the participant or that of other participants if they would be endangered by the further stay of a particular participant in the center.

B. There shall be a written report detailing the circumstances leading to any discharge.

C. Prior to a planned discharge, the center's ID Team shall formulate an aftercare plan specifying needed supports and the resources available to the participant.

D. When the participant is going to another home and community-based program or institutional center, discharge planning shall include the participant's needs, medication history, social data and any other information that will assist in his/her care in the new program or center.

1. A center member of the ID Team shall confer with the representatives of the new program regarding the individual needs and problems of the participant, if at all possible.

2. Upon discharge, the center shall provide a summary of the participant's health record to the person or agency responsible for the future planning and care of the participant. The discharge summary shall include:

a. medical diagnoses;

b. medication regimen (current physicians orders);

c. treatment regimen (current physicians orders);

d. functional needs (inabilities);

e. any special equipment utilized (dentures, ambulatory aids, eye glasses, etc.);

f. social needs;

g. financial resources; and

h. any other information which will enable the receiving center/caregivers to provide the continued necessary care without interruption.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2190 (October 2008), repromulgated LR 34:2635 (December 2008).

§4277. Interdisciplinary Team Responsibilities

A. It shall be the responsibility of the ID team to assess and develop an individualized service plan for each participant prior to or within 20 days of admission of a participant.

B. Prior to the individual staffing of a participant by the ID team, each team member shall complete an assessment to be used at the team meeting. This assessment shall, at a minimum, include a physical assessment and a social evaluation.

C. The ID team shall meet, reassess, and reevaluate each participant at least quarterly to review the individualized service plan to ensure that it is sufficient for each participant.

D. The ID team shall make referrals, as indicated, to other disciplines and for any service which would enhance the functional capacity of a participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2190 (October 2008), repromulgated LR 34:2636 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1975 (October 2017).

§4279. Interdisciplinary Team-Composition

A. The ID team may be composed of either full-time staff members, contractual consultants or a combination of both.

B. The ID team shall be composed of:

1. a registered nurse licensed to practice in the state of Louisiana;

2. a social service designee/social worker; and

3. at least one direct care staff person from the center.

C. In addition, dietitians, physical therapists, occupational therapists, recreational therapists, physicians and others may sit on the team to staff an individual participant on an as needed basis.

D. The participant, and/or family members or legal or personal representative if appropriate, shall be involved in the ID team staffing and any other meeting involving the care needed by the participant while receiving services at the ADHC center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2190 (October 2008), repromulgated LR 34:2636 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1975 (October 2017).

§4281. Individualized Service Plan

A. The participant's ADHC individualized service plan shall:

1. be developed from the staffing performed by the ID team of each participant;

2. state the individual needs and identified problems of the participant for which intervention is indicated in assessments, progress notes and medical reports;

3. include the number of days and time of scheduled attendance required to meet the needs of the participant;

4. use the strengths of the participant to develop approaches and list these approaches with the frequency that each will be used to meet the needs of the participant;

5. identify the staff member who will be responsible for carrying out each item in the plan (the position, rather than the name of the employee, may be indicated in the plan);

6. ensure that all persons working with the participant are appropriately informed of the services required by the individualized service plan;

7. propose a reasonable time-limited goal with established priorities. The projected resolution date or review date for each problem shall be noted;

8. contain the necessary elements of the self-administration or other medication administration plan, if applicable;

9. include discharge as a goal;

10. be legible and written in terminology which all staff personnel can understand;

11. be signed and dated by all the team members; and

12. be included as a part of the participant's case record.

B. Unless it is clearly not feasible to do so, a center shall ensure that the individualized service plan and any subsequent revisions are explained to the participant and, where appropriate, the legally responsible person/personal representative or family member in language understandable to these persons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2190 (October 2008), repromulgated LR 34:2636 (December 2008).

§4283. Individualized Service Plan Review

A. The individualized service plan shall be reviewed and updated at least quarterly and whenever there is a change in problems, goals or approaches as indicated.

B. This review shall be done by the person indicated on the plan as the individual primarily responsible for carrying out the plan.

C. This review shall be accomplished by reviewing the individual reports of all persons responsible for meeting the needs of the participant. These reports shall include any reports from physicians, social service designees/social workers, nurses, therapists, dietitians, and family members as well as incident reports.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2191 (October 2008), repromulgated LR 34:2637 (December 2008).

Subchapter I. Emergency and Safety

§4285. Emergency and Safety Procedures

A. A center shall have a written overall plan of emergency and safety procedures. The plan shall:

1. provide for the evacuation of participants to safe or sheltered areas;

2. include provisions for training staff and, as appropriate, participants in preventing, reporting and responding to fires and other emergencies;

3. provide means for an on-going safety program including continuous inspection of the center for possible hazards, continuous monitoring of safety equipment, and investigation of all accidents or emergencies; and

4. include provisions for training personnel in their emergency duties and in the use of any fire-fighting or other emergency equipment in their immediate work areas.

B. The center shall ensure the immediate accessibility of appropriate first aid supplies in kits that are to be located in the center's building and all vehicles used to transport participants.

C. A center shall have access to telephone service whenever participants are in attendance.

1. Emergency telephone numbers shall be posted for easy access, including fire department, police, medical services, poison control and ambulance.

D. A center shall immediately notify the department and other appropriate agencies of any fire, disaster or other emergency which may present a danger to participants or require their evacuation from the center.

E. At any time that the ADHC has an interruption in services or a change in the licensed location due to an emergency situation, the center shall notify HSS no later than the next stated business day.

F. There shall be a policy and procedure that insures the notification of family members or responsible parties whenever an emergency occurs for an individual participant.

G. Upon the identification of the non-responsiveness of a participant at the center, the center's staff shall implement the emergency medical procedures and notify the participant's family members and other medical personnel.

H. A center shall conduct emergency drills at least once every three months.

I. A center shall make every effort to ensure that staff and participants recognize the nature and importance of such drills.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2191 (October 2008), repromulgated LR 34:2637 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1975 (October 2017).

§4287. General Safety Practices

A. A center shall not maintain any firearms or chemical weapons where participants may have access to them.

B. A center shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers that are labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of participants, staff and visitors.

C. The center shall not have less than two remote exits.

D. Doors in means of egress shall swing in the direction of exit travel.

E. Every bathroom door lock shall be designed to permit opening of the locked door from the outside in an emergency, and the opening device shall be readily accessible to the staff.

F. Unvented or open-flame heaters shall not be utilized in center.

G. All exterior and interior doors used by participants shall be at least 32 inches wide.

H. All hallways/corridors shall be at least 36 inches wide.

I. At least one primary entrance shall be accessible to people with disabilities or impairments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2191 (October 2008), repromulgated LR 34:2637 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1975 (October 2017).

Subchapter J. Physical Environment

§4289. General Appearance and Conditions

A. The center shall present an attractive outside and inside appearance and be designed and furnished with consideration for the special needs and interests of the population to be served as well as the activities and services to be provided.

1. Illumination levels in all areas shall be adequate and careful attention shall be given to avoiding glare.

2. The design shall facilitate the participant's movement throughout the center and involvement in activities and services.

3. Heating, cooling and ventilation system(s) shall permit comfortable conditions.

4. Sufficient furniture shall be available to facilitate usage by the entire participant population in attendance.

5. Furniture and equipment that will be used by participants shall be selected for comfort and safety as well as be appropriate for use by persons with visual and mobility limitations, and other physical disabilities.

6. Floors and steps shall have a non-slippery surface and be dry when in use by the participants. Doorways and passageways shall be kept clear to allow free and unhindered passage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2192 (October 2008), repromulgated LR 34:2637 (December 2008).

§4291. Space Requirements

A. The center shall have sufficient space and equipment to accommodate the full range of program activities and services.

B. The center shall provide at least 40 square feet of indoor space for each participant. The square footage excludes hallways, offices, restrooms, storage rooms, kitchens, etc.

C. The center shall be flexible and adaptable for large and small groups and individual activities and services.

D. There shall be sufficient office space to permit staff to work effectively and without interruption.

E. There shall be adequate storage space for program and operating supplies.

F. There shall be sufficient parking area available for the safe daily delivery and pick-up of participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2192 (October 2008), repromulgated LR 34:2638 (December 2008).

§4293. ADHC Furnishings

A. The center shall be furnished so as to meet the needs of the participants. All furnishings and equipment shall be kept clean and in good repair.

B. Lounge and Recreational Areas. Adequate furniture shall be available and shall be appropriate for use by the participants in terms of comfort and safety.

C. Dining Area. Furnishings shall include tables and comfortable chairs sufficient in number to serve all participants. Meals may be served either cafeteria style or directly at the table depending upon the method of food preparation or physical condition of the participants.

D. Kitchen. If the center has a kitchen area, it shall meet all health and sanitation requirements and shall be of sufficient size to accommodate meal preparation for the proposed number of participants.

E. Toilet Facilities. There shall be sufficient toilet and hand-washing facilities to meet the needs of both males and females. The number of toilets and hand- washing facilities shall be not less than one for each 12 participants.

1. There shall be at least two toilet facilities when males and females are served.

2. Toilets and hand-washing facilities shall be equipped so as to be accessible for people with disabilities.

F. Isolation/Treatment Room. There shall be a separate room or partitioned area for temporarily isolating a participant in case of illness. This room may be furnished with a bed or a recliner for the participant's use.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2192 (October 2008), repromulgated LR 34:2638 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1975 (October 2017).

§4295. Location of Center

A. An adult day health care center that is located within any center or program that is also licensed by the department shall have its own identifiable staff, space, and storage. These centers shall meet specific requirements if they are located within the same physical location as another program that is also licensed by the department.

1. The program or center within which the ADHC center is located shall meet the requirements of its own license.

B. New centers may not be located within 1,500 feet of another adult day health care center unless both centers are owned and managed by the same organization.

C. The location or site of an ADHC center shall be chosen so as to be conducive to the program and the participants served.

D. ADHC Centers within Nursing Centers. An adult day care center can only be located within a nursing center when the following conditions are met.

1. Space required for licensure of the nursing center cannot be utilized as space for the licensure of the adult day care center.

2. If space to be used for the ADHC center is nursing center bedroom space, the number of beds associated with the space occupied by the ADHC program shall be reduced from the licensed capacity of the nursing center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.41-46.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2192 (October 2008), repromulgated LR 34:2638 (December 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1976 (October 2017).

Chapter 44. Abortion Facilities

Subchapter A. General Provisions

§4401. Definitions

Abortion—any surgical procedure performed, after pregnancy has been medically verified, with the intent to cause the termination of the pregnancy, other than for the purpose of:

1. producing a live birth;

2. removing an ectopic pregnancy; or

3. removing a dead fetus caused by a spontaneous abortion.

Active Admitting Privileges—the physician is a member in good standing of the medical staff of a hospital that is currently licensed by the department, with the ability to admit a patient and to provide diagnostic and surgical services to such patient.

1. The hospital shall be located not further than 30 miles from the location at which the abortion is performed or induced, and shall provide obstetrical or gynecological health care services.

2. Violations of active admitting privileges provisions shall be fined not more than $4,000 per violation.

Administrator—the person responsible for the day-to-day management, supervision, and operation of the outpatient abortion facility.

Change of Ownership (CHOW)—transfer of ownership to someone other than the owner listed on the initial licensing application or license renewal application.

Coerced Abortion—the use of force, intimidation, threat of force, threat of deprivation of food and shelter, or the deprivation of food and shelter by a parent or any other person in order to compel a female child to undergo an abortion against her will, whether or not the abortion procedure has been attempted or completed.

CRNA—a certified registered nurse anesthetist licensed by the Louisiana State Board of Nursing who is under the supervision of the physician performing the abortion or an anesthesiologist who is immediately available if needed as defined in the medical staff bylaws and in accordance with applicable licensing boards. A CRNA is an advanced practice registered nurse educated in the field of nurse anesthesia and certified according to the requirements of a nationally recognized certifying body such as the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, as approved by the board and who is authorized to select and administer anesthetics or ancillary services to patients under their care.

Department—the Department of Health and Hospitals (DHH).

Facility Need Review (FNR)—pursuant to R.S. 40:2116, a process that requires licensure applicants to prove the need for the services prior to applying for licensure.

First Trimester—the time period up to 14 weeks after the first day of the last menstrual period.

General Anesthesia—any drug, element, or other material which, when administered, results in a controlled state of unconsciousness accompanied by a partial or complete loss of protective reflexes, including a loss of ability to independently maintain an airway and respond purposefully to physical stimuli or verbal command.

Gestational Age—the age of the unborn child as measured by the time elapsed since the first day of the last menstrual period as determined by a physician and confirmed through the use of an ultrasound.

Health Standards Section (*HSS)*—the Department of Health and Hospitals, Health Standards Section.

Medical Director—a physician who is responsible for all of the medical care provided to patients in the outpatient abortion facility, and for the ethical and professional practices of the medical staff.

OPH—the Department of Health and Hospitals, Office of Public Health.

OSFM—the Department of Public Safety and Corrections, Office of State Fire Marshal, Public Safety Services.

Outpatient Abortion Facility—any outpatient facility or clinic, other than a hospital or an ambulatory surgical center as defined by applicable state law, in which any second trimester or five or more first trimester abortions per calendar year are performed.

Patient—the woman receiving services from an outpatient abortion facility.

Peer Review—the evaluation of work by one or more persons of similar competence to the producers of the work.

Physician—a doctor who possesses a current license to practice medicine in Louisiana, is in good standing with the Louisiana State Board of Medical Examiners, and whose

license does not restrict the doctor from performing the services at the outpatient abortion facility.

Physician Assistant (PA)—an individual who is currently approved by, licensed by, and in good standing with the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed by and registered with the Louisiana State Board of Medical Examiners to supervise a physician assistant and who is acting within the scope of all applicable state laws and the individual's professional license.

Products of Conception—placenta, amniotic sac or membrane, embryo, or fetal elements that result from a human pregnancy.

Second Trimester—the time period from 14 to 23 weeks after the first day of the last menstrual period.

Secretary—the secretary of the Louisiana Department of Health and Hospitals.

Telecommunications—any means of transmitting messages at a distance, including but not limited to:

1. telephones;
2. cell phones;
3. pagers; or
4. other similar devices which foster communication.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:685 (April 2015).

§4403. General Licensing Provisions

A. It shall be unlawful for outpatient abortion facilities in the initial licensing application process to accept patients or provide abortion services until licensed by the Department of Health and Hospitals (DHH). The department is the only licensing authority for outpatient abortion facilities in Louisiana.

B. Types of Licenses. The department shall have the authority to issue the following types of licenses:

1. full initial license;
2. provisional initial license;
3. full renewal license; and
4. provisional license.

C. An outpatient abortion facility shall be in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to an abortion or abortion procedures before the outpatient abortion facility will be issued an initial license to operate.

D. An outpatient abortion facility license shall:

1. be issued only to the person or entity named in the initial licensing application;

2. be valid only for the outpatient abortion facility to which it is issued and only for the physical address named in the initial licensing application;

3. be valid for one year from the date of issuance, unless revoked or suspended, prior to that date, or unless a provisional initial license or provisional license is issued;

4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the outpatient abortion facility;

5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

E. An outpatient abortion facility licensed by the department may only perform first and second trimester abortions pursuant to R.S. 40:2175.3.

F. A separately licensed outpatient abortion facility shall not use a name which is substantially the same as the name of another such facility licensed by the department. An outpatient abortion facility shall not use a name which is likely to mislead the patient or their family into believing it is owned, endorsed, or operated by the state of Louisiana.

G. No branches, satellite locations, or offsite campuses shall be authorized for an outpatient abortion facility.

H. Plan Review Process. Submission of plan review to the Office of the State Fire Marshall is required for initial licensure, major renovation, and change of location.

1. Applicants are required to refer to the OSFM for laws, rules, and editions of adopted codes and standards applicable to plan review by the OSFM.

2. One complete set of plans and specifications (construction documents), with application and review fee, shall be submitted to the OSFM for review.

3. Plan review submittal to the OSFM shall be in accordance with applicable state laws, rules, regulations, and the following.

a. Modifications to Physical Environment which involve Major Renovations. Any proposed change to the physical environment which involves major renovations shall require plan review for compliance with requirements applicable at the time of the proposed change.

i. Painting, re-tiling floors, installation of carpet, and repairing of roof damage or reroofing are not considered to be major renovations. Normal maintenance of a building does not require plan review by the OSFM.

ii. Major renovations may require a physical environment survey pursuant to §4407.D.5 and §4445.A.3.

b. The specific requirements outlined in the physical environment section of this Chapter.

c. Where services or treatment for four or more patients can be accommodated at more than one time, requirements applicable to Ambulatory Health Care occupancies, as defined by the most recently state-adopted edition of National Fire Protection Association (NFPA) 101, shall apply.

d. Where services or treatment for three or less patients can be accommodated at more than one time, requirements applicable to construction of business occupancies, as defined by the most recently state-adopted edition of NFPA 101, shall apply.

4. Upon approval, one copy of the documents reviewed by the OSFM and one copy of the OSFM plan review letter shall be submitted to the department. Electronic transfer of documents by the OSFM to the department is allowed to satisfy this requirement.

5. Waivers. When a requirement of these rules regarding plan review would impose a hardship, financial or otherwise, but would not adversely affect the health and safety of any patient, the outpatient abortion facility may submit a waiver request to the department, with supporting documentation. The issuance of a waiver by the department does not apply to the OSFM requirements for approval, which must be addressed exclusively by the outpatient abortion facility with the OSFM or the state health officer, as appropriate to the subject matter.

a. Waivers are granted only at the discretion of the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:686 (April 2015).

§4405. Initial Licensing Application Process

A. The initial licensing application process requires submission and approval of plans and specifications (construction documents) and requires submission and approval of an initial licensing application packet, including but not limited to, a facility need review approval letter. No outpatient abortion facility shall accept patients or provide abortion services until in compliance with the provisions of this Chapter.

B. Plan Review Approval. All plans and specifications (construction documents) submitted by, or on behalf of, the outpatient abortion facility are required to be submitted and approved by the Office of State Fire Marshal (OSFM) as part of the licensing application process.

C. Initial Licensing Application Packet. An initial licensing application packet for an outpatient abortion facility shall be obtained from the department. A complete initial licensing application packet shall be submitted to the department for approval and onsite survey. The applicant may not provide outpatient abortion services until properly licensed by the department.

D. To be considered complete, the initial licensing application packet shall include the following:

1. a completed outpatient abortion facility initial licensing application and the non-refundable initial licensing fee;

2. a copy of the approval letter of the architectural facility plans for the outpatient abortion facility by the OSFM;

3. a copy of the on-site inspection report with approval for occupancy from the OSFM;

4. a copy of the health inspection report from the Office of Public Health (OPH);

5. an organizational chart identifying the name, position, and title of each person composing the governing body and key administrative personnel;

6. a floor sketch or drawing of the premises to be licensed;

7. pursuant to R.S. 40:2116, a copy of the facility need review approval letter; and

8. any other documentation or information required by the department for licensure, including but not limited to, a copy of any waiver approval letter, if applicable.

E. If the initial licensing application packet is incomplete as submitted, the applicant shall be notified in writing of the missing information and shall have 90 calendar days from receipt of the notification to submit the additional requested information. If the additional requested information is not timely submitted to the department within 90 calendar days, the initial licensing application shall be closed. If an initial licensing application is closed, an applicant who is still interested in operating an outpatient abortion facility must submit a newly completed initial licensing application packet and a new non-refundable initial licensing fee to begin the initial licensing application process again, subject to any facility need review approval.

F. Initial Licensing Surveys. Upon receipt of a complete initial licensing application packet, the department shall conduct an on-site initial licensing survey prior to issuing a full initial license. The initial licensing survey shall be announced.

1. If it is determined that the applicant is not in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, and a potential threat to the health, safety, and welfare of the patients is presented, the department shall deny the initial licensing application.

2. If it is determined that the applicant is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, the department shall issue a full initial license to the applicant.

3. If it is determined that the applicant is not in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, but the department, in its sole discretion, determines that the noncompliance does not present a threat to the health, safety, and welfare of the patients, the department may issue a provisional initial license.

G. Full Initial License. The full initial license issued by the department shall be valid until the expiration date shown on the license unless the license is revoked or suspended prior to that date.

H. Provisional Initial License. The provisional initial license issued by the department shall be valid for a period not to exceed six months.

1. When a provisional initial license is issued by the department, the applicant shall submit a plan of correction to the department for approval and also shall be required to correct all deficiencies prior to the expiration of the provisional initial license.

2. Upon receipt of the applicant's plan of correction, the department shall conduct an unannounced follow-up survey, either on-site or by administrative desk review, to ensure the applicant is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures.

a. Following the follow-up survey, if it is determined that the applicant has corrected all deficiencies and has maintained compliance during the period of the provisional license, the department shall issue a full initial license for the remainder of the year.

b. Following the follow-up survey, if it is determined that the applicant has failed to correct all deficiencies, the provisional initial license shall expire unless otherwise determined by the department. The applicant shall be required to submit a newly completed initial licensing application packet and a new non-refundable initial licensing fee to begin the initial licensing application process again subject to any facility need review approval.

I. Informal Reconsideration and Administrative Appeal. The outpatient abortion facility does not have the right to request an informal reconsideration and/or an administrative appeal of the issuance or the expiration of a provisional initial license. An outpatient abortion facility that has been issued a provisional initial license is considered licensed and operational for the term of the provisional initial license. The issuance of a provisional initial license is not considered to be a denial of an initial licensing application, denial of a license renewal application, or license revocation for the purposes of this Chapter.

1. Informal Reconsideration. An outpatient abortion facility that has been issued a provisional initial license has the right to request an informal reconsideration regarding the validity of the deficiencies cited during the follow-up survey.

a. The request for an informal reconsideration must be in writing and received by HSS within five calendar days of receipt of the statement of deficiencies. If a timely request for an informal reconsideration is received, HSS shall schedule the informal reconsideration and notify the outpatient abortion facility in writing.

b. The request for an informal reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

c. Correction of a deficiency or deficiencies cited in a follow-up survey shall not be the basis for an informal reconsideration.

d. The outpatient abortion facility shall be notified in writing of the results of the informal reconsideration.

2. Administrative Appeal. An outpatient abortion facility that has been issued a provisional initial license has the right to request an administrative appeal regarding the validity of the deficiencies cited during the follow-up survey.

a. The request for an administrative appeal must be in writing and received by the Division of Administrative Law (DAL), or its successor, within 15 days of receipt of the statement of deficiencies cited during the follow-up survey.

b. The request for an administrative appeal must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

c. Correction of a deficiency or deficiencies cited in a follow-up survey shall not be the basis for an administrative appeal.

d. Upon expiration of the provisional initial license, the outpatient abortion facility shall immediately cease and desist providing abortion services unless the DAL, or its successor, issues a stay of the expiration.

e. Stay of the Expiration. The request for a stay of the expiration must be submitted with the request for an administrative appeal and received by the DAL, or its

successor, within 15 days of receipt of the statement of deficiencies.

i. Following a contradictory hearing and only upon a showing that there is no potential harm to the patients being served by the outpatient abortion facility, the stay may be granted by the DAL, or its successor.

f. If a timely request for an administrative appeal is received, the DAL, or its successor, shall conduct the administrative appeal in accordance with the Administrative Procedure Act.

i. If the final decision of the DAL, or its successor, is to remove all deficiencies, the outpatient abortion facility's license shall be granted/re-instated upon the payment of any licensing fees, outstanding sanctions, or other fees due to the department.

ii. If the final decision of the DAL, or its successor, is to uphold any of the deficiencies thereby affirming the expiration of the provisional initial license, the outpatient abortion facility shall:

(a). immediately cease and desist providing abortion services as an outpatient abortion facility;

(b). return the outpatient abortion facility license to the department; and

(c). notify the department in writing of the secure and confidential location where the patient medical records will be stored, including the name, physical address, and contact person, within 10 days of the rendering of the administrative appeal judgment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:687 (April 2015).

§4407. Survey Activities

A. Any applicant or outpatient abortion facility shall be subject to licensing surveys conducted by department surveyors to ensure that an applicant or outpatient abortion facility is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, and also to ensure there is no present threat to the health, safety, and welfare of the patient.

B. Any applicant or outpatient abortion facility subject to licensing surveys conducted by the department shall:

1. allow department surveyors access to any and all requested documents and information on the licensed premises, including, but not limited to, patient medical records and outpatient abortion facility records that are relevant or necessary for the survey;

2. allow department surveyors access to interview any staff or other persons as necessary or required; and

3. not interfere with or impede the survey process for department surveyors while conducting any survey.

C. The department is entitled to access all books, records, or other documents maintained by or on behalf of the outpatient abortion facility on the licensed premises to the extent necessary to ensure compliance with this Chapter. Ensuring compliance includes permitting photocopying by the department or providing photocopies to the department of any records or other information by or on behalf of the outpatient abortion facility as necessary to determine or verify compliance with this Chapter.

D. Types of Surveys. The department shall have the authority to conduct the following types of surveys.

1. Initial Licensing Surveys. The department shall conduct an on-site initial licensing survey to ensure the applicant is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures prior to issuing a full initial license. All initial licensing surveys shall be announced.

2. Annual Licensing Surveys. The department shall conduct an annual licensing survey. All annual licensing surveys shall be unannounced.

3. Complaint Surveys. The department shall conduct complaint surveys when a complaint is lodged against an outpatient abortion facility in accordance with R.S. 40:2009.13 et seq. All complaint surveys shall be unannounced.

4. Follow-up Surveys. The department may conduct a follow-up survey to ensure the outpatient abortion facility has corrected all deficiencies cited in the previous survey and is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures. All follow-up surveys shall be unannounced.

5. Physical Environment Survey

a. An announced on-site survey to ensure the outpatient abortion facility is compliant with the applicable physical environment regulations due to the following:

i. major renovations of a currently licensed outpatient abortion facility; or

ii. relocation of a currently licensed outpatient abortion facility.

b. A physical environment survey may be conducted alone or conducted in conjunction with another survey.

E. Statement of Deficiencies. Following any survey, the department surveyors shall complete the statement of deficiencies documenting relevant findings including the deficiency, the applicable governing rule, and the evidence supporting why the rule was not met including, but not limited to, observations, interviews, and record review of information obtained during the survey. The outpatient abortion facility shall receive a copy of the statement of deficiencies.

1. Display. The following statements of deficiencies issued by the department to the outpatient abortion facility must be posted in a conspicuous place on the licensed premises:

a. the most recent annual licensing survey statement of deficiencies; and

b. any follow-up and/or complaint survey statement of deficiencies issued after the most recent annual licensing survey.

2. Public Disclosure. Any statement of deficiencies issued by the department to an outpatient abortion facility shall be available for disclosure to the public within 30 calendar days after the outpatient abortion facility submits an acceptable plan of correction to the deficiencies or within 90 days of receipt of the statement of deficiencies, whichever occurs first.

F. Plan of Correction. The department may require a plan of correction from an outpatient abortion facility following any survey wherein deficiencies have been cited. The fact that a plan of correction is accepted by the department does not preclude the department from pursuing other actions against the outpatient abortion facility as a result of the cited deficiencies.

G. Informal Reconsideration. The applicant and/or outpatient abortion facility shall have the right to request an informal reconsideration of any deficiencies cited during any initial licensing survey, annual licensing survey, and follow-up survey.

1. The request for an informal reconsideration must be in writing and received by HSS within 10 calendar days of receipt of the statement of deficiencies. If a timely request for an informal reconsideration is received, HSS shall schedule the informal reconsideration and notify the outpatient abortion facility in writing.

2. The request for an informal reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

3. Correction of the deficiency or deficiencies cited in any survey shall not be the basis for an informal reconsideration.

4. The outpatient abortion facility may appear in person at the informal reconsideration and may be represented by counsel.

5. The outpatient abortion facility shall receive written notice of the results of the informal reconsideration.

6. The results of the informal reconsideration shall be the final administrative decision regarding the deficiencies and no right to an administrative appeal shall be available.

H. Complaint Survey Informal Reconsideration. Pursuant to R.S. 40:2009.13 et seq., an outpatient abortion facility shall have the right to request an informal reconsideration of the validity of the deficiencies cited during any complaint survey, and the complainant shall be afforded the opportunity to request an informal reconsideration of the findings.

1. The department shall conduct the informal reconsideration by administrative desk review.

2. The outpatient abortion facility and/or the complainant shall receive written notice of the results of the informal reconsideration.

3. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the results of the informal reconsideration shall be the final administrative decision and no right to an administrative appeal shall be available.

I. Sanctions. The department may impose sanctions as a result of deficiencies cited following any survey. A sanction may include, but is not limited to:

1. civil fine(s);

2. revocation of license;

3. denial of license renewal application;

4. immediate suspension of license; and

5. any and all sanctions allowed under federal or state law or regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:689 (April 2015).

§4409. Changes in Outpatient Abortion Facility Information or Key Administrative Personnel

A. An outpatient abortion facility license shall be valid for the person or entity named as the outpatient abortion facility and for the physical address provided by the applicant on the initial licensing application or by the outpatient abortion facility in the licensing renewal application submitted to the department.

B. Change of Information. Any change regarding the outpatient abortion facility's entity name, "doing business as" name, mailing address, telephone number, or any combination thereof, shall be reported in writing to the department within five calendar days of the change. Any change regarding the entity name or "doing business as"

name requires a change to the outpatient abortion facility license and shall require a $25 fee for the issuance of an amended license.

C. Change of Key Administrative Personnel. Any change regarding the outpatient abortion facility's key administrative personnel shall be reported in writing to the department within five calendar days of the change. For the purposes of this Chapter, key administrative personnel includes the administrator and medical director, and the outpatient abortion facility shall provide the individual's name, hire date, and qualifications as defined in this Chapter.

D. Change of Ownership. A change of ownership (CHOW) of an outpatient abortion facility shall be reported in writing to the department at least five calendar days prior to the change. Within five calendar days following the change, the new owner shall submit to HSS all legal documents relating to the CHOW, an initial licensing application packet, and the non-refundable initial licensing fee. Once all required documentation and information is submitted and complete, HSS will review. If the CHOW is approved, the department shall issue a new license in the name of the new owner.

1. If the department has issued a notice of license revocation, denial of renewal, provisional license, or a notice of immediate suspension at the time the CHOW is submitted, the department shall deny the CHOW.

2. If there are any outstanding fees, fines, or monies owed to the department by the existing licensed entity, the CHOW will be suspended until payment of all outstanding amounts.

E. Change of Physical Address. An outpatient abortion facility that intends to change the physical address is required to obtain plan review approval from the OSFM in accordance with the provisions of this Chapter.

1. Because the license of an outpatient abortion facility is not transferrable or assignable, any proposed change in the physical address requires the outpatient abortion facility to submit a newly completed initial licensing application packet and a new non-refundable initial licensing fee. In addition, the outpatient abortion facility must submit a written notice of intent to relocate to the HSS at the time the plan review request is submitted to the OSFM for approval.

2. The department shall conduct an announced on-site survey at the proposed new location prior to relocation of the facility.

3. Any change regarding the outpatient abortion facility's physical address shall result in a new anniversary date for the license issued.

F. Duplicate License. Any request for a duplicate license shall be accompanied by a $25 fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:690 (April 2015).

§4411. License Renewal Application Process

A. License Renewal Application Packet. A license renewal application packet for an outpatient abortion facility shall be obtained from the department. A complete license renewal application packet shall be submitted to the department at least 30 calendar days prior to the expiration of the current license.

B. To be considered complete, the license renewal application packet shall include the following:

1. a completed outpatient abortion facility license renewal application and the non-refundable license renewal fee;

2. a copy of the most current on-site inspection report with approval for occupancy from the OSFM;

3. a copy of the most current health inspection report with recommendation for licensing from the OPH;

4. payment of any outstanding fees, fines, or monies owed to the department; and

5. any other documentation required by the department for licensure.

C. If the license renewal application packet is incomplete as submitted, the outpatient abortion facility shall be notified in writing of the missing information, and shall have 10 calendar days from receipt of the notification to submit the additional requested information. If the additional requested information is not received within 10 calendar days or prior to the expiration of the current license, it will result in the voluntary non-renewal of the outpatient abortion facility license.

D. Licensing Renewal—Annual Licensing Survey. Upon receipt of a complete license renewal application packet, the department may conduct an on-site annual licensing survey. This annual licensing survey shall be unannounced.

1. If it is determined that the outpatient abortion facility is not in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, and that a potential threat to the health, safety, and welfare of the patients is presented, the department shall deny the license renewal application.

2. If it is determined that the outpatient abortion facility is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other

matter addressed by law related to abortion or abortion procedures, the department shall issue a full renewal license to the outpatient abortion facility.

3. If it is determined that the outpatient abortion facility is not in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, but the department, in its sole discretion, determines that the noncompliance does not present a threat to the health, safety, and welfare of the patients, the department may issue a provisional license.

E. The issuance of a full renewal license does not in any manner affect any previously existing sanction by the department against an outpatient abortion facility including, but not limited to, civil fine(s) and/or plan of correction(s).

F. If the department has issued a notice of license revocation or a notice of immediate suspension of license at the time the license renewal application packet is submitted, the department shall deny the license renewal application.

G. Full Renewal License. The full renewal license issued by the department shall be valid until the expiration date shown on the license, unless the license is modified, revoked, or suspended.

H. Provisional License. The provisional license issued by the department shall be valid for a period not to exceed six months.

1. At the discretion of the department, the provisional license may be extended for an additional period not to exceed 90 calendar days in order for the outpatient abortion facility to correct the deficiencies cited following any survey.

2. When a provisional license is issued by the department, the outpatient abortion facility shall submit a plan of correction to the department for approval and also shall be required to correct all deficiencies prior to the expiration of the provisional license.

3. Upon receipt of the outpatient abortion facility's plan of correction, the department shall conduct an unannounced follow-up survey, either on-site or by desk review, to ensure the outpatient abortion facility is in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures.

a. Following the follow-up survey, if it is determined that the outpatient abortion facility has corrected all deficiencies and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the issuance of the outpatient abortion facility license.

b. Following the follow-up survey, if it determined that the outpatient abortion facility has failed to correct all deficiencies or has not maintained compliance during the period of the provisional license, or if new deficiencies are cited during the follow-up survey that present a threat to the health, safety, and welfare of a patient, the provisional license shall expire unless otherwise determined by the department. The outpatient abortion facility shall submit a newly completed initial licensing application packet and a new non-refundable initial licensing fee to begin the initial licensing application process again, subject to any facility need review approval.

I. Informal Reconsideration and Administrative Appeal. The outpatient abortion facility does not have the right to request an informal reconsideration and/or an administrative appeal of the issuance or expiration of a provisional license. An outpatient abortion facility that has been issued a provisional license is considered licensed and operational for the term of the provisional license. The issuance of a provisional license is not considered to be a denial of an initial licensing application, denial of a license renewal application, or license revocation for the purposes of this Chapter.

1. Informal Reconsideration. An outpatient abortion facility that has been issued a provisional license has the right to request an informal reconsideration regarding the validity of the deficiencies cited during the follow-up survey.

a. The request for an informal reconsideration must be in writing and received by HSS within five calendar days of receipt of the statement of deficiencies cited during the follow-up survey. If a timely request for an informal reconsideration is received, HSS shall schedule the informal reconsideration and notify the outpatient abortion facility in writing.

b. The request for an informal reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

c. Correction of a deficiency or deficiencies cited in a follow-up survey shall not be the basis for an informal reconsideration.

d. The outpatient abortion facility shall be notified in writing of the results of the informal reconsideration.

2. Administrative Appeal. An outpatient abortion facility that has been issued a provisional license has the right to request an administrative appeal regarding the validity of the deficiencies cited during the follow-up survey.

a. The request for an administrative appeal must be in writing and received by the DAL, or its successor, within 15 days of receipt of the statement of deficiencies cited during the follow-up survey.

b. The request for an administrative appeal must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

c. Correction of a deficiency or deficiencies cited in a follow-up survey shall not be the basis for an administrative appeal.

d. Upon expiration of the provisional license, the outpatient abortion facility shall immediately cease and desist providing abortion services unless the DAL, or its successor, issues a stay of the expiration.

e. Stay of the Expiration. The request for a stay of the expiration must be submitted with the request for an administrative appeal and received by the DAL, or its successor, within 15 days of receipt of the statement of deficiencies.

i. Following a contradictory hearing and only upon a showing that there is no potential harm to the patients being served by the outpatient abortion facility, the stay may be granted by the DAL, or its successor.

f. If a timely request for an administrative appeal is received, the DAL, or its successor, shall conduct the administrative appeal in accordance with the Administrative Procedure Act.

i. If the final decision of the DAL, or its successor, is to remove all deficiencies, the outpatient abortion facility's license will be granted/re-instated upon the payment of any licensing fees, outstanding sanctions, or other fees due to the department.

ii. If the final decision of the DAL, or its successor, is to remove some but not all deficiencies, the department shall have the discretion to determine the operational status of the outpatient abortion facility.

iii. If the final decision of the DAL, or its successor, is to uphold the deficiencies thereby affirming the expiration of the provisional license, the outpatient abortion facility shall:

(a). immediately cease and desist providing abortion services as an outpatient abortion facility;

(b). return the outpatient abortion facility license to the department; and

(c). notify the department in writing of the secure and confidential location where the patient medical records will be stored, including the name, physical address, and contact person, within 10 days of the rendering of the administrative appeal judgment.

J. Voluntary Non-Renewal of License

1. If an outpatient abortion facility fails to timely renew its license, the license shall expire on its face and is considered to be a voluntary non-renewal of license. At such time, the outpatient abortion facility shall immediately cease and desist providing abortions as an outpatient abortion facility.

2. Notice of Voluntary Non-Renewal of License. The outpatient abortion facility must provide advanced written notice of its voluntary non-renewal of license at least 30 calendar days prior to the date of the expiration of the outpatient abortion facility license. The notice of voluntary non-renewal of the license must be provided to all of the outpatient abortion facility's staff, including the medical director, to any patient having an abortion procedure within the last 30 calendar days of operation, and to HSS.

3. In addition, the outpatient abortion facility shall notify HSS in writing of the secure and confidential location where the patient medical records will be stored, including the name, physical address, and contact person.

4. As this is a voluntary action on the part of the outpatient abortion facility, no informal reconsideration or administrative appeal rights shall be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:690 (April 2015).

§4413. Cessation of Business

A. Outpatient Abortion Facility Duties and Responsibilities. An outpatient abortion facility that voluntarily closes or ceases operations is considered to have surrendered its license to operate.

B. Except as provided in §4453 of these licensing regulations, a license shall be immediately null and void if an outpatient abortion facility ceases to operate.

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

D. Upon the cessation of business, the facility shall immediately return the original license to the department.

E. Cessation of business is deemed to be a voluntary action on the part of the facility. The outpatient abortion facility does not have a right to appeal a cessation of business.

1. Notice of Cessation of Business. To the extent possible, the outpatient abortion facility shall provide advanced written notice of its cessation of business at least 30 calendar days prior to the date it intends to cease business operations. The notice of cessation of business must be provided to all the outpatient abortion facility's staff, including the medical director, to any patient having an abortion procedure within the last 30 days of operation, and to HSS.

2. In addition to the notice, the outpatient abortion facility shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

a. the effective date of the closure;

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

c. the name of an appointed custodian(s) who shall provide the following:

i. access to the records and copies of the records to the patient or authorized representative, upon presentation of proper authorization(s); and

ii. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss, and destruction; and

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

F. If an outpatient abortion facility fails to follow the procedures of this Section, any owner, officer, member, manager, director, or administrator of the outpatient abortion facility may be prohibited from owning, managing, directing, or operating another outpatient abortion facility in the state of Louisiana for two years.

G. Once an outpatient abortion facility has ceased doing business, the facility shall not provide services until it has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:692 (April 2015).

§4415. Denial of an Initial License, Denial of License Renewal Application, and License Revocation

A. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the outpatient abortion facility is not in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures, and a potential threat to the health, safety, and welfare of the patients is presented.

2. The department shall deny an initial license for any of the reasons a license may be revoked or non-renewed pursuant to the provisions of this Chapter.

B. Denial of License Renewal Application and License Revocation. The department may deny a license renewal application or revoke a license for any of the following reasons:

1. failure to be in substantial compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures;

2. failure to comply with the terms and provisions of an education letter or settlement agreement;

3. failure to protect a patient from any act by staff, employee or other patient posing a threat to a patient's health and safety while on the licensed premises receiving services provided by the outpatient abortion facility;

4. knowingly providing false, forged, or altered statements or information on any documentation required to be submitted to the department or required to be maintained by the outpatient abortion facility, including, but not limited to:

a. the initial licensing application packet or the license renewal application packet;

b. data forms;

c. patient medical records or outpatient abortion facility records; or

d. matters under investigation by the department, the Office of the Attorney General, or law enforcement agencies;

5. knowingly making a false statement or providing false, forged, or altered information or documentation to DHH employees or to law enforcement agencies;

6. employing false, fraudulent, or misleading advertising practices;

7. an owner, officer, member, manager, administrator, director, managing employee, or person designated to manage or supervise patient care has either pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the adjudicating court:

a. for purposes of these provisions, conviction of a felony means a felony relating to any of the following:

i. the assault, abuse, or neglect of a patient;

ii. cruelty, exploitation, or the sexual battery of a juvenile or the infirmed;

iii. a drug offense;

iv. crimes of a sexual nature;

vi. possession, use of a firearm or deadly weapon; or

vii. fraud or misappropriation of federal or state funds;

8. failure to comply with all reporting requirements in a timely manner, as required by all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound

requirements, informed consent requirements or any other matter addressed by law related to abortion or abortion procedures;

9. failure to allow the department surveyors access to any and all requested documents and information on the licensed premises, including, but not limited to, patient medical records and outpatient abortion facility records, that are relevant or necessary for the survey;

10. failure to allow the department surveyors access to interview any staff or other persons as necessary or required;

11. interfering or impeding with the survey process;

12. bribery, harassment, intimidation, or solicitation of any patient, by or on behalf of the outpatient abortion facility, designed to cause that patient to use or retain the services of the outpatient abortion facility; or

13. failure to timely pay any licensing fees, outstanding sanctions, or other fees due to the department. For the purposes of this Chapter, any payments returned for insufficient funds are considered failure to timely pay.

C. Notice. The secretary shall provide 30 calendar days written notice of the denial of initial license, notice of denial of license renewal application, and notice of license revocation.

D. Administrative Reconsideration. The applicant and/or outpatient abortion facility has the right to request an administrative reconsideration of a decision by the department to deny an initial license, to deny a license renewal application, or to issue a revocation action of a license to operate an outpatient abortion facility. The applicant and/or outpatient abortion facility will receive written notice of the final results and decision. However, there is no right to request an informal reconsideration of a voluntary non-renewal of license as provided in this Chapter.

1. The request for an administrative reconsideration must be in writing and received by HSS within 15 calendar days of receipt of the notice of the denial of initial license, notice of denial of license renewal application, or notice of license revocation.

2. The request for an administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received, HSS shall schedule the informal reconsideration and notify the applicant and/or outpatient abortion facility in writing.

4. The applicant and/or outpatient abortion facility shall have the right to appear in person at the administrative reconsideration and may be represented by counsel.

5. Correction of a deficiency or deficiencies that are the basis for the denial of initial license, denial of license renewal application, or license revocation shall not be a basis for an administrative reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The applicant and/or outpatient abortion facility shall receive written notice of the results of the informal reconsideration.

E. Administrative Appeals. The applicant and/or outpatient abortion facility has the right to request a suspensive administrative appeal of the secretary's decision to deny an initial license, deny a license renewal application, or to revoke a license to operate an outpatient abortion facility. There is no right to request a suspensive administrative appeal of a voluntary non-renewal of license as provided in this Chapter.

1. The request for a suspensive administrative appeal must be in writing and received by the Office of the Secretary within 30 calendar days of receipt of the notice of the results of the administrative reconsideration. A copy of the request for a suspensive administrative appeal shall be submitted to the DAL, or its successor, for docketing and handling the appeal.

a. Administrative Appeal Only. The applicant and/or outpatient abortion facility may forego its right to an administrative reconsideration and proceed directly to a suspensive administrative appeal. In such a case, the request for a suspensive administrative appeal must be in writing and received by the Office of the Secretary within 30 calendar days of receipt of the notice of denial of initial licensing application, notice of denial of license renewal application, or notice of license revocation. The provisions of this Chapter shall otherwise govern this suspensive administrative appeal.

2. If a timely request for a suspensive administrative appeal is received, the Office of the Secretary shall forward the applicant and/or outpatient abortion facility's request and any accompanying documentation, to the DAL, or its successor, to be docketed, and send a copy of such request to the applicant or outpatient abortion facility either by U.S. mail, facsimile, or email.

3. The request for a suspensive administrative appeal shall state the basis and specific reasons for the appeal, and include any documentation that demonstrates that the determination was made in error.

4. If a timely request for a suspensive administrative appeal is received by the Office of the Secretary, the denial of license renewal application or license revocation shall be suspensive, and the outpatient abortion facility shall be allowed to continue to operate and provide abortions services until such time as the DAL, or its successor, issues a final administrative decision.

5. Correction of a deficiency or deficiencies that is the basis for the denial of the initial license, denial of the license renewal application, or license revocation shall not be a basis for a suspensive administrative appeal.

6. If the final decision of the DAL, or its successor, is to reverse the denial of an initial license, the applicant's

license will be granted upon the payment of any licensing fees, outstanding sanctions, or other fees due to the department. If the final decision of the DAL, or its successor, is to reverse the denial of a license renewal application or license revocation, the license will be reinstated upon the payment of any licensing fees, outstanding sanctions, or other fees due to the department.

7. If the final decision of the DAL, or its successor, is to affirm the denial of a license renewal application or license revocation, the outpatient abortion facility shall:

a. immediately cease and desist providing abortion services as an outpatient abortion facility;

b. provide written notice to all of the outpatient abortion facility's staff, including the medical director, and to any patient having an abortion procedure within the last 30 calendar days of operation;

c. return the outpatient abortion facility license to the department; and

d. notify the department in writing of the secure and confidential location where the patient medical records will be stored, including the name, physical address, and contact person, within 10 days of the rendering of the administrative appeal judgment.

F. Prohibition Following Loss of License. If a license is revoked or renewal of license is denied, other than for cessation of business or non-operational status, or if the license is surrendered in lieu of an adverse action, any owner, officer, member, manager, director, or administrator of the outpatient abortion facility may be prohibited from owning, managing, directing, or operating another outpatient abortion facility in the state of Louisiana for two years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:693 (April 2015).

§4417. Immediate Suspension of License

A. Pursuant to applicable state law, the secretary may issue an immediate suspension of a license if any investigation or survey determines that the applicant or outpatient abortion facility is in violation of any provision of applicable state laws, in violation of the rules promulgated by the department, or in violation of any other federal or state law or regulation, and the secretary determines that the violation or violations pose an imminent or immediate threat to the health, welfare, or safety of a client or patient.

B. Notice of Immediate Suspension of License. The secretary shall provide written notice of the immediate suspension of license.

C. Effective Date. The suspension of the license is effective immediately upon the receipt of the written notice of immediate suspension of license.

D. Administrative Appeal. The outpatient abortion facility shall have the right to request a devolutive administrative appeal of the immediate suspension of license.

1. The request for a devolutive administrative appeal must be in writing and submitted to the DHH Office of the Secretary within 30 calendar days of receipt of the notice of immediate suspension of license.

2. The request for a devolutive administrative appeal shall specify in detail the reasons why the appeal is lodged.

E. Injunctive Relief. The outpatient abortion facility shall have the right to file for injunctive relief from the immediate suspension of license.

1. Venue. Any action for injunctive relief shall be filed with the district court for the Parish of East Baton Rouge.

2. Burden of Proof. Before injunctive relief may be granted, the outpatient abortion facility shall prove by clear and convincing evidence that the secretary's decision to issue the immediate suspension of license was arbitrary and capricious.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:695 (April 2015).

Subchapter B. Administration and Organization

§4421. Governing Body

A. The outpatient abortion facility shall be in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances.

B. The outpatient abortion facility shall have a governing body that assumes full responsibility for the total operation of the outpatient abortion facility.

1. The governing body shall consist of at least one individual who will assume full responsibility.

2. The outpatient abortion facility shall maintain documentation on the licensed premises identifying the following information for each member of the governing body:

a. name;

b. contact information;

c. address; and

d. terms of membership.

3. The governing body shall develop and adopt bylaws which address its duties and responsibilities.

4. The governing body shall, at minimum, meet annually and maintain minutes of such meetings documenting the discharge of its duties and responsibilities.

C. The governing body shall be responsible for:

1. ensuring the outpatient abortion facility's continued compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements, prohibited activity requirements, e.g. presenting or otherwise delivering any instruction or program on any health topic, including but not limited to human sexuality or family planning, to students at a public elementary or secondary school, or at a charter school that receives state funding or knowingly providing any materials or media regarding human sexuality or family planning for distribution or viewing at a public elementary or secondary school, or at a charter school that receives state funding, or any other matter addressed by law related to abortion or abortion procedures;

2. designating a person to act as the administrator and delegating sufficient authority to this person to manage the day-to-day operations of the facility;

3. designating a person to act as the medical director and delegating authority to this person to allow him/her to direct the medical staff, nursing personnel, and medical services provided to each patient;

4. evaluating the administrator and medical director's performance annually, and maintaining documentation of such in their respective personnel files;

5. ensuring that upon hire and prior to providing care to patients and, at a minimum, annually, each employee is provided with orientation, training, and evaluation for competency according to their respective job descriptions;

6. developing, implementing, enforcing, monitoring, and annually reviewing in collaboration with the administrator, medical director, and registered nurse, written policies and procedures governing the following:

a. the scope of medical services offered;

b. personnel practices, including, but not limited to:

i. developing job descriptions for licensed and non-licensed personnel consistent with the applicable scope of practice as defined by federal and state law;

ii. developing a program for orientation, training, and evaluation for competency; and

iii. developing a program for health screening;

c. the management of medical emergencies and the immediate transfer to a hospital of patients and born alive infants regardless of gestational age requiring emergency medical care beyond the capabilities of the outpatient abortion facility and such policies and procedures shall identify emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care; and

d. disaster plans for both internal and external occurrences;

7. approving all bylaws, rules, policies, and procedures formulated in accordance with all applicable state laws, rules, and regulations;

8. ensuring all bylaws, rules, policies, and procedures formulated in accordance with all applicable state laws, rules, and regulations are maintained on the licensed premises and readily accessible to all staff;

9. maintaining organization and administration of the outpatient abortion facility;

10. acting upon recommendations from the medical director relative to appointments of persons to the medical staff;

11. ensuring that the outpatient abortion facility is equipped and staffed to meet the needs of its patients;

12. ensuring services that are provided through a contract with an outside source are provided in a safe and effective manner;

13. ensuring that the outpatient abortion facility develops, implements, monitors, enforces, and reviews at a minimum, quarterly, a quality assurance and performance improvement (QAPI) program;

14. developing, implementing, monitoring, enforcing, and reviewing annually written policies and procedures relating to communication with the administrator, medical director, and medical staff to address problems, including, but not limited to, patient care, cost containment, and improved practices;

15. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The outpatient abortion facility shall maintain documentation on the licensed premises indicating the date, type of drill, participants, and materials;

16. ensuring that the outpatient abortion facility procures emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care;

17. ensuring that the outpatient abortion facility orders and maintains a supply of emergency drugs for stabilizing and/or treating medical and surgical complications for intra-operative and post-operative care on the licensed premises, subject to the approval by the medical director; and

18. ensuring that the outpatient abortion facility develops, implements, enforces, monitors, and annually reviews written policies and procedures to ensure that products of conception are disposed of in compliance with the Occupational Safety and Health Administration (OSHA), the Environmental Protection Agency (EPA), and with any other applicable federal, state, and local statutes, laws, ordinances, and department rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:695 (April 2015).

§4423. Staffing Requirements, Qualifications, and Responsibilities

A. General Provisions. An outpatient abortion facility shall have enough qualified personnel as indicated under this Chapter who are available to provide direct patient care as needed to all patients and to provide administrative and nonclinical services needed to maintain the operation of the outpatient abortion facility in accordance with the provisions of this Chapter.

B. Administrator. The outpatient abortion facility shall have an administrator designated by the governing body who is responsible for the day-to-day management, supervision, and operation of the outpatient abortion facility. The administrator shall be a full-time employee, available and on-site, during the designated business hours.

1. Qualifications. The administrator shall be at least 18 years of age and possess a high school diploma or equivalent.

2. The outpatient abortion facility shall designate a person to act in the administrator's absence, and shall ensure this person meets the qualifications of the administrator pursuant to this Chapter. The outpatient abortion facility shall maintain documentation on the licensed premises identifying this person and evidence of their qualifications.

3. Duties and Responsibilities. The administrator shall be responsible for:

a. employing licensed and non-licensed qualified personnel to provide the medical and clinical care services to meet the needs of the patients being served;

b. ensuring that upon hire and prior to providing care to patients, each employee is provided with orientation, training, and evaluation for competency as provided in this Chapter;

c. ensuring that written policies and procedures for the management of medical emergencies and the immediate transfer to a hospital of patients and born alive infants regardless of gestational age requiring emergency medical care beyond the capabilities of the outpatient abortion facility are developed, implemented, monitored, enforced, and annually reviewed, and readily accessible to all staff;

d. ensuring that emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care are maintained in proper working order and are available for use on a day-to-day basis on the licensed premises;

e. ensuring that a licensed physician, who has admitting privileges at a hospital located not further than 30 miles from the location at which the abortion is performed or induced and provides obstetrical or gynecological health care services, to facilitate emergency care is on the licensed premises when a patient is scheduled to undergo an abortion procedure;

NOTE: The Department acknowledges that federal litigation is pending on the issue of admitting privileges. As such, licensing provisions regarding admitting privileges will only be enforced pursuant to Order, Judgment, Stipulation, or Agreement in the matter entitled June Medical Services LLC, et al versus Caldwell, et al, Case No. 3:14-cv-525, United States District Court, Middle District, and any matter consolidated with such matter.

f. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The outpatient abortion facility shall maintain documentation on the licensed premises indicating the date, type of drill, participants, and materials;

g. ensuring that a licensed medical professional trained in CPR and trained in the use of emergency medical equipment is on the licensed premises at all times when abortion procedures are being performed;

h. ensuring that patient medical records are completely and accurately documented in accordance with the provisions of this Chapter within 30 days from the abortion procedure; and

i. maintaining current credentialing and/or personnel files on each employee that shall include documentation of the following:

i. a completed employment application;

ii. job description;

iii. a copy of current health screening reports conducted in accordance with the outpatient abortion facility policies and procedures and in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, and regulations;

iv. documentation that each employee has successfully completed orientation, training, and evaluation for competency related to each job skill as delineated in their respective job description;

v. documentation that all licensed nurses have successfully completed a Basic Life Support course; and

vi. other pertinent information as required by the outpatient abortion facility's policies and procedures, including but not limited to, prohibited activity, e.g. presenting or otherwise delivering any instruction or program on any health topic, including but not limited to human sexuality or family planning, to students at a public elementary or secondary school, or at a charter school that receives state funding or knowingly providing any materials or media regarding human sexuality or family planning for distribution or viewing at a public elementary or secondary school, or at a charter school that receives state funding requirements in accordance with applicable state laws, rules and regulations.

4. All credentialing and/or personnel files shall be current and maintained on the licensed premises at all times.

C. Medical Staff. The outpatient abortion facility shall provide medical and clinical services. The outpatient abortion facility shall employ qualified medical staff to meet the needs of the patients. No person shall perform or induce an abortion unless that person is a physician who meets the following qualifications and requirements.

1. Qualifications. Each member of the facility's medical staff shall be a physician, as defined in this Chapter, who meets the following requirements:

a. is currently licensed to practice medicine in the state of Louisiana;

b. is in good standing currently with the Louisiana State Board of Medical Examiners;

c. is currently enrolled in, or has completed, a residency rotation in obstetrics and gynecology or family medicine; and

d. is not restricted from performing such services and whose license is not restricted from performing such services at an abortion facility.

2. Physician Requirements. On the date the abortion is performed or induced, the physician performing or inducing the abortion shall:

a. have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced and that provides obstetrical or gynecological health care services; and

NOTE: The Department acknowledges that federal litigation is pending on the issue of admitting privileges. As such, licensing provisions regarding admitting privileges will only be enforced pursuant to Order, Judgment, Stipulation, or Agreement in the matter entitled June Medical Services LLC, et al versus Caldwell, et al, Case No. 3:14-cv-525, United States District Court, Middle District, and any matter consolidated with such matter.

b. provide the pregnant woman with all of the following before the abortion is performed or induced:

i. a telephone number by which the pregnant woman may reach the physician or licensed nurse or PA employed by the facility by which the abortion was performed or induced, who has 24 hours per day access to the woman's medical records so that the woman may request assistance related to any complications that arises from the performance or induction of the abortion, or to ask health-related questions regarding the abortion; and

ii. the name and telephone number of the hospital nearest to the home of the pregnant woman at which an emergency arising from the abortion would be treated.

3. Medical Director. The outpatient abortion facility shall have a medical director designated and approved by and accountable to the governing body who is responsible for all medical care provided to patients in the facility, and for the ethical and professional practices of the medical staff.

a. When an outpatient abortion facility has only one medical staff member, that individual shall serve as medical director.

b. The outpatient abortion facility shall designate a physician, as defined in this Chapter, to act in the medical director's absence. The outpatient abortion facility shall maintain documentation on the licensed premises identifying this physician and evidence of his/her qualifications.

c. Duties and Responsibilities. The medical director shall be responsible for:

i. developing, implementing, enforcing, monitoring, and annually reviewing written policies and procedures governing the medical and clinical services at the outpatient abortion facility, including, but not limited to:

(a). pre-operative procedures, intraoperative procedures, post-operative care and procedures, discharge, and follow-up care;

(b). laboratory services;

(c). infection control;

(d). pharmaceutical services, including, but not limited to, identifying the drugs dispensed and/or administered to patients on the licensed premises;

(e). anesthesia services;

(f). emergency medical treatment, including, but not limited to:

(i). identifying emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care;

(ii). identifying and ensuring that a supply of emergency drugs for stabilizing and/or treating medical and surgical complications are maintained on the licensed premises;

(iii). identifying and ensuring that each patient, before an abortion is performed or induced, is given by the physician performing or inducing the abortion, a telephone number of the hospital nearest to the home of the pregnant woman at which an emergency arising from the abortion would be treated; and

(iv). identifying and ensuring that each patient, before an abortion is performed or induced, is given by the physician performing or inducing the abortion, a telephone number by which the pregnant woman may reach the physician, or licensed nurse or PA employed by the physician or facility at which the abortion was performed or induced, who has 24 hours per day access to the woman's relevant medical records so that the woman may request assistance related to any complication that arises from the performance or induction of the abortion, or to ask health-related questions regarding the abortion;

(g). patient medical records and reporting requirements;

(h). the examination of fetal tissue;

(i). the disposition of medical waste;

(j). physical environment; and

(k). quality assurance and performance improvement (QAPI) program;

ii. developing, implementing, enforcing, monitoring, annually reviewing written bylaws, rules, policies, and procedures for self-governing of the professional activity of all medical staff members including, but not be limited to:

(a). the structure of the medical staff;

(b). review of the credentials, and training, and competency of each medical staff member to perform medical and clinical services, at least every two years, and to delineate and to recommend approval for individual privileges;

(i). the recommendation shall be in writing and maintained on the licensed premises in the credentialing file;

(ii). verification that each member of the medical staff is a physician who possesses a current license to practice medicine in Louisiana, is in good standing with the Louisiana State Board of Medical Examiners, and whose license does not restrict the physician from performing the services at the outpatient abortion facility;

(iii). evaluation for competency and past performance of each medical staff member, at a minimum, annually, which shall include monitoring and evaluation of patient care provided;

(iv). medical staff discipline; and

(v). grievance process;

iii. monitoring and reviewing, at a minimum, quarterly, in collaboration with the QAPI team/committee, the medical and clinical services provided by the outpatient abortion facility to ensure acceptable levels of quality of care and services;

iv. reviewing reports of all accidents or unusual incidents occurring on the licensed premises and reporting to the administrator potential health and safety hazards;

v. ensuring that each patient receiving medical and clinical services is under the professional care of a member of the medical staff who shall assess, supervise, and evaluate the care of the patient;

vi. ensuring that a member of the medical staff remains on the licensed premises until each patient is assessed to be awake, alert, and medically stable prior to discharge; and

vii. ensuring that a member of the medical staff shall be either present or immediately available by telecommunications to the staff when there is a patient on the licensed premises.

D. Nursing Staff. The outpatient abortion facility shall provide nursing services and shall employ qualified nursing staff to meet the needs of the patients.

1. Registered Nurse. The outpatient abortion facility shall have a registered nurse (RN) who is responsible for the overall direction of all nursing staff and nursing services provided.

a. Qualifications. The RN shall:

i. have a current, unrestricted Louisiana registered nurse license; and

ii. be in good standing with the Louisiana State Board of Nursing.

2. Duties and Responsibilities. The RN shall be responsible for:

a. developing, implementing, enforcing, monitoring, and annually reviewing written policies and procedures governing the following:

i. nursing personnel, including, but not limited to:

(a). developing a job description that delineates responsibilities and duties for each category of licensed and non-licensed nursing staff consistent with acceptable nursing standards of practice;

(b). orientation;

(c). training; and

(d). evaluation for competency;

ii. nursing care and services consistent with accepted nursing standards of practice;

b. assigning duties and functions to each licensed and non-licensed employee commensurate with his/her licensure, certification, experience, and competence consistent with acceptable nursing standards of practice;

c. verifying that each licensed nurse possesses a current and unrestricted license to practice nursing in Louisiana and is in good standing with their applicable state licensing board;

d. ensuring that the number of nursing staff on duty is sufficient to meet the needs of the patient(s);

e. ensuring that at least one licensed nurse is present when there is a patient receiving or recovering from an abortion procedure on the licensed premises;

f. ensuring that each licensed nurse working at the outpatient abortion facility has successfully completed a basic life support course; and

g. developing, implementing, enforcing, monitoring, and reviewing annually in collaboration with the medical director, written policies and procedures establishing a formalized program of in-service training and evaluation for competency for each category of licensed and non-licensed nursing staff and for all nursing care and services provided at the outpatient abortion facility.

i. The RN shall ensure that the training is related to each job skill as delineated in their respective job description.

ii. The RN shall ensure an evaluation for competency is performed for each category of licensed and non-licensed nursing staff and for all nursing care and services provided.

iii. The RN shall maintain documentation in the personnel file of each nursing staff member evidencing the content of the training that was provided, including the name of the evaluator, date, nurse's name, and documents provided.

iv. The RN shall maintain documentation in the personnel file of each nursing staff member evidencing that an evaluation for competency was conducted, including the name of the evaluator, date, nurse's name, and a notation that the nurse is competent in each job skill as delineated in their respective job description.

E. Orientation and Training. The administrator shall develop, implement, enforce, monitor, and annually review, in collaboration with the medical director and registered nurse, written policies and procedures regarding orientation and training of all employees.

1. Orientation. Upon hire and prior to providing care to patients, all employees shall be provided orientation related to the outpatient abortion facility's written policies and procedures governing the following:

a. organizational structure;

b. confidentiality;

c. grievance process;

d. disaster plan for internal and external occurrences;

e. emergency medical treatment;

f. program mission;

g. personnel practices;

h. reporting requirements; and

i. basic skills required to meet the health needs of the patients.

2. Training. Upon hire, and at a minimum, annually, all employees shall be provided training in each job skill as delineated in their respective job description.

a. Medical training of a licensed medical professional shall only be provided by a medical professional with an equivalent or higher license.

b. Training of a non-licensed employee related to the performance of job skills relative to medical and clinical services shall only be provided by a licensed medical professional consistent with the applicable standards of practice.

c. All training programs and materials used shall be available for review by HSS.

d. The administrator shall maintain documentation of all of the training provided in each employee's personnel files.

F. Evaluation for Competency. Upon hire, and at a minimum, annually, the outpatient abortion facility shall conduct an evaluation for competency of all employees related to each job skill as delineated in their respective job description.

1. The evaluation for competency shall include the observation of job skills and return demonstration by the employee.

2. Evaluation for competency of a licensed medical professional shall only be provided by a medical professional with an equivalent or higher license.

3. Evaluation for competency of a non-licensed employee related to the performance of job skills relative to medical and clinical services shall only be provided by a licensed medical professional consistent with their applicable scope of practice.

4. The administrator shall maintain documentation of all evaluations for competencies in each employee's personnel file.

G. Health Screening. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review written policies and procedures governing health screening of personnel in accordance with all applicable federal, state, and local statutes, laws, ordinances, and department rules and regulations. The administrator shall maintain documentation of health screening reports in each employee's personnel file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:696 (April 2015).

§4425. Patient Medical Records and Reporting Requirements

A. General Provisions

1. The outpatient abortion facility shall establish and maintain a patient medical record on each patient.

2. The patient medical record shall be:

a. completely and accurately documented; and

b. readily available and systematically organized to facilitate the gathering of information.

3. The outpatient abortion facility shall ensure compliance with privacy and confidentiality of patient medical records, including information in a computerized medical record system, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, and/or all applicable state laws, rules, and regulations.

4. Safeguards shall be established to protect the patient medical records from loss or damage and/or breach

of confidentiality in accordance with all applicable state laws, rules, and regulations.

B. Retention of Patient Medical Records. Patient medical records shall be retained by the outpatient abortion facility for a period of not less than seven years from the date of discharge. If the woman is a minor, then the medical record of the minor shall be kept for a minimum of 10 years from the time the minor reaches the age of majority. Patient medical records shall be maintained on the premises for at least one year and shall not be removed except under court orders or subpoenas. Any patient medical record maintained off-site after the first year shall be provided to the department for review no later than 24 hours from the time of the department's request.

NOTE: Refer to R.S. 9:2800.9.

C. Contents of Patient Medical Record

1. The following minimum data shall be kept on all patients:

a. identification data;

b. date of procedure;

c. medical and social history;

d. anesthesia and surgical history;

e. physical examination notes;

f. chief complaint or diagnosis;

g. clinical laboratory reports;

h. pathology reports;

i. individualized physician's orders;

j. radiological/ultrasound reports;

k. consultation reports (when appropriate);

l. medical and surgical treatment;

m. progress notes, discharge notes, and discharge summary;

n. nurses' notes, including, but not limited to, all pertinent observations, treatments, and medications dispensed and/or administered;

o. medication administration records, including, but not limited to, the date, time, medication, dose, and route;

p. documentation of any and all prescription drugs dispensed to each patient, including, but not limited to the:

i. full name of the patient;

ii. name of the prescribing physician;

iii. name and strength of the drug;

iv. quantity dispensed; and

v. date of issue;

q. signed and dated authorizations, consents, releases, or notices required by all applicable federal, state, and local statutes, laws, ordinances, and department rules and regulations, including but not limited to:

i. a signed receipt of *Point of Rescue* pamphlet; and

ii. a signed certification form in accordance with applicable state law indicating acknowledged receipt of informational materials concerning psychological impacts, illegal coercion, abuse, and human trafficking;

NOTE: The provisions of this Section requiring a physician or qualified person to provide required printed materials to a woman considering an abortion shall become effective 30 days after the department publishes a notice of the availability of such materials.

r. operative report;

s. anesthesia report, including, but not limited to, the date, time, type of anesthesia, dose, and route; and

t. special procedures reports.

2. Each entry documented in the patient's medical record shall be signed by the physician as appropriate, e.g., attending physician, consulting physician, anesthesiologist, pathologist, etc. Nursing notes and observations shall be signed by the licensed nurse. All entries shall be in writing and contain the date, time, and signature of the individual(s) delivering the patient care and services.

D. Nothing in this Section is intended to preclude the use of automated or centralized computer systems or any other techniques for the storing of medical records, provided the regulations stated herein are met.

E. Other Reports. The outpatient abortion facility shall maintain a daily patient roster of all patients receiving a surgical or chemically induced abortion. Patients may be identified corresponding to the patient's medical record. This daily patient roster shall be retained for a period of three years.

F. Reporting Requirements

1. The outpatient abortion facility shall maintain documentation to support that the outpatient abortion facility is compliant with all reporting requirements, including, but not limited to, the induced termination of pregnancy (ITOP) form and other documentation as required by federal, state, and local statutes, laws, ordinances, and department rules and regulations.

2. The outpatient abortion facility shall report in accordance with all applicable state laws for the reporting of crimes against a child that include but are not limited to:

a. rape;

b. sexual battery;

c. incest; and

d. carnal knowledge of a juvenile.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:699 (April 2015).

§4427. Quality Assurance and Performance Improvement Program (QAPI)

A. The outpatient abortion facility shall develop, implement, enforce, maintain, and annually review a written QAPI program subject to approval by the governing body, which puts systems in place to effectively identify issues for which quality monitoring and performance improvement activities are necessary. The QAPI program shall include plans of action to correct identified issues including, but not limited to, monitoring the effect of implemented changes and making necessary revisions to the plan of action.

1. Plans of Action. The outpatient abortion facility shall develop and implement a QAPI plan of action designed to effectively identify issues for which quality monitoring and performance improvement activities are necessary.

2. The QAPI plan of action shall include on a quarterly basis the following:

a. processes for receiving input regarding the quality of medical and clinical services received;

b. processes for review of patient medical records to ensure that such are complete and current;

c. processes for identifying on a quarterly basis the risk factors that affect or may affect the health and safety of the patients of the outpatient abortion facility receiving medical and clinical services. Examples may include, but are not limited to:

i. review and resolution of patient grievances; and

ii. review and resolution of patient/employee incidents involving medication errors and equipment failure;

d. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above.

3. The QAPI outcomes shall be documented and reported to the administrator in writing for action, as necessary, for any identified systemic problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:700 (April 2015).

Subchapter C. Pre-Operative, Intra-Operative, and Post-Operative Procedures

§4431. Screening and Pre-Operative Services

A. Verification of Pregnancy. The presence of an intrauterine pregnancy shall be verified by the following:

1. urine or serum pregnancy test performed on-site; and

2. either a detection of fetal heart tones or ultrasonography.

B. Gestational age shall be estimated by the following methods pre-operatively:

1. first date of last menstrual period, if known;

2. pelvic examination; and

3. ultrasonography.

C. Laboratory Tests

1. The laboratory tests listed below shall be performed within 30 days prior to the abortion procedure:

a. hematocrit or hemoglobin determination; and

b. Rh Factor status.

2. The results of the laboratory tests as required in §4331.C.1.a-b shall be documented in the patient's medical record.

3. The physician performing the abortion shall document acknowledgement of the results of the laboratory tests in the patient's medical record prior to the abortion procedure.

D. Minors

1. No physician shall perform or induce an abortion upon any pregnant woman who is under the age of 18 years and who is not emancipated judicially or by marriage unless the physician has received the following:

a. one of the following documents:

i. a notarized statement, pursuant to applicable state laws, rules, and regulations, signed by either the mother, father, legal guardian, or tutor of the minor declaring that the affiant has been informed that the minor intends to seek an abortion and that the affiant consents to the abortion; or

ii. a court order pursuant to applicable state laws, rules, and regulations; and

b. a signed, dated, and timed document obtained by the attending physician and/or licensed nurse, before the administration of any type of anesthesia which indicates if any person has or has not compelled the female child to undergo an abortion against her will.

2. All documentation related to consent and coercion shall be maintained in the medical record.

E. Ultrasound Requirements. Except in the case of a medical emergency, consent to an abortion of an unborn child at any stage of gestational development is voluntary and informed only if an obstetric ultrasound is performed in accordance with the provisions of this Section and applicable state laws, rules, and regulations.

1. Qualifications to Perform Ultrasound. The ultrasound shall be performed by the physician who is to perform the abortion or a qualified person who is the physician's agent. For purposes of this Section, "qualified

person" means a person having documented evidence that he or she has completed a course in the operation of ultrasound equipment and is in compliance with any other requirements of law regarding the operation of ultrasound equipment.

2. Requirements. At least 24 hours prior to the pregnant woman having any part of an abortion performed or induced, and prior to the administration of any anesthesia or medication in preparation for the abortion on the pregnant woman, the physician who is to perform the abortion or a qualified person who is the physician's agent shall comply with all of the following requirements:

a. perform an obstetric ultrasound on the pregnant woman, offer to simultaneously display the screen which depicts the active ultrasound images so that the pregnant woman may view them and make audible the fetal heartbeat, if present, in a quality consistent with current medical practice. Nothing in this Section shall be construed to prevent the pregnant woman from not listening to the sounds detected by the fetal heart monitor, or from not viewing the images displayed on the ultrasound screen;

b. provide a simultaneous and objectively accurate oral explanation of what the ultrasound is depicting, in a manner understandable to a layperson, which shall include the presence and location of the unborn child within the uterus and the number of unborn children depicted, the dimensions of the unborn child, and the presence of cardiac activity if present and viewable, along with the opportunity for the pregnant woman to ask questions;

c. offer the pregnant woman the option of requesting an ultrasound photograph or print of her unborn child of a quality consistent with current standard medical practice that accurately portrays, to the extent feasible, the body of the unborn child including limbs, if present and viewable;

d. from a form that shall be produced and made available by the department, staff will orally read the statement on the form to the pregnant woman in the ultrasound examination room prior to beginning the ultrasound examination, and obtain from the pregnant woman a copy of a completed, signed, and dated form;

e. retain copies of the election form and certification prescribed above. The certification shall be placed in the medical file of the woman and shall be kept by the outpatient abortion facility for a period of not less than seven years. If the woman is a minor, the certification shall be placed in the medical file of the minor and kept for at least ten years from the time the minor reaches the age of majority. The woman's medical files shall be kept confidential as provided by law.

3. Options to view or listen to required medical information shall be in accordance with applicable state laws, rules, and regulations.

a. A pregnant woman may choose not to exercise her option to request an ultrasound photograph print.

b. A pregnant woman may choose not to view the ultrasound images required to be provided to and reviewed with the pregnant woman.

c. A pregnant woman may choose not to listen to the sounds detected by the fetal heart monitor required to be provided to the pregnant woman.

F. Medical Emergencies. Upon a determination by a physician that a medical emergency, as defined pursuant to applicable state law, exists with respect to a pregnant woman, the outpatient abortion facility shall certify in writing the specific medical conditions that constitute the emergency. The certification shall be placed in the medical file of the woman.

G. Information and Informed Consent

1. Oral and Written Information Provided by Physician or Referring Physician

a. At least 24 hours before the abortion the physician who is to perform the abortion or the referring physician shall provide informed consent to the pregnant woman seeking an abortion. The informed consent shall be communicated both orally and in-person, and in writing, and shall be provided in a private room.

b. Documentation. The documentation of all such informed consent provided shall be maintained in the patient’s medical record.

c. The informed consent shall also contain language explaining the following information to the pregnant woman seeking an abortion:

i. the option of reviewing and receiving an oral explanation of an obstetric ultrasound image of the unborn child;

ii. that the pregnant woman shall not be required to view or receive an explanation of the obstetric ultrasound images;

iii. that the pregnant woman shall not be penalized if she chooses not to view or receive an explanation of the obstetric ultrasound images;

iv. that the physician shall not be penalized if the pregnant woman chooses not to view or receive an explanation of the obstetric ultrasound images; and

v. inclusion in the patient’s printed materials of a comprehensive list, compiled by the department, of facilities that offer obstetric ultrasounds free of charge.

2. Oral Information from a Physician or Qualified Person

a. When an initial contact is made by a person seeking to schedule an abortion for herself, a minor, or other adult woman, regardless of the means of contact, the physician who is to perform the abortion or any qualified person acting on behalf of the physician shall inform the person of the internet address of the department’s abortion alternatives and informed consent website which includes links to mental health counseling.

3. Oral Information Provided by Physician, Referring Physician, or Qualified Person

a. At least 24 hours before a scheduled abortion the physician who is to perform the abortion, the referring physician, or a qualified person shall inform the pregnant woman seeking an abortion, orally and in-person that:

i. medical assistance may be available for prenatal care, childbirth, and neonatal care and that more detailed information on the availability of such assistance is contained on the department's website and printed materials;

ii. a pamphlet is available that describes the unborn child and contains a directory of agencies that offer an abortion alternative;

iii. the father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. In the case of rape this information may be omitted;

iv. the pregnant woman seeking an abortion is free to withhold or withdraw consent to the abortion at any time before or during the abortion without affecting her right to future care or treatment and without loss of any state or federally funded benefits to which she might otherwise be entitled.

4. Provision of Printed Materials

a. At least 24 hours before the abortion, the pregnant woman seeking an abortion shall be given a copy of the printed materials, pursuant to any applicable state laws, rules, and regulations, by the physician who is to perform the abortion, the referring physician, or a qualified person, including but not limited to the following:

i. as a condition for consent to undergoing an elective abortion and, as such to be deemed voluntary and informed, the woman or minor female considering abortion shall be given a copy of the DHH *Point of Rescue* pamphlet by the physician who is to perform the abortion or a qualified person, except in the case of medical emergency as defined by applicable state laws.

NOTE: The provisions of this Section requiring a physician or qualified person to provide required printed materials to a woman considering an abortion shall become effective 30 days after the department publishes a notice of the availability of such materials.

b. If the pregnant woman seeking an abortion is unable to read the materials, the material shall be read to her.

c. If the pregnant woman seeking an abortion asks questions concerning any of the information or materials, answers shall be provided to her in her own language.

5. Certification and Reporting

a. Prior to the abortion, the outpatient abortion facility shall ensure the pregnant woman seeking an abortion has certified, in writing on a form provided by the department that the information and materials required were provided at least 24 hours prior to the abortion. This form shall be maintained in the woman's medical record.

b. Prior to performing the abortion, the physician who is to perform the abortion or his agent receives a copy of the written certification.

c. The pregnant woman seeking an abortion is not required to pay any amount for the abortion procedures until the 24-hour period has expired.

6. Reporting Requirements. Any physician who has provided the information and materials to any woman in accordance with the requirements of this Section shall provide to the department:

a. with respect to a woman upon whom an abortion is performed, all information as required by applicable state laws, rules, and regulations as well as the date upon which the information and materials required to be provided under this Section were provided, as well as an executed copy of the certification form. This form shall be maintained in the woman's medical record;

b. with respect to any woman to whom the printed and oral information and materials have been provided pursuant to applicable state laws, rules, and regulations, but upon whom the physician has not performed an abortion, the name and address of the facility where the required information was provided and if executed by the woman, a copy of the certification form required. This form shall be maintained in the woman's medical record.

7. Information Provided by the Physician Performing or Inducing an Abortion. On the date the abortion is performed or induced, a physician performing or inducing the abortion shall provide the pregnant woman with all of the following before the abortion is performed or induced:

a. a telephone number by which the pregnant woman may reach the physician, or other health care personnel employed by the physician or facility at which the abortion was performed or induced, who has 24 hours per day access to the woman's relevant medical records so that the woman may request assistance related to any complication that arises from the performance or induction of the abortion, or to ask health-related questions regarding the abortion; and

b. the name and telephone number of the hospital nearest to the home of the pregnant woman at which an emergency arising from the abortion would be treated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:700 (April 2015).

§4433. Drug or Chemically Induced Abortion

A. When any drug or chemical is used for the purpose of inducing an abortion as defined in R.S. 40:1299.35.1, the physician who prescribed the drug or chemical shall be in the same room and in the physical presence of the pregnant woman when the drug or chemical is initially administered, dispensed, or otherwise provided to the pregnant woman.

B. The drug or chemical shall not be administered, dispensed, or otherwise provided to the pregnant woman by a physician or any person acting under the physician's direction unless the physician has obtained the voluntary and informed consent of the pregnant woman pursuant to the provisions of state laws, rules and regulations and the requirements set forth in this Section.

C. If a physician prescribes, dispenses, administers, or provides any drug or chemical to a pregnant woman for the purpose of inducing an abortion as defined in R.S. 40:1299.35.1, the physician shall report the abortion to the Department of Health and Hospitals in accordance with applicable state laws, rules, and regulations, including R.S. 40:1299.35.10.

D. Documentation shall be recorded as to the date, time, method and name and signature of the physician who initially administered, dispensed, or otherwise provided the drug or chemical to the pregnant woman. This documentation shall be maintained in the patient's medical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:703 (April 2015).

§4435. Intra-operative Procedures

A. The outpatient abortion facility shall ensure that emergency medical equipment and supplies as required by the governing body, medical director and medical staff are available for intra-operative care and shall include, but are not limited to:

1. surgical or gynecologic table;

2. surgical instrumentation;

3. emergency drugs for stabilizing and/or treating medical and surgical complications as approved by the medical director;

4. oxygen;

5. intravenous fluids; and

6. sterile dressing supplies.

B. The outpatient abortion facility shall ensure that the medical equipment required for an abortion shall be maintained and immediately available to the physician in the procedure and/or post-anesthesia recovery area to provide emergency medical care and treatment.

C. During the abortion procedure, the patient shall be assessed and monitored by a licensed nurse for the following: level of consciousness, respiratory status, cardio-vascular status, and any potential adverse outcomes related to the abortion procedure such as adverse drug reactions, uncontrolled or excessive bleeding, etc. The results of this assessment shall be documented in the patient's medical record by the licensed nurse.

D. Immediately following the abortion procedure and prior to transfer to post-anesthesia recovery area, the patient shall be assessed and monitored by a licensed nurse for the following: level of consciousness, respiratory status, cardio-vascular status, and any potential adverse outcomes related to the abortion procedure. The results of this assessment shall be documented in the patient's medical record by the licensed nurse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:703 (April 2015).

§4437. Post-Operative Care, Procedures, and Discharge

A. Post-Operative Care and Procedures

1. The outpatient abortion facility shall have immediately available a supply of emergency drugs for stabilizing and/or treating medical and surgical complications for post-operative care on the licensed premises.

2. The patient's recovery shall be supervised by a licensed physician or a licensed nurse trained in post-operative care.

3. If general anesthesia is administered during the abortion procedure, the outpatient abortion facility shall have licensed nursing personnel trained in post-anesthesia care.

4. Upon completion of an abortion procedure, the physician shall immediately perform a gross examination of the uterine contents and shall document the findings in the patient's medical record. If no products of conception are visible, the physician shall assess the patient for risk of complications of an incomplete abortion or ectopic pregnancy.

5. Upon admission to the post-anesthesia recovery area, the patient shall be assessed by the licensed nurse for the following: level of consciousness, respiratory status, cardio-vascular status, pain level, bleeding, any potential outcomes related to the abortion procedure and any other medically appropriate assessments. The results of this assessment shall be documented by the licensed nurse in the patient's medical record.

6. A patient shall not be left unattended in the post-anesthesia recovery area.

7. RH immunoglobulin administration shall be offered to the woman who is Rh-negative and such shall be documented in the patient's medical record. If Rh immunoglobulin is not administered in the facility, one of the following is required:

a. informed waiver signed by a patient who refuses RH immunoglobulin; or

b. documentation of other arrangements for administration of RH Immunoglobulin.

B. Discharge Procedures

1. The patient shall be given verbal and written post-operative instructions for follow-up care. Such instructions given or provided by the physician performing or inducing the abortion shall include the telephone number by which the pregnant woman may reach the physician, or other health care personnel employed by the physician, or facility at which the abortion was performed or induced, who has 24 hours per day access to the woman's relevant medical records so that the woman may request assistance related to any complication that arises from the performance or induction of the abortion, or to ask health-related questions regarding the abortion.

2. The patient shall also be given or provided, by the physician performing or inducing the abortion, the name and telephone number of the hospital nearest to the home of the pregnant woman at which an emergency arising from the abortion would be treated.

3. A member of the medical staff shall remain on the licensed premises until each patient is assessed to be awake, alert, and medically stable prior to discharge.

4. A copy of the discharge instructions signed by the patient and the physician shall be maintained in the patient's medical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:703 (April 2015).

§4439. Anesthesia Services

A. Subject to the approval of the medical director, the outpatient abortion facility shall develop, implement, monitor, enforce, and annually review written policies and procedures governing the preparation of and administration of drugs relating to the types of anesthesia administered during the abortion procedure.

B. Local anesthesia, nitrous oxide, intramuscular, oral, and intravenous sedation shall be administered by the physician performing the abortion or by licensed nursing staff who have been deemed competent to administer sedation under the orders and supervision of the physician and pursuant to their scope of practice.

C. The physician performing the abortion shall be present on the licensed premises prior to and during the administration of all types of anesthesia.

D. General anesthesia, if used, shall be administered by an anesthesiologist or certified registered nurse-anesthetist (CRNA) who is under the supervision of the physician performing the abortion.

E. If general anesthesia is administered, the outpatient abortion facility shall ensure that professional staff, trained and deemed competent to provide post-anesthesia care, shall be present on-site to meet the needs of the patient.

F. If general anesthesia is administered, the outpatient abortion facility shall ensure that emergency medical equipment related to the delivery of general anesthesia shall be available on the premises.

G. A physician shall be present on the licensed premises during the post-anesthesia recovery period until the patient is fully reacted and stable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:704 (April 2015).

Subchapter D. Physical Environment

§4445. General Requirements

A. General Provisions

1. The outpatient abortion facility shall be designed, constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public at all times.

2. The outpatient abortion facility shall meet the provisions for physical environment under this Section, unless otherwise noted herein.

3. For the purposes of this Section, major renovations are defined as such renovations that affect the alteration to the functionality or original design of the facility's construction. Painting walls, re-tiling floors, installation of carpet, repairing roof damage or reroofing are not considered to be major renovations for purposes of this Section.

4. A separate waiting area shall be provided that is sufficient in size to provide seating space for patients, staff, and visitors of the patient.

5. Toilet facilities for patients, staff, and visitors shall be installed and maintained in accordance with the requirements of *LAC Title 51, Public Health—Sanitary Code*.

a. Every toilet room shall contain at least one water closet and one lavatory. Such toilet facilities shall be provided with ventilation in accordance with the requirements of *LAC Title 51, Public Health—Sanitary Code*.

b. Hot and cold water delivered through a mixing faucet, soap, and mechanical hand drying devices and/or disposable paper towels shall be provided at all hand washing lavatories/stations.

c. Showers or shower/tub combinations, if provided, shall meet the requirements of *LAC Title 51, Public Health—Sanitary Code*.

6. Additional General Provisions. For outpatient abortion facilities that receive their initial outpatient abortion license after the effective date of the promulgation of this Rule, receive plan review approval for major renovations after the effective date of the promulgation of this Rule or change their geographical address after the effective date of the promulgation of this Rule, the following additional general provisions shall apply:

a. flooring in all patient areas shall be readily cleanable, monolithic and joint free, and slip-resistant;

b. wall finishes in all patient areas shall be smooth, moisture resistant, washable, and free of fissures, open joints, or crevices that may retain or permit passage of dirt particles; and

c. wall bases in all patient areas shall be monolithic and coved with the floor, tightly sealed to the wall, and constructed without voids.

B. Signage. The outpatient abortion facility shall provide:

1. an exterior sign that can be viewed by the public. The sign shall contain, at a minimum, the doing business as name of the facility as it appears on the outpatient abortion facility license issued by the department;

2. clearly identifiable and distinguishable signs for outpatient abortion facilities operating within another facility which shall comply with the provisions of applicable state laws, rules, and regulations.

C. Procedure Room

1. Abortion procedures shall be performed in a segregated procedure room, removed from general traffic lines with a minimum clear floor area of 120 square feet, exclusive of vestibule, toilets or closets.

2. There shall be a hand-washing station within each procedure room and within each post-anesthesia recovery area. Fixtures shall not encroach upon any required egress path or other required clear dimension.

D. Post-Anesthesia Recovery Area

1. The outpatient abortion facility shall have a separate post-anesthesia recovery area with a minimum clear recovery area with a minimum clear area of 2 feet, 6 inches around the three sides of each stretcher or lounge chair for work and circulation.

2. The outpatient abortion facility shall have a nurse's station equipped with a countertop, space for supplies, provisions for charting, and a communication system. The nursing station shall be arranged to provide for direct visual observation of all traffic into the recovery area.

E. Equipment and Supply Storage Area. For outpatient abortion facilities that receive their initial outpatient abortion license after the effective date of the promulgation of this Rule, receive plan review approval for major renovations after the effective date of the promulgation of this Rule, or change their geographical address after the effective date of the promulgation of this Rule, the outpatient abortion facility shall have:

1. a soiled utility room which contains a utility sink, a work counter, a hand washing station, waste receptacle(s), and a space for soiled linen or equipment;

a. a designated separate space shall be provided for soiled materials storage;

b. soiled materials shall not be stored or transported through the clean laundry area;

2. a clean utility room which is used for clean or sterile supplies;

3. an equipment and supply storage room with sufficient floor space for equipment and supplies used in the procedure room which shall not encroach upon any required egress path or other required clear dimension;

4. at least one stretcher and one wheelchair for patient use; and

5. sufficient pathway to accommodate the usage of a stretcher and a wheelchair.

F. If the outpatient abortion facility maintains an in-house laundry, the areas shall be designed in accordance with infection control standards and *LAC Title 51, Public Health—Sanitary Code*, as applicable.

G. Forced Abortion Prevention Signage. Each outpatient abortion facility shall ensure a sign is obtained from the department in accordance with the Forced Abortion Prevention Sign Act.

1. Display. The sign shall be posted on the licensed premises and shall be clearly visible to patients. The sign provided shall be conspicuously posted in each patient admission area, waiting room, and patient consultation room used by patients on whom abortions are performed, induced, prescribed for, or who are provided with the means for an abortion.

H. National Human Trafficking Resource Center Hotline. Each outpatient abortion facility shall post information regarding the National Human Trafficking Resource Center Hotline.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:704 (April 2015).

§4447. Infection Control

A. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review its written infection control program. The purpose of this program shall seek to minimize infections and communicable diseases through prevention, investigation, and reporting of infections. This program shall include all contracted services.

B. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review, with the approval of the medical director, written policies and procedures for preventing, identifying, reporting, investigating, controlling, and immediately implementing corrective actions relative to infections and communicable diseases of patients and personnel. At a minimum, the policies shall address:

1. alcohol based hand rub and hand hygiene;

2. use of all types of gloves;

3. decontamination of equipment between each patient use, including, but not limited to, chairs and procedure room tables;

4. linen cleaning, if applicable;

5. waste management including, but not limited to, the requirements of Part XXVII of *LAC Title 51, Public Health—Sanitary Code*;

6. environmental cleaning;

7. reporting, investigating, and monitoring of surgical infections;

8. sterilization procedures and processes, if applicable;

9. single use devices;

10. disinfecting procedures and processes; and

11. breaches of infection control practices.

C. Supplies shall not be reused if labeled for single use.

D. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review written policies and procedures which require immediate reporting of the suspected or confirmed diagnosis of a communicable disease pursuant to applicable federal, state and local rules, laws, regulations and ordinance.

E. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review a written waste management program that identifies and controls wastes and hazardous materials to prevent contamination and spread of infection within the facility. The program shall comply with all applicable laws and regulations governing wastes and hazardous materials and the safe handling of these materials.

F. There shall be a separate sink for cleaning instruments and disposal of liquid waste.

G. The outpatient abortion facility shall develop, implement, and enforce/maintain written policies and procedures to ensure items are contained and handled during the sterilization process to assure sterility is not compromised prior to use.

H. After sterilization, instruments shall be stored in a designated clean area so that sterility is not compromised.

I. Sterile packages shall be inspected for integrity and compromised packages shall be reprocessed before use in accordance with manufacturer's recommendations.

J. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review written policies and procedures governing the following:

1. the handling, processing, storing, and transporting of clean and dirty laundry;

2. special cleaning and decontamination processes are employed for contaminated linens, if an in-house laundry is maintained on the licensed premises; and

3. housekeeping services maintain a safe and clean environment.

K. Housekeeping supplies shall be provided to adequately maintain the licensed premises.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:705 (April 2015).

§4449. Laboratory Services

A. The outpatient abortion facility shall have laboratory services available to meet the needs of its patients.

B. The outpatient abortion facility shall maintain a clinical laboratory improvement amendment (CLIA) certificate for the laboratory services provided on the licensed premises.

C. The outpatient abortion facility shall ensure that all contracted laboratory services are provided by a CLIA certified laboratory.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:706 (April 2015).

§4451. Pharmaceutical Services

A. All outpatient abortion facilities shall have a controlled dangerous substance (CDS) license issued by the Louisiana Board of Pharmacy and a Drug Enforcement Agency (DEA) registration in accordance with applicable state and federal laws.

B. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review written policies and procedures that govern the safe storage, prescribing, dispensing, preparing and administering of drugs and biologicals on the licensed premises.

C. Storage Areas. The outpatient abortion facility shall provide a designated secure storage area for storing drugs and biologicals.

1. The designated storage area shall be constructed and maintained to prevent unauthorized access.

2. The designated storage area shall adhere to the manufacturer's suggested recommendations for storage of drugs.

3. Locked areas that are used to store medications including controlled substances, shall conform to all applicable federal and state laws, and the outpatient abortion facility's policies and procedures.

D. The outpatient abortion facility shall maintain written records documenting the ordering, receiving, dispensing, and administering of drugs.

E. The outpatient abortion facility shall maintain written records documenting the disposing of unused drugs.

F. The outpatient abortion facility shall maintain written documentation of all drugs prescribed and/or dispensed to each patient, including, but not limited to the:

1. full name of the patient;

2. name of the prescribing and/or dispensing physician;

3. name and strength of the drug;

4. quantity prescribed and/or dispensed; and

5. date of issue.

G. Preparation and Administration of Drugs. The outpatient abortion facility shall develop, implement, enforce, monitor, and review annually written policies and procedures governing the preparation of drugs and biologicals.

1. The outpatient abortion facility shall ensure that all drugs and biologicals are prepared and administered pursuant to an order from an individual, employed or under contractual agreement, who has prescriptive authority in accordance with applicable state laws. Each order shall be in writing, patient specific, dated, timed, and signed by that individual. A copy of such orders shall be maintained in each, individual patient medical record.

H. The outpatient abortion facility shall order and maintain a supply of emergency drugs for stabilizing and/or treating medical and surgical complications on the licensed premises as authorized by the medical director.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:706 (April 2015).

§4453. Inactivation of License due to a Declared Disaster or Emergency

A. An outpatient abortion facility located in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with applicable state laws, may seek to inactivate its license for a period not to exceed one year, provided that the facility:

1. submits written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the facility has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with applicable state law;

b. the facility intends to resume operation as an outpatient abortion facility in the same service area;

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

d. includes an attestation that all clients have been discharged or transferred to another facility in accordance with the provisions of this Chapter;

2. resumes operating as an outpatient abortion facility in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state law;

3. continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil fines; and

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

B. Upon receiving a completed request to inactivate an outpatient abortion facility license, the department shall issue a notice of inactivation of license to the facility.

C. In order to obtain license reinstatement, an outpatient abortion facility with a department-issued notice of inactivation of license shall:

1. submit a written license reinstatement request to HSS 60 days prior to the anticipated date of reopening. The written request shall include:

a. the anticipated date of opening, and a request to schedule a licensing survey;

b. a completed licensing application, plan review approval, if applicable, and other required documents with licensing fees, if applicable; and

c. written approvals for occupancy from OSFM/Live Safety Code and OPH recommendation for license.

D. Upon receiving a completed written request to reinstate an outpatient abortion facility license and other required documentation, the department shall conduct a licensing survey.

E. If the facility meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the facility's license.

F. During the period of inactivation, the department prohibits a change of ownership (CHOW) in the outpatient abortion facility.

G. The provisions of this Section shall not apply to an outpatient abortion facility which has voluntarily surrendered its license.

H. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the facility's license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:706 (April 2015).

Chapter 45. Ambulatory Surgical Center

Subchapter A. General Provisions

§4501. Introduction

A. These regulations contain the minimum licensing standards for ambulatory surgical centers, pursuant to R.S. 40:2131-2141. Ambulatory surgical centers are established for the purpose of rendering surgical procedures to its patients on an outpatient basis.

B. The care and services to be provided by an ambulatory surgical center (ASC) shall include:

1. surgical procedures;

2. medications as needed for medical and surgical procedures rendered;

3. services necessary to provide for the physical and emotional well-being of patients;

4. emergency medical services; and

5. organized administrative structure and support services.

C. Licensed ASCs shall have one year from the date of promulgation of the final Rule to comply with all of the provisions herein.

D. For those ASCs that apply for their initial ASC license after the effective date of the promulgation of this Rule, or receive plan review approval for initial construction or major renovations after the effective date of the promulgation of this Rule, or change their geographic address after the effective date of the promulgation of this Rule, such shall be required to comply with all of the provisions herein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1732 (September 2017).

§4503. Definitions

Administrator—the person responsible for the on-site, daily implementation and supervision of the overall ASC's operation commensurate with the authority conferred by the governing body.

Ambulatory Surgical Center (*ASC*)—a distinct entity that is wholly separate and clearly distinguishable from any other healthcare facility or office-based physician's practice. An ASC shall be composed of operating room(s) and/or procedure room(s) with an organized medical staff of physicians and permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures. An ASC provides continuous physician and professional nursing services to patients whenever a patient is in the ASC, but does not provide services or accommodations for patients to stay overnight.

1. The following services shall be offered by the ASC when a patient is in the center:

a. drug services as needed for medical operations and procedures performed;

b. provisions for the physical and emotional well-being of patients;

c. provision of emergency services;

d. organized administrative structure; and

e. administrative, statistical and medical records.

2. An ASC may also be defined as a treatment center that is organized primarily for the purpose of offering stereotactic radiosurgery by use of a gamma knife or similar neurosurgical tool.

3. An ASC that enters into a use agreement with another entity/individual shall have separate, designated hours of operation.

Certified Registered Nurse Anesthetist (*CRNA*)—an advanced practice registered nurse who administers anesthetics or ancillary services in accordance with the licensing requirements of the State Board of Nursing (LSBN) and under the supervision of a physician or dentist who is licensed under the laws of the state of Louisiana. The CRNA determines and implements the anesthesia care plan for a patient during a procedure and, for the safety of the patient, shall not be involved in other aspects of the procedure.

Cessation of Business—when an ASC is non-operational and voluntarily stops rendering services to the community.

Controlled Dangerous Substance (*CDS*)—a drug, substance or immediate precursor in schedule I through V of R.S. 40:964.

Department (*LDH*)—the Louisiana Department of Health.

Division of Administrative Law (*DAL*)—the agency authorized to conduct fair hearings and take actions on appeals of departmental decisions as provided for in the Administrative Procedure Act, or its successor.

Endoscopic Retrograde Cholangiopancreatography (*ERCP*)—a procedure used to diagnose diseases of the gallbladder, biliary system, pancreas and liver.

Endoscopic Ultrasound/Fine Needle Aspiration (*EUS/FNA*)—a technique using sound waves during an endoscopic procedure to look at, or through, the wall of the gastrointestinal tract.

Governing Body—the individual or group of individuals who are legally responsible for the operation of the ASC, including management, control, conduct and functioning of the ASC, also known as the governing authority.

Immediately Available—a person that is not assigned to any uninterruptible tasks.

Invasive Procedure—a procedure that:

1. penetrates the protective surfaces of a patient's body;

2. is performed in an aseptic surgical field;

3. generally requires entry into a body cavity; and

4. may involve insertion of an indwelling foreign body.

NOTE: The intent is to differentiate those procedures that carry a high risk of infection, either by exposure of a usually sterile body cavity to the external environment or by implantation of a foreign object(s) into a normally sterile site. Procedures performed through orifices normally colonized with bacteria and percutaneous procedures that do not involve an incision deeper than skin would not be included.

Length of Patient Stay—the period of time that begins with the admission of the patient to the ASC and ends with the discharge of the patient from the ASC. The time of admission shall be calculated in accordance with the ASC's written policy. The length of any patient stay shall be documented.

Licensing Agency—the Louisiana Department of Health.

Medical Staff—physicians, dentists, podiatrists and other professional licensed medical practitioners who are authorized to practice in the ASC according to these standards and the requirements of the governing authority.

Minimal Sedation—as defined by the American Society of Anesthesiology (ASA), a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, ventilatory and cardiovascular functions are unaffected.

Minor Alterations—the painting of walls, changing of flooring products or any other cosmetic changes to the ASC which do not involve moving structural walls, doors, windows, electrical or plumbing.

Miscarried Child—the fetal remains resulting from a spontaneous fetal death that does not require compulsory registration pursuant to the provisions of R.S. 40:47.

New Construction—any of the following structures that will be started after promulgation of these provisions shall be considered new construction:

1. newly constructed buildings;

2. additions to existing buildings;

3. conversions of existing buildings or portions thereof;

4. alterations, other than minor alterations, to an already existing ASC; or

5. any previously licensed ASC that has voluntarily or involuntarily ceased providing ASC services and surrendered its license shall be considered new construction for plan review purposes.

Non-Operational—when the ASC is not open for business operation on designated days and hours as stated on the licensing application.

Operating Room (*OR*)—a room in the surgical center that meets the requirements of a restricted area and is designated and equipped for performing surgical or other invasive procedures. An aseptic field is required for all procedures performed in an OR. Any form of anesthesia may be administered in an OR if proper anesthesia gas administration devices are present and exhaust systems are provided.

Overnight—the length of admission to an ASC of any patient that exceeds 23 hours, which is calculated as the time of admission to the time of discharge from the ASC.

Physician—a licensed medical practitioner who possesses an unrestricted license and is in good standing with the State Board of Medical Examiners. This includes a doctor of:

1. medicine;

2. osteopathy;

3. podiatry;

4. optometry;

5. dental surgery or dental medicine; or

6. chiropracty.

Procedure Room—a room designated for the performance of a procedure that is not deemed to be an invasive procedure. The procedure may require the use of sterile instruments or supplies but not the use of special ventilation or scavenging equipment for anesthetic agents.

Standards—the rules, regulations and policies duly adopted and promulgated by the Department of Health with the approval of the secretary.

Unlicensed Assistive Personnel (*UAP*)—any unlicensed trained personnel who cannot practice independently or without supervision by a registered nurse. This may include operating and/or procedure room technicians, instrument cleaning and/or sterilization technicians and nursing assistants or orderlies.

Use Agreement—a written agreement between a licensed ASC and an individual or entity in which the ASC allows the individual or entity to use its facility, or a portion thereof, on a part-time basis to provide the services of an ASC. All use agreements shall comply with applicable federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1732 (September 2017).

§4505. Licensing Requirements

A. The Department of Health, Health Standards Section (HSS) is the only licensing authority for ASCs in the state of Louisiana.

B. Each ASC license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the ASC to which it is issued and only for the specific geographic address of that ASC;

3. be valid for one year from the date of issuance, unless revoked, suspended, modified or terminated prior to that date, or unless a provisional license is issued:

a. a provisional license shall be valid for a period of six months if the department determines that there is no immediate and serious threat to the health and safety of patients;

4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the ASC;

5. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

C. The ASC shall abide by and adhere to any federal, state, and local laws, rules, policies, procedures, manuals or memorandums applicable to such facilities. ASCs that have entered into a use agreement shall be responsible for compliance with these licensing standards and any applicable state and federal rules and regulations during the period of use of the ASC.

D. A separately licensed ASC shall not use a name which is the same as the name of another such ASC licensed by the department.

E. A licensed ASC shall notify the department prior to any changes or additions of surgical services. If these surgical services are new to the ASC, the ASC shall provide these surgical services in accordance with the provisions of this Chapter and in accordance with accepted standards of practice.

F. All accredited, or deemed ASCs, shall notify the department prior to the expiration date of any changes in accreditation or deemed status.

G. An ASC shall not have any off-site campuses.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1733 (September 2017).

§4507. Initial Licensure Application Process

A. An initial application for licensing as an ASC shall be obtained from the department. A completed initial license application packet for an ASC shall be submitted to, and approved by the department, prior to an applicant providing services.

B. The initial licensing application packet shall include:

1. a completed licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter(s) of the architectural and licensing facility plans from the Office of the State Fire Marshal (OSFM) and any other office/entity designated by the department to review and approve the facility's architectural and licensing plan review;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal, if applicable;

4. a copy of the on-site health inspection report with approval for occupancy from the Office of Public Health (OPH);

5. proof of each insurance coverage as follows:

a. general liability insurance of at least $300,000 per occurrence;

b. worker's compensation insurance as required by state law;

c. professional liability insurance of at least $300,000 per occurrence/$300,000 per annual aggregate, or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient's Compensation Fund (PCF):

i. if the ASC is not enrolled in the PCF, professional liability limits shall be $1 million per occurrence/$3 million per annual aggregate; and

d. the LDH Health Standards Section shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent);

6. proof of a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

7. disclosure of ownership and control information;

8. the usual and customary days and hours of operation;

9. an organizational chart and names, including position titles, of key administrative personnel and governing body;

10. controlled dangerous substance application;

11. fiscal intermediary, if applicable;

12. Secretary of State's articles of incorporation;

13. clinical laboratory improvement amendments (CLIA) certificate or CLIA certificate of waiver, if applicable;

14. an 8.5 x 11 inch mapped floor plan; and

15. any other documentation or information required by the department for licensure.

C. If the initial licensing packet is incomplete, the applicant shall be notified of the missing information, and shall have 90 days from receipt of the notification to submit the additional requested information. If the additional

requested information is not submitted to the department within 90 days, the application shall be closed. If an initial licensing application is closed, an applicant who is still interested in becoming an ASC shall be required to submit a new initial licensing application packet with the required fee to start the initial licensing process.

D. Once the initial licensing application packet has been approved by the department, notification of such approval shall be forwarded to the applicant. Within 90 days of receipt of the approval of the application, the applicant shall notify the department that the ASC is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a licensed ASC shall be required to submit a new initial licensing packet with the required fee to start the initial licensing process.

E. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the ASC will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1734 (September 2017).

§4509. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial on-site licensing survey shall be conducted to ensure compliance with the licensing laws and standards.

1. The initial licensing survey of an ASC shall be an announced survey. Follow-up surveys to the initial licensing surveys are unannounced surveys.

B. The ASC shall not provide services to any patient until the initial licensing survey has been performed and the ASC has been determined to be in compliance with the licensing regulations and has received written approval from the Health Standards Section (HSS).

C. In the event that the initial licensing survey finds that the ASC is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the center. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

D. In the event that the initial licensing survey finds that the ASC is noncompliant with any licensing laws or regulations, or any other required rules or regulations that present a potential threat to the health, safety, or welfare of the patients, the department shall deny the initial license.

E. In the event that the initial licensing survey finds that the ASC is noncompliant with any licensing laws or regulations, or any other required rules or regulations, but the department in its sole discretion determines that the noncompliance does not present a threat to the health, safety or welfare of the patients, the department may issue a provisional initial license for a period not to exceed six months. The ASC shall submit a plan of correction to the department for approval, and shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

1. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license may be issued.

2. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a patient are cited, the provisional license will expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and the required licensing fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1735 (September 2017).

§4511. Types of Licenses and Expiration Dates

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the ASC when the initial licensing survey finds that the ASC is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. The department may issue a provisional initial license to the ASC when the initial licensing survey finds that the ASC is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the patients.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed ASC that is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

B. The department, in its sole discretion, may issue a provisional license to an existing licensed ASC for a period not to exceed six months for any of the following reasons.

1. The existing ASC has more than five deficient practices or deficiencies cited during any one survey.

2. The existing ASC has more than three substantiated complaints in a 12-month period.

3. The existing ASC has been issued a deficiency that involved placing a patient at risk for serious harm or death.

4. The existing ASC has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey.

5. The existing ASC is not in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules, regulations and fees at the time of renewal of the license.

C. When the department issues a provisional license to an existing licensed ASC, the ASC shall submit a plan of correction to the department for approval and shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct a follow-up survey, either on-site or by desk review, of the ASC prior to the expiration of the provisional license.

1. If the follow-up survey determines that the ASC has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the ASC license.

2. If the follow-up survey determines that all non-compliance or deficiencies have not been corrected, or if new deficiencies that are a threat to the health, safety or welfare of a patient are cited on the follow-up survey, the provisional license shall expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

3. The department shall issue written notice to the ASC of the results of the follow-up survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1735 (September 2017).

§4513. Changes in Licensee Information or Personnel

A. An ASC license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any permanent change regarding the entity ASC's name, "doing business as" name, mailing address, telephone number, stated days and hours of operation, or any combination thereof, shall be reported in writing to the department within five business days of the change.

1. For any temporary closures of the ASC greater than 24 hours, other than weekends or holidays, the ASC shall notify HSS in advance.

2. At any time that the ASC has an interruption in services or a change in the licensed location due to an emergency situation, the ASC shall notify HSS no later than the next stated business day.

C. Any change regarding the ASC's key administrative personnel shall be reported in writing to the department within 10 days of the change.

1. Key administrative personnel include the:

a. administrator; and

b. director of nursing.

2. The ASC's notice to the department shall include the individual's:

a. name;

b. address;

c. hire date; and

d. qualifications.

D. A change of ownership (CHOW) of the ASC shall be reported in writing to the department within five days of the change. A CHOW may include one of the following.

1. Partnership. In the case of a partnership, the removal, addition, or the substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law, constitutes a change of ownership.

2. Unincorporated Sole Proprietorship. Transfer of title and property to another party constitutes a change of ownership.

3. Corporation. The merger of the ASC corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes a change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

E. The license of an ASC is not transferable or assignable and cannot be sold. The new owner shall submit the legal CHOW document, all documents required for a new license and the applicable licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

1. An ASC that is under license revocation, provisional licensure and/or denial of license renewal may not undergo a CHOW.

2. If the CHOW results in a change of geographic address, an on-site survey shall be required prior to issuance of the new license.

F. If the ASC changes its name without a change in ownership, the ASC shall report such change to the department in writing five days prior to the change. The change in the ASC's name requires a change in the license and payment of the required fee for a name change and re-issuance of a license.

G. Any request for a duplicate license shall be accompanied by the applicable required fee.

H. If the ASC changes the physical address of its geographic location without a change in ownership, the ASC shall report such change to the department in writing at least

six weeks prior to the change. Because the license of an ASC is valid only for the geographic location of that ASC, and is not transferrable or assignable, the ASC shall submit a new licensing application and all of the required fees, licensing inspection reports, and licensing plan reviews for the new location.

1. An on-site survey shall be required prior to the issuance of the new license.

2. The change in the ASC's physical address results in a new anniversary date and the full licensing fee shall be paid.

I. An ASC that enters into a use agreement shall submit written notification to the department within five days of the effective date of the agreement. This notice shall include:

1. a copy of the signed use agreement;

2. the designated days and hours of operation that each entity/individual will be using the licensed ASC; and

3. the type of surgical procedures, by specialty, that each entity/individual will be performing at the licensed ASC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1736 (September 2017).

§4515. Renewal of License

A. The ASC shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the current license. The license renewal application packet shall include:

1. the license renewal application;

2. the non-refundable license renewal fee;

3. the stated days and hours of operation;

4. a current State Fire Marshal report;

5. a current OPH inspection report;

6. proof of each insurance coverage as follows:

a. general liability insurance of at least $300,000 per occurrence;

b. worker's compensation insurance of at least $100,000 as required by state law;

c. professional liability insurance of at least $300,000 per occurrence/$300,000 per annual aggregate, or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient's Compensation Fund (PCF):

i. if the ASC is not enrolled in the PCF, professional liability limits shall be $1,000,000 per occurrence/$3,000,000 per annual aggregate;

d. the LDH Health Standards Section shall specifically be identified as the certificate holder on the any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent);

7. proof of a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

8. statement of attestation of ASC compliance with the provisions of §4581; and

9. any other documentation required by the department or CMS if applicable.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license will result in the voluntary non-renewal of the ASC license. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the ASC.

D. If an existing licensed ASC has been issued a notice of license revocation, suspension or termination, and the ASC's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

1. If a timely administrative appeal has been filed by the ASC regarding the license revocation, suspension, or termination, the administrative appeal shall be suspensive, and the ASC shall be allowed to continue to operate and provide services until such time as the administrative tribunal or department issues a decision on the license revocation, suspension, or termination.

2. If the secretary of the department determines that the violations of the ASC pose an imminent or immediate threat to the health, welfare, or safety of a patient, the imposition of such action may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the ASC will be notified in writing.

3. The denial of the license renewal application does not affect in any manner the license revocation, suspension, or termination.

E. The renewal of a license does not in any manner affect any sanction, civil monetary penalty or other action imposed by the department against the ASC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1736 (September 2017).

§4517. Survey Activities

A. The department may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing ASCs and to ensure patient health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. The department may require an acceptable plan of correction from the ASC for any survey where deficiencies have been cited, regardless of whether the department takes other action against the ASC for the deficiencies cited in the survey. The acceptable plan of correction shall be submitted for approval to the department within the prescribed timeframe.

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

D. The department may issue appropriate sanctions for noncompliance, deficiencies and violations of law, rules and regulations. Sanctions may include, but are not limited to:

1. civil fines;

2. directed plans of correction;

3. denial of license renewal; and/or

4. license revocation.

E. LDH surveyors and staff shall be:

1. given access to all areas of the ASC and all relevant files and other documentation as necessary or required to conduct the survey:

a. for any records or other documentation stored on-site, such shall be provided within one to two hours of surveyor request; and

b. for any records or other documentation stored off-site, such shall be provided to the surveyor for review no later than 24 hours from the time of the surveyor's request.

2. allowed to interview any facility staff, patient or other persons as necessary or required to conduct the survey; and

3. allowed to photocopy any records/files requested by surveyors during the survey process.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1737 (September 2017).

§4519. Statement of Deficiencies

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

B. Unless otherwise provided in statute or in these licensing provisions, the ASC shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

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

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

3. The request for informal reconsideration of the deficiencies shall be made to HSS and will be considered timely if received by HSS within 10 calendar days of the ASC's receipt of the statement of deficiencies.

4. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration. The ASC shall be notified in writing of the results of the informal reconsideration.

5. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided in these licensing provisions for initial license denials, license revocations and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1737 (September 2017).

§4521. Denial of Initial License, Revocation of License, Denial of License Renewal

A. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the provisions of the Administrative Procedure Act.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the ASC is noncompliant with any licensing laws or regulations, or any other required statutes or regulations that present a potential threat to the health, safety or welfare of the patients.

2. The department shall deny an initial license for any of the reasons a license may be revoked or denied renewal pursuant to these licensing provisions.

3. If the department denies an initial license, the applicant for an ASC license shall not render services to patients.

C. Voluntary Non-Renewal of a License. If the ASC fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the facility.

D. Revocation of License or Denial of License Renewal. An ASC license may be revoked or denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the ASC licensing laws, rules and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to uphold patient rights whereby deficient practices result in harm, injury or death of a patient;

4. failure to protect a patient from a harmful act by an ASC employee or other patient on the premises including, but not limited to:

a. any action which poses a threat to patient or public health and safety;

b. coercion;

c. threat or intimidation;

d. harassment;

e. abuse; or

f. neglect;

5. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in §4521.D.4;

6. failure to employ qualified personnel;

7. failure to submit an acceptable plan of correction for deficient practices cited during an on-site survey within the stipulated timeframes;

8. failure to submit the required fees, including but not limited to:

a. fees for address or name changes;

b. any fine assessed by the department; or

c. fee for a CHOW;

9. failure to allow entry into the ASC or access to requested records during a survey;

10. failure to protect patients from unsafe care by an individual employed by the ASC;

11. when the ASC staff or owner knowingly (or with reason to know) makes a false statement of a material fact in any of the following:

a. the application for licensure;

b. data forms;

c. clinical records;

d. matters under investigation by the department;

e. information submitted for reimbursement from any payment source; or

f. advertising;

12. conviction of a felony or entering a plea of guilty or nolo contendere to a felony by an owner, administrator, director of nursing, or medical director as evidenced by a certified copy of the conviction;

13. failure to comply with all of the reporting requirements in a timely manner as requested by the department;

14. failure to comply with the terms and provisions of a settlement agreement with the department or an educational letter;

15. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment; or

16. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department.

E. In the event an ASC license is revoked, renewal is denied or the license is surrendered in lieu of an adverse action, any owner, officer, member, manager, director or administrator of such ASC is prohibited from owning, managing, directing or operating another ASC for a period of two years from the date of the final disposition of the revocation, denial action or surrender.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1737 (September 2017).

§4523. Notice and Appeal of Initial License Denial, License Revocation and Denial of License Renewal

A. Notice of an initial license denial, license revocation or denial of license renewal shall be given to the ASC in writing.

B. The ASC has a right to an administrative reconsideration of the initial license denial, license revocation or denial of license renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the ASC.

1. The request for the administrative reconsideration shall be submitted within 15 days of the receipt of the notice of the initial license denial, license revocation or denial of license renewal. The request for administrative reconsideration shall be in writing and shall be forwarded to HSS.

2. The request for administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received by HSS, an administrative reconsideration shall be scheduled and the ASC will receive written notification of the date of the administrative reconsideration.

4. The ASC shall have the right to appear in person at the administrative reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the initial license denial, revocation or denial of license renewal shall not be a basis for reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The ASC will be notified in writing of the results of the administrative reconsideration.

C. The ASC has a right to an administrative appeal of the initial license denial, license revocation or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the ASC.

1. The ASC shall request the administrative appeal within 30 days of the receipt of the results of the administrative reconsideration.

a. The ASC may forego its rights to an administrative reconsideration, and if so, shall request the administrative appeal within 30 days of the receipt of the notice of the initial license denial, license revocation or denial of license renewal.

2. The request for administrative appeal shall be in writing and shall be submitted to the DAL. The request shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the ASC shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the ASC pose an imminent or immediate threat to the health, welfare or safety of a patient, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the ASC will be notified in writing.

4. Correction of a violation or a deficiency which is the basis for the denial of initial licensure, revocation or denial of license renewal shall not be a basis for an administrative appeal.

D. If an existing licensed ASC has been issued a notice of license revocation, and the ASC's license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

E. If a timely administrative appeal has been filed by the ASC on an initial license denial, denial of license renewal or license revocation, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

1. If the final decision is to reverse the initial license denial, denial of license renewal or license revocation, the ASC's license will be re-instated or granted upon the payment of any licensing fees, outstanding sanctions or other fees due to the department.

2. If the final decision is to affirm the denial of license renewal or license revocation, the ASC shall stop rendering services to patients.

a. Within 10 days of the final decision, the ASC shall notify HSS, in writing, of the secure and confidential location where the patient records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new ASC or the issuance of a provisional license to an existing ASC. An ASC that has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license is not considered to be a denial of initial licensure, denial of license renewal or revocation.

G. An ASC with a provisional initial license or an existing ASC with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey shall have the right to an informal reconsideration and the right to an administrative appeal of the validity of the deficiencies cited at the follow-up survey.

1. The correction of a violation, noncompliance or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The ASC shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five calendar days of receipt of the notice of the results of the follow-up survey from the department.

4. The ASC shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the DAL.

5. An ASC with a provisional initial license or an existing ASC with a provisional license that expires under the provisions of this Chapter shall cease providing services to patients unless the DAL issues a stay of the expiration.

a. The stay may be granted by the DAL upon application by the ASC at the time the administrative appeal is filed and only after a contradictory hearing and only upon a showing that there is no potential harm to the patients being served by the ASC.

6. If a timely administrative appeal has been filed by the ASC with a provisional initial license that has expired, or by an existing ASC whose provisional license has expired under the provisions of this Chapter, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

a. If the final decision is to remove all deficiencies, the ASC's license will be re-instated upon the payment of

any outstanding sanctions and licensing or other fees due to the department.

b. If the final decision is to uphold the deficiencies thereby affirming the expiration of the provisional license, the ASC shall cease rendering services to patients.

i. Within 10 days of the final decision, the ASC shall notify HSS in writing of the secure and confidential location where the patient records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1738 (September 2017).

§4525. Cessation of Business

A. Except as provided in §4583 and §4585 of these licensing regulations, a license shall be immediately null and void if an ASC ceases to operate.

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

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

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

E. The ASC shall notify the department in writing 30 days prior to the effective date of the closure or cessation. In addition to the notice, the ASC shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

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

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

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

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

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

G. Once the ASC has ceased doing business, the center shall not provide services until the ASC has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1739 (September 2017).

Subchapter B. Administration and Organization

§4531. Governing Body

A. An ASC shall have an identifiable governing body with responsibility for, and authority over, the policies and activities of the ASC, which shall include use agreements and all contracts. The governing body is the ultimate governing authority of the ASC and shall adopt bylaws which address its responsibilities. No contract or other arrangements, including use agreements, shall limit or diminish the responsibilities of the governing body.

B. An ASC shall have documents identifying the following information regarding the governing body:

1. names and addresses of all members;

2. terms of membership;

3. officers of the governing body; and

4. terms of office for any officers.

C. The governing body shall be comprised of one or more persons and shall hold formal meetings at least twice a year. There shall be written minutes of all formal meetings, and the bylaws shall specify the frequency of meetings and quorum requirements.

D. The governing body of an ASC shall:

1. ensure the ASC's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. ensure that the ASC is adequately funded and fiscally sound which entails:

a. verification of sufficient assets equal to $100,000 or the cost of three months of operation, whichever is less; or

b. a letter of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000 or the cost of three months of operation, whichever is less;

3. review and approve the ASC's annual budget;

4. designate a person to act as the administrator and delegate sufficient authority to this person to manage the day-to-day operations of the ASC;

5. annually evaluate the administrator's performance;

6. have the authority to dismiss the administrator;

7. formulate and annually review, in consultation with the administrator, written policies and procedures concerning the ASC's philosophy, goals, current services, personnel practices, job descriptions, fiscal management, contracts and use agreements:

a. the ASC's written policies and procedures shall be maintained within the ASC and made available to all staff at all times;

8. determine, in accordance with state law, which practitioners are eligible candidates for appointment to the medical staff and make the necessary appointments;

9. determine, in conjunction with the medical staff, whether the ASC will provide services beyond the customary hours of operation by allowing a patient to stay up to 23 hours. If permitted the ASC shall provide continuous physician (on call and available to be on-site as needed) and professional nursing services (registered nurse) on-site. In addition, the ASC shall provide for ancillary services to accommodate patient needs during this extended stay including but not limited to medication and nutrition;

10. ensure and maintain quality of care, inclusive of a quality assurance/performance improvement process that measures patient, process, and structural (e.g. system) outcome indicators to enhance patient care;

11. ensure that surgical or invasive procedures shall not be performed in areas other than the operating room or other designated and approved treatment rooms;

12. ensure that surgical or invasive procedures are initiated in accordance with acceptable standards of practice, which includes the use of standard procedures, such as a timeout to ensure proper identification of the patient and surgical site, in order to avoid wrong site, wrong person or wrong procedure errors;

13. meet with designated representatives of the department whenever required to do so;

14. inform the department, or its designee, prior to initiating any substantial changes in the services provided by the ASC; and

15. ensure that pursuant to R.S. 40:1191.2, prior to the final disposition of a miscarried child, but not more than 24 hours after a miscarriage occurs in an ASC, the ASC shall notify the patient, or if the patient is incapacitated, the spouse of the patient, both orally and in writing, of both of the following:

a. the parent's right to arrange for the final disposition of the miscarried child through the use of the notice of parental rights form as provided for in R.S. 40:1191.3; and

b. the availability of a chaplain or other counseling services concerning the death of the miscarried child, if such services are provided by the ASC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1740 (September 2017).

§4533. Policy and Procedures

A. An ASC, through collaboration by the administrator, medical staff, director of nursing, pharmacist, and other professional persons deemed appropriate by the ASC, shall develop, implement and maintain written policies and procedures governing all services rendered at the ASC. The ASC shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

B. All policies and procedures shall be reviewed at least annually and revised as needed.

C. Direct care and medical staff shall have access to information concerning patients that is necessary for effective performance of the employee's assigned tasks.

D. The ASC shall have written policies and procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of records and to whom records may be released.

E. The ASC shall allow designated representatives of the department, in the performance of their mandated duties, to:

1. inspect all aspects of an ASC's operations which directly or indirectly impact patients; and

2. interview any physician, staff member or patient.

F. An ASC shall make any required information or records, and any information reasonably related to assessment of compliance with these provisions, available to the department.

G. An ASC shall, upon request by the department, make available the legal ownership documents, use agreements and any other legal contracts or agreements in place.

H. The ASC shall have written policies and procedures approved by the governing body, which shall be implemented and followed, that address, at a minimum, the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. personnel;

5. patient rights;

6. grievance procedures;

7. emergency preparedness;

8. abuse and neglect;

9. incidents and accidents, including medical emergencies;

10. universal precautions;

11. documentation, whether electronic or in paper form;

12. admission and discharge procedures;

13. hours outside of stated usual and customary operation, including but not limited to early closures, extended business hours and holidays; and

14. conditions for coverage, if applicable.

I. An ASC shall have written personnel policies, which shall be implemented and followed, that include:

1. written job descriptions for each staff position, including volunteers;

2. policies which provide for staff, upon offer of employment, to have a health assessment as defined by the ASC and in accordance with LAC Title 51, *Public Health—Sanitary Code* guidelines;

3. policies which verify that all physicians, clinic employees, including contracted personnel and personnel practicing under a use agreement, prior to, and at the time of employment and annually thereafter, shall be free of tuberculosis in a communicable state, in accordance with the current LAC Title 51, *Public Health—Sanitary Code*;

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment, whether that abuse or mistreatment is done by another staff member, a family member, a patient or any other person;

6. a written policy to prevent discrimination; and

7. a written policy to address prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media and include, at a minimum, ensuring confidentiality of patient information and preservation of patient dignity and respect, including protection of patient privacy and personal and property rights.

J. The ASC shall maintain, in force at all times, the requirements for financial viability under this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1741 (September 2017).

Subchapter C. Admissions, Transfers and Discharges

§4539. Admissions and Assessments

A. Each ASC shall have written admission and assessment policies and criteria.

B. An individual or entity that enters into a use agreement with a licensed ASC shall be required to adhere to all of the provisions of this Section.

C. An ASC shall ensure that each patient has the appropriate pre-surgical and post-surgical assessments completed, inclusive of suitability for less than 23-hour timeframe of patient stay, ability of the ASC to provide services needed in the post-operative period in accordance with prescribed plan of care, and discharge plans to home or another licensed facility setting.

D. Within 30 days prior to the date of the scheduled surgery, each patient shall have a comprehensive medical history and physical assessment completed by a physician or other qualified licensed professional practitioner in accordance with applicable state health and safety laws, ASC policies, and standards of practice.

E. The history and physical assessment prior to surgery shall specify that the patient is medically cleared for surgery in an ambulatory setting and is required on all patients regardless of whether the patient is referred for surgery on the same day that the referral is made and the referring physician has indicated that it is medically necessary for the patient to have the surgery on the same day.

F. Upon admission, each patient shall have a pre-surgical assessment completed by a physician or other qualified licensed health practitioner. The pre-surgical assessment shall include, at a minimum:

1. an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment; and

2. documentation of any known allergies to drugs and/or biological agents.

G. The patient's medical history and physical assessment shall be placed in the patient's medical record prior to the surgical procedure.

H. The patient's post-surgical condition shall be assessed and documented in the medical record by a physician, other licensed medical practitioner, or a registered nurse (RN) with, at a minimum, the required post-operative care experience in accordance with applicable state health and safety laws, ASC policies and standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1741 (September 2017).

§4541. Transfer Agreements and Patient Transfers

A. The ASC shall secure a written transfer agreement with at least one hospital in the community. A transfer agreement shall serve as evidence of a procedure whereby patients can be transferred to a hospital should an emergency arise which would necessitate hospital admission.

1. If a written transfer agreement is established with a hospital in the community, medical staff at the ASC shall still be required to adhere to the provisions of §4541.B and C.

2. If the ASC is not able to secure a written transfer agreement, the ASC's compliance with §4541.C shall substantiate the ASC's capability to obtain hospital care for a patient if the need arises.

B. Each member of the medical staff of the ASC, including physicians who practice under a use agreement, shall be a member in good standing on the medical staff of at least one hospital in the community and that hospital shall be licensed by the department. Members of the ASC medical staff shall be granted surgical privileges compatible with privileges granted by the hospital for that physician.

C. The admitting physician of the ASC shall be responsible for effecting the safe and immediate transfer of patients from the ASC to a hospital when, in his/her medical opinion, hospital care is indicated.

D. The ASC is responsible for developing written policies and procedures for the safe transfer of patients and coordination of admission, when necessary, into an inpatient facility. The written policy shall include, but is not limited to:

1. identification of the ASC personnel who shall be responsible for the coordination of admission into an inpatient facility;

2. procedures for securing inpatient services; and

3. procedures for the procurement of pertinent and necessary copies of the patient's medical record that will be sent with the transferring patient so that the information may be included in the patient's inpatient medical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1742 (September 2017).

§4543. Discharges

A. Each ASC shall have written discharge policies and procedures. The written description of discharge policies shall be provided to the department upon request and made available to the patient or his/her legal representative. The ASC shall ensure that all elements of the discharge requirements are completed.

B. Any individual or entity that enters into a use agreement with a licensed ASC shall be required to adhere to all of the provisions of this Section.

C. The post-surgical needs of each patient shall be addressed and documented in the discharge notes.

D. Upon discharge, the ASC shall:

1. provide each patient with written discharge instructions;

2. provide each patient with all supplies deemed medically necessary per the discharge orders, excluding medications;

3. make the follow-up appointment with the physician, when appropriate; and

4. ensure that all patients are informed, either in advance of their surgical procedure or prior to leaving the ASC, of the following:

a. necessary prescriptions;

b. post-operative instructions; and

c. physician contact information for follow-up care.

E. The ASC shall ensure that each patient has a discharge order signed by the physician who performed the surgery or procedure.

F. The ASC shall ensure and document that all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician. Such exemptions shall be specific and documented for individual patients. Blanket exemptions are prohibited.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1742 (September 2017).

Subchapter D. Service Delivery

§4549. Surgical Services

A. Surgical services shall be well organized and provided in accordance with current acceptable standards of practice adopted from national associations or organizations.

B. Private areas should include pre- and post-operative care areas and should allow for parental presence for pediatric patients.

C. The ASC shall ensure that the scheduled surgeries do not exceed the capabilities of the surgical center, including the post-anesthesia care area, and any length of patient does not exceed 23 hours from patient admission to discharge from the ASC.

D. At least one RN trained in the use of emergency equipment and certified in advanced cardiac life support (ACLS) and/or pediatric advanced life support (PALS), if a pediatric patient is present, shall be immediately available whenever there is a patient in the ASC.

E. A roster of physicians and other medical practitioners, specifying the surgical privileges of each, shall be kept in the surgical center and available to all professional staff.

F. Medical staff and approved policies shall define which surgical procedures require a qualified first assistant physician, registered nurse or surgical technician.

1. A registered nurse or a surgical technician may be a surgical assistant if the individual:

a. has been approved by the medical director and director of nurses;

b. has documented competency and training to assist in such procedures; and

c. is acting within the scope of practice of his/her respective licensing board(s) and/or certification(s).

G. An operating and procedure room register shall be accurately maintained and kept up-to-date and complete. This register shall be maintained for a five year period. The register shall include, at a minimum, the:

1. patient's complete name;

2. patient's ASC identification number;

3. physician's name;

4. date of the surgery/procedure; and

5. type of surgery/procedure performed.

H. An RN shall be assigned to, and directly responsible for, the post-anesthesia care area. There shall be a sufficient number of nurses assigned to the post-anesthesia care area to meet the nursing needs of patients in recovery. At a minimum, one licensed RN and one direct care staff shall be onsite and available for the length of any patient stay in the ASC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1742 (September 2017).

§4551. Anesthesia Services

A. Anesthesia services shall be available when surgical services are provided.

B. Anesthesia services shall be provided in a well-organized manner under the direction of an anesthesiologist or the treating physician who is licensed and in good standing with the State Board of Medical Examiners.

C. Anesthesia services and/or conscious sedation shall be administered by licensed practitioners with clinical privileges for which they have been licensed, trained and determined to be competent to administer anesthesia and/or conscious sedation in accordance with their respective state licensing board.

D. Anesthesia and conscious sedation may be administered by the following practitioners who are qualified to administer anesthesia under state law and within the scope of their practice:

1. anesthesiologists;

2. doctors of medicine or osteopathy;

3. dentists or oral surgeons;

4. podiatrists;

5. certified registered nurse anesthetists (CRNAs) licensed by the State Board of Nursing who are under the supervision of a physician or an anesthesiologist who is immediately available if needed, as defined in the medical staff bylaws; and

6. registered nurses who have documented education and demonstrated competency to administer minimal or moderate sedation in accordance with the Nurse Practice Act, and who are under the supervision of the treating physician.

a. The RN (non-CRNA) monitoring the patient shall have no additional responsibility that would require leaving the patient unattended or would compromise continuous monitoring during the procedure.

E. The practitioner administering the anesthesia and/or conscious sedation shall be present and immediately available during the post-anesthesia recovery period until the patient is assessed as stable in accordance with the ASC's established criteria.

F. The ASC shall develop policies and procedures which are approved by the governing body including, but not limited to:

1. staff privileges of licensed personnel that administer anesthesia;

2. delineation of pre-anesthesia and post-anesthesia responsibilities;

3. the qualifications, responsibilities and supervision required of all licensed personnel who administer any type or level of anesthesia;

4. patient consent for anesthesia, including the American Society of Anesthesiologists (ASA) physical status classification system;

5. infection control measures;

6. safety practices in all anesthetizing areas;

7. protocol for supportive life functions, e.g., cardiac and respiratory emergencies;

8. reporting requirements;

9. documentation requirements;

10. inspection and maintenance reports on all of the supplies and equipment used to administer anesthesia; and

11. monitoring of trace gases and reporting requirements.

G. Anesthesia policies shall ensure that the following are provided for each patient:

1. a pre-anesthesia evaluation performed and recorded immediately prior to surgery to evaluate the risk of anesthesia and of the procedure to be performed by an individual qualified to administer anesthesia;

2. an intra-operative anesthesia record that records monitoring of the patient during any type or level of anesthesia and documentation of at least the following:

a. prior to induction of any type or level of anesthesia, all anesthesia drugs and equipment to be used have been checked and are immediately available and are determined to be functional by the practitioner who is to administer the anesthetic;

b. dosages of each drug used, including the total dosages of all drugs and agents used;

c. type and amount of all fluid(s) administered, including blood and blood products;

d. estimated blood loss;

e. technique(s) used;

f. unusual events during the anesthesia period;

g. the status of the patient at the conclusion of any type or level of anesthesia; and

h. a post-anesthesia report written prior to discharge of the patient by the individual who administers the anesthesia or another fully qualified practitioner within the anesthesia department; and

3. policies developed, approved and implemented that define:

a. minimal, moderate and deep sedation;

b. the method of determining the sedation status of the patient;

c. how the sedation is to be carried out;

d. who is to be present while the patient is under any type or level of anesthesia; and

e. what body systems are to be monitored and equipment to be used with each type of anesthesia administered.

H. Anesthesia policies and procedures shall be developed and approved for all invasive procedures including, but not limited to:

1. percutaneous aspirations and biopsies;

2. cardiac and vascular catheterization; and

3. endoscopies.

I. The ASC shall adopt an individualized patient identification system for all patients who:

1. are administered general, spinal or other types of anesthesia; and

2. undergo surgery or other invasive procedures when receiving general, spinal or other major regional anesthesia and/or intravenous, intramuscular or inhalation sedation/analgesia, including conscious sedation that, in the manner used in the ASC, may result in the loss of the patient's protective reflexes.

J. The ASC shall develop, approve and implement policies and procedures to ensure that the following requirements are met for each patient undergoing:

1. general anesthesia/total intravenous anesthesia:

a. the use of an anesthesia machine that provides the availability and use of safety devices including, but not limited to:

i. an oxygen analyzer;

ii. a pressure and disconnect alarm;

iii. a pin-index safety system;

iv. a gas-scavenging system; and

v. an oxygen pressure interlock system;

b. continuous monitoring of the patient's temperature and vital signs, as well as the continuous use of:

i. an electrocardiogram (EKG/ECG);

ii. a pulse oximetry monitor; and

iii. an end tidal carbon dioxide volume monitor;

2. monitored anesthesia care (MAC):

a. monitored anesthesia care includes the monitoring of the patient by an anesthesiologist and/or a CRNA. Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC;

b. equipment sufficient to maintain the patient's airway and ventilatory function shall be immediately available and in the OR/procedure room where the procedure is being performed;

c. continuous monitoring of the patient's vital signs and temperature as well as continuous use of an EKG/ECG and pulse oximetry monitor; and

d. monitoring by the licensed practitioner who administers the anesthetic;

3. conscious sedation:

a. policies and procedures shall be developed, approved, and implemented by the medical staff as to the need for pre-operative cardiac and pulmonary assessments of patients prior to being administered conscious sedation; and

b. there shall be a minimum requirement of a registered nurse to continuously monitor the patient who is receiving conscious sedation;

4. regional anesthesia (major nerve blocks):

a. equipment sufficient to maintain the patient's airway and to convert the case to another form of anesthesia shall be immediately available and in the operating/procedure room where the procedure is being performed;

b. continuous monitoring of the patient's vital signs and temperature, as well as the continuous use of an EKG/ECG and pulse oximetry monitor;

c. monitoring by the licensed practitioner who administers the regional anesthetic;

5. local anesthesia (infiltration or topical):

a. continuous monitoring of the patient's vital signs and temperature as well as the continuous use of an EKG/ECG and pulse oximetry monitor; and

b. local anesthesia, interpreted to mean those anesthetizing agents administered and affecting a very small

localized area that may be administered by the treating physician.

K. The ASC shall develop, approve and implement policies and procedures regarding qualifications and duties of all licensed personnel who administer any type or level of anesthesia.

L. Policies and procedures shall be developed, approved and implemented in accordance with manufacturer's guidelines for the equipment and medications to be used to administer any level or type of anesthesia.

M. Policies and procedures shall be developed, approved, and implemented as stipulated under the current state licensing boards for patients undergoing any level or type of anesthesia sedation. The patient under sedation shall be monitored for blood pressure, respiratory rate, oxygen saturation, cardiac rate and rhythm and level of consciousness. This information shall be recorded at least every five minutes during the therapeutic, diagnostic or surgical procedure and, at a minimum, every 15 minutes during the recovery period or more frequently as deemed appropriate by the authorized prescriber.

N. The ASC shall define in policy and procedures whether the use of reversal agents is to be considered an adverse patient event.

O. The patient shall be kept in the recovery room until assessed by a qualified anesthesia professional as being stable in accordance with the ASCs established criteria.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1743 (September 2017).

§4553. Radiology Services

A. All ASCs shall provide radiology services commensurate with the needs of the ASC and to meet the needs of the patients being served.

B. The scope and complexity of radiological services provided within the ASC, either directly or under arrangement, as an integral part of the ASC's services should be specified in writing and approved by the governing body.

C. The ASC is equally responsible for the compliance of radiological services performed in the ASC, regardless of whether the service is provided directly by the ASC or under arrangement.

D. Radiological determinations made by the physician within 72 hours prior to admission shall be acceptable if documented by the physician on the patient's medical record and the determinations conform to the medical staff bylaws and rules and regulations of the center.

E. All radiological determinations shall be in writing and the original shall be a part of the patient's chart.

F. When radiology services are provided by the ASC directly, at a minimum, the following criteria shall be met.

1. The ASC shall comply with periodic inspections of equipment and testing for radiation hazards, and shall promptly correct any identified problems.

2. Radiologic services shall be provided in an area of sufficient size and arrangement to provide for the safety of personnel and patients.

3. Supervision of radiologic services should be appropriate to the types of procedures conducted by the ASC.

4. The ASC governing body is responsible for the oversight and accountability for the quality assessment and performance improvement program, and is responsible for ensuring that all policies and services provide quality healthcare in a safe environment.

5. The governing body is responsible for determining if any procedures, now or in the future, require additional review by a radiologist.

6. The governing body is accountable for the medical staff to ensure that such staff members are legally and professionally qualified for the positions to which they are appointed and for the performance of the privileges granted.

7. The treating physician is expected to demonstrate documented competency in using imaging as an integral part of the surgery or procedure.

8. A licensed practitioner who is qualified by education and experience in accordance with state law, rules and regulations and in accordance with ASC policy shall supervise the provision of radiologic services.

a. For purposes of this Section, a *licensed practitioner* means a person licensed to practice medicine, dentistry, podiatry, chiropracty or osteopathy in this state, or an advanced practice registered nurse licensed to practice in this state.

9. Radiologic reports shall be signed by the licensed medical practitioner who reads and interprets the reports.

10. The ASC shall adopt written policies and procedures to ensure that radiologic services are rendered in a manner which provides for the safety and health of patients and ASC personnel. At a minimum, the policies and procedures shall cover the following:

a. shielding for patients and personnel;

b. storage, use and disposal of radioactive materials;

c. documented periodic inspection of equipment and handling of identified hazards;

d. documented periodic checks by exposure meters or test badges on all personnel working around radiological equipment which shall also include knowledge of exposure readings at other places of employment;

e. managing medical emergencies in the radiologic department; and

f. methods for identifying pregnant patients.

11. Only personnel who are registered and/or licensed in the appropriate radiologic technology modality or category by the state Radiologic Technology Board of Examiners and designated as qualified by the medical staff may use the radiologic equipment and administer procedures under the direction of a physician

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1745 (September 2017).

§4555. Laboratory Services

A. The ASC shall either provide a clinical laboratory directly or make contractual arrangements with a laboratory certified in accordance with the clinical laboratory improvement amendments to perform services commensurate with the needs of the ASC.

B. Contractual arrangements for laboratory services shall be deemed as meeting the requirements of this Section when those arrangements contain written policies and procedures defining the scope of services.

C. When laboratory services are provided directly by the ASC, the services shall be performed by a qualified and/or licensed person with documented training and experience to supervise and perform the testing.

1. The ASC shall have sufficient numbers of licensed clinical laboratory and supportive technical staff to perform the required tests.

2. The laboratory shall be of sufficient size and adequately equipped to perform the necessary services of the ASC.

D. Written laboratory policies and procedures shall be developed and implemented for all laboratory services provided directly by the center and/or by contractual arrangement. Policies shall define "stat" labs and the timelines for processing and reporting "stat" labs.

E. Written reports of all ASC performed and contractually performed lab results shall be made a part of the patient's medical record.

F. Documentation shall be maintained for preventive maintenance and quality control programs governing all types of analyses performed in the laboratory.

G. The ASC shall make provisions for the immediate pathological examination of tissue specimens by a pathologist, if applicable. The pathology report shall be made part of the patient's medical record.

H. Handling of Blood and Blood Products

1. Written policies and procedures shall be developed, approved by the governing body and implemented by the ASC, relative to the administration of blood and blood products as well as any medical treatment and notification of the treating physician in the event of an adverse reaction.

2. If the treating physician determines that blood and blood products shall be administered, the ASC shall provide for the procurement, safekeeping and transfusion of the blood and blood products so that it is readily available.

3. The administration of blood shall be monitored by the registered nurse to detect any adverse reaction. Prompt investigation of the cause of an adverse reaction shall be instituted and reported according to ASC policy and procedures.

4. If the ASC regularly uses the services of an outside blood bank, the ASC shall have a written agreement with the blood bank whereby the ASC is promptly notified by the blood bank of blood or blood products that have been determined at increased risk of transmitting infectious disease.

5. The ASC shall have a system in place which is defined in a "look back" policy and procedure for appropriate action to take when notified that blood or blood products that the ASC has received are at increased risk of transmitting infectious disease. The look back policy shall include, but not be limited to:

a. quarantine of the contaminated products;

b. documented notification to the patient or legal representative and the patient's physician; and

c. the safe and sanitary disposal of blood and blood products not suitable for distribution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1745 (September 2017).

§4557. Pharmaceutical Services

A. The ASC shall provide pharmacy services commensurate with the needs of the patients and in conformity with state and federal laws. Pharmacy services may be provided directly by the ASC or under a contractual agreement as long as all regulatory requirements are met.

1. At a minimum, the ASC shall designate a qualified and licensed healthcare professional to provide direction to the ASC's pharmaceutical service.

B. All ASCs shall have a controlled dangerous substance license issued by the Board of Pharmacy and a Drug Enforcement Agency (DEA) license allowing for the ordering, storage, dispensing and delivery of controlled substances to patients.

C. Drugs and biologicals shall be provided safely and in an effective manner, consistent with accepted professional standards of pharmaceutical practice.

D. When the ASC provides pharmaceutical services, there shall be a current permit issued by the Board of Pharmacy.

E. The designated licensed healthcare professional responsible for pharmaceutical services shall maintain

complete, current and accurate records of all drug transactions by the pharmacy.

1. Current and accurate records shall be maintained on the receipt, distribution, dispensing and/or destruction of all scheduled drugs in such a manner as to facilitate complete accounting for the handling of these controlled substances.

F. Dispensing of prescription legend or controlled substance drugs directly to the public or patient by vending machines is prohibited.

G. Medications are to be dispensed only upon written or verbal orders from a licensed medical practitioner. All verbal orders shall be taken by a licensed medical professional.

H. The designated licensed healthcare professional responsible for pharmaceutical services shall assist the center in the development of policies and procedures to:

1. address the distribution, storage and handling of drugs;

2. monitor drug and medication-related activities; and

3. immediately notify the director of nurses to return drugs to the pharmacy or contracted pharmacist for proper disposition in the event of a drug recall.

I. The designated licensed healthcare professional responsible for pharmaceutical services shall assist the ASC with drug administration errors, adverse drug reactions and incompatibilities of medications, and shall report data relative to these issues to the quality assessment performance improvement committee.

J. The designated licensed healthcare professional responsible for pharmaceutical services shall assist the ASC in developing a formulary of medications that will be available for immediate patient use.

K. The designated licensed healthcare professional responsible for pharmaceutical services shall ensure that medication and supplies are on-site at all times and immediately available for the management of malignant hyperthermia, where applicable, based upon the type and level of anesthesia delivered and all other anesthesia-related complications.

L. The consultant pharmacist shall provide consultation to the ASC on an as needed basis and consistent with provisions of the state Board of Pharmacy. The consultations shall be documented in writing showing the date, amount of time spent, subjects reviewed and recommendations made.

M. All drug errors, adverse drug reactions and incompatibilities of medications shall be entered into the patient's medical record and reported according to federal and state laws and per ASC policy and procedure.

N. The ASC shall provide for a drug administration storage area which allows for the proper storage, safeguarding and distribution of drugs. All drug cabinets or drug storage areas at the nursing station(s) are to be constructed and organized to ensure proper handling and safeguard against access and removal by unauthorized personnel. All drug cabinets or drug storage areas are to be kept clean, in good repair and are to be inspected each month by a designated licensed healthcare professional responsible for pharmaceutical services. Compartments appropriately marked shall be provided for the storage of poisons and external use drugs and biological, separate from internal and injectable medications.

O. All drug storage areas shall have proper controls for ventilation, lighting and temperature. Proper documentation shall be maintained relative to routine monitoring of temperature controls.

P. Drugs and biologicals that require temperature controlled refrigeration shall be refrigerated separately from food, beverages, blood and laboratory specimens.

Q. Locked areas that maintain medications, including controlled substances, shall conform to state and federal laws and the ASC's policies and procedures.

R. Unit dose systems shall include on each unit dose the:

1. name of the drug;

2. strength of the drug;

3. lot and control number or equivalent; and

4. expiration date.

S. Outdated, mislabeled or otherwise unusable drugs and biologicals shall:

1. be separated from useable stock;

2. not be available for patient use or other use; and

3. be returned to an authorized agency for credit or destroyed according to current state and/or federal laws as applicable.

T. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the chief executive officer or administrator, the director of nurses, the Board of Pharmacy, and to the Regional DEA office, and according to ASC policy and procedure.

U. Any medications administered to a patient shall be administered only as ordered by a licensed medical practitioner and shall have documentation entered into the patient's medical record of the name of the drug, amount, route, the date and time administered, response and/or any adverse reactions to medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1746 (September 2017).

§4559. Stereotactic Radiosurgery Services

A. Ambulatory surgical centers operated primarily for the purpose of offering stereotactic radiosurgery by use of a gamma knife or similar neurosurgical tool are exempt from the following requirements:

1. having a minimum of two operating/procedure rooms and one post-anesthesia recovery room within the ASC;

2. caseload shall not exceed the capabilities of the surgical center including the recovery room;

3. the surgical area shall be located within the facility as to be removed from the general lines of traffic of both visitors and other ASC personnel; and

4. the following requirements:

a. scrub station(s) shall be provided directly adjacent to the entrance to each operating or procedure room;

b. a scrub station may serve two operating or procedure rooms if it is located directly adjacent to the entrances to both; and

c. scrub stations shall be arranged to minimize splatter on nearby personnel or supply carts.

B. The aforementioned exemptions do not apply to ASCs performing surgical procedures in conjunction with stereotactic radiosurgery.

C. These facilities shall be responsible for compliance with these licensing standards and any applicable state and federal laws, rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1747 (September 2017).

Subchapter E. Facility Responsibilities

§4565. General Provisions

A. Ambulatory surgical centers shall comply and show proof of compliance with all relevant federal, state, local rules and regulations. It is the ASC's responsibility to secure the necessary approvals from the following entities:

1. Health Standards Section;

2. Office of the State Fire Marshal's plan review;

3. Office of Public Health;

4. Office of the State Fire Marshal's *Life Safety Code* inspection; and

5. the applicable local governing authority (e.g., zoning, building department or permit office).

B. The administrator or person authorized to act on behalf of the administrator shall be accessible to ASC staff or designated representatives of the department any time there is a patient in the ASC.

C. An ASC shall have qualified staff sufficient in number to meet the needs of patients and to ensure provision of services.

D. The ASC shall develop and maintain documentation of an orientation program for all employees of sufficient scope and duration to inform the individual about his/her responsibilities, how to fulfill them, review of policies and procedures, job descriptions, competency evaluations and performance expectations. An orientation program and documented competency evaluation and/or job expectations of assigned or reassigned duties shall be conducted prior to any assignments or reassignments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1747 (September 2017).

§4567. Staffing Requirements

A. Administrative Staff. The following administrative staff is required for all ASCs:

1. a qualified administrator at each licensed geographic location who shall meet the qualifications as established in these provisions;

2. other administrative staff as necessary to operate the ASC and to properly safeguard the health, safety and welfare of the patients receiving services; and

3. an administrative staff person on-call after routine daytime or office hours for the length of any patient stay in the ASC.

B. Administrator/Director

1. Each ASC shall have a qualified administrator/director who is an on-site employee responsible for the day-to-day management, supervision and operation of the ASC.

2. Any current administrator employed by a licensed and certified ASC, at the time these licensing provisions are adopted and become effective, shall be deemed to meet the qualifications of the position of administrator as long as the individual holds his/her current position. If the individual leaves his/her current position, he/she shall be required to meet the qualifications stated in these licensing provisions to be re-employed into such a position.

3. The administrator shall meet the following qualifications:

a. possess a college degree from an accredited university; and

b. have one year of previous work experience involving administrative duties in a healthcare facility.

4. An RN shall meet the following qualifications to hold the position of administrator:

a. maintain a current and unrestricted RN license; and

b. have at least one year of management experience in a healthcare facility.

5. Changes in administrator shall be reported to the department within 10 days.

C. Medical Staff

1. The ASC shall have an organized medical staff, including any licensed medical practitioners who practice under a use agreement with the ASC.

2. All medical staff shall be accountable to the governing body for the quality of all medical and surgical care provided to patients and for the ethical and professional practices of its members.

3. Members of the medical staff shall be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted.

4. The medical staff shall develop, adopt, implement and monitor bylaws and rules for self-governing of the professional activity of its members. The medical staff bylaws shall be maintained within the ASC. The bylaws and rules shall contain provisions for at least the following:

a. developing the structure of the medical staff, including allied health professionals and categories of membership;

b. developing, implementing and monitoring to review credentials, at least every two years, and to delineate and recommend approval for individual privileges;

c. developing, implementing and monitoring to ensure that all medical staff possess current and unrestricted Louisiana licenses and that each member of the medical staff is in good standing with his/her respective licensing board;

d. recommendations to the governing body for membership to the medical staff with initial appointments and reappointments not to exceed two years;

e. developing, implementing and monitoring for suspension and/or termination of membership to the medical staff;

f. developing, implementing and monitoring criteria and frequency for review and evaluation of past performance of its individual members. This process shall include monitoring and evaluation of the quality of patient care provided by each individual;

g. the election of officers for the ensuing year;

h. the appointment of committees as deemed appropriate; and

i. reviewing and making recommendations for revisions to all policy and procedures at least annually.

5. Medical staff shall meet at least semi-annually. One of these meetings shall be designated as the official annual meeting. A record of attendance and minutes of all medical staff meetings shall be maintained within the ASC.

6. A physician shall remain within the ASC until all patients have reacted and are assessed as stable.

7. The patient's attending physician, or designated on-call physician, shall be available by phone for consultation and evaluation of the patient, and available to be onsite if needed, until the patient is discharged from the ASC.

8. Each patient admitted to the ASC shall be under the professional supervision of a member of the ASC's medical staff who shall assess, supervise and evaluate the care of the patient.

9. Credentialing files for each staff physician shall be kept current and maintained within the ASC at all times.

D. Nursing Staff. A staffing pattern shall be developed for each nursing care unit (preoperative unit, operating/procedure rooms, post anesthesia recovery area). The staffing pattern shall provide for sufficient nursing personnel and for adequate supervision and direction by registered nurses consistent with the size and complexity of the procedure(s) performed and throughout the length of any patient stay in the ASC.

1. Nursing services shall be under the direction of an RN that includes a plan of administrative authority with written delineation of responsibilities and duties for each category of nursing personnel.

2. The ASC shall ensure that the nursing service is directed under the leadership of a qualified RN. The ASC shall have documentation that it has designated an RN to direct nursing services.

3. The director of nursing (DON) shall:

a. have a current, unrestricted Louisiana RN license;

b. be in good standing with the State Board of Nursing; and

c. shall have a minimum of one year administrative experience in a health care setting and the knowledge, skills and experience consistent with the complexity and scope of surgical services provided by the ASC.

4. The RN holding dual administrative/nursing director roles shall meet the qualifications of each role.

5. Changes in the director of nursing position shall be reported in writing to the department within 10 days of the change on the appropriate form designated by the department.

6. Nursing care policies and procedures shall be in writing, formally approved, reviewed annually and revised as needed, and consistent with accepted nursing standards of practice. Policies and procedures shall be developed, implemented and monitored for all nursing service procedures.

7. There shall be a sufficient number of duly licensed registered nurses on duty at all times to plan, assign, supervise and evaluate nursing care, as well as to give patients the high quality nursing care that requires the judgment and specialized skills of a registered nurse.

a. There shall be sufficient nursing staff with the appropriate qualifications to assure ongoing assessment of patients' needs for nursing care and that these identified needs are addressed. The number and types of nursing staff is determined by the volume and types of surgery the ASC performs.

8. All professional nurses employed, contracted or working under a use agreement with the ASC shall have a current, unrestricted and valid Louisiana nursing license. Nonprofessional or unlicensed personnel employed, contracted, or working under a use agreement and performing nursing services shall be under the supervision of a licensed registered nurse.

9. There shall be, at minimum, one RN with ACLS certification and, at minimum, one RN with PALS certification, if a pediatric population is served, on duty and immediately available at any time there is a patient in the ASC.

10. The RN who supervises the surgical center shall have documented education and competency in the management of surgical services.

11. A formalized program on in-service training shall be developed and implemented for all categories of nursing personnel, employed or contracted, and shall include contracted employees and those working under a use agreement. Training is required on a quarterly basis related to required job skills.

a. Documentation of such in-service training shall be maintained on-site in the ASC's files. Documentation shall include the:

i. training content;

ii. date and time of the training;

iii. names and signatures of personnel in attendance; and

iv. name of the presenter(s).

12. General staffing provisions for the OR/procedure rooms shall be the following.

a. Circulating duties for each surgical procedure and for any pediatric procedure shall be performed by a licensed RN. The RN shall be assigned as the circulating nurse for one patient at a time for the duration of any surgical procedure performed in the center.

b. Appropriately trained licensed practical nurses (LPNs) and operating/procedure room technicians may perform scrub functions under the supervision of a licensed registered nurse.

c. Staffing for any nonsurgical, endoscopic procedure shall be based upon the level of sedation being provided to the adult patient, the complexity of the procedure, and the assessment of the patient. The role and scope of the nurses staffing the procedure rooms shall be in accordance with the Nurse Practice Act and nursing staff shall only perform duties that are in accordance with the applicable requirements for such personnel set forth in the Nurse Practice Act. A physician shall be required to complete a pre-procedural assessment to determine the suitability of the patient for the planned level of sedation. Depending upon the level of sedation deemed appropriate and administered, at a minimum, the following staffing levels shall be utilized for each nonsurgical, endoscopic procedure.

i. Patient is Unsedated. The OR/procedure room shall be staffed with a single assistant who may be an RN, licensed practical nurse (LPN) or unlicensed assistive personnel (UAP).

ii. Patient Receives Moderate/Conscious Sedation. With moderate/conscious sedation, a single RN may administer the sedation under physician supervision, and such RN may assist only with minor, interruptible technical portions or tasks of the procedure. In accordance with the LSBN, the RN monitoring the patient shall have no additional responsibility that would require leaving the patient unattended or that would compromise continuous monitoring during the procedure.

iii. Complex Endoscopy Procedure (with or without sedation). For any complex endoscopy procedure (e.g. ERCP, EUS/FNA, etc.), there shall be an RN in the operating/procedure room to continuously monitor the patient, and a second RN, LPN or UAP to provide technical assistance to the physician.

NOTE: For purposes of §4567.D.12.c.i-iii, a reference to RN may be substituted by a CRNA or advanced practiced registered nurse. Said nursing staff shall have documentation of knowledge, skills, training, ability and competency of assigned tasks.

iv. Deep Sedation. This level requires a CRNA or anesthesiologist to administer the deep sedation and to monitor the patient. There shall be a second staff person (RN, LPN or UAP) dedicated to provide technical assistance for the endoscopy procedure.

NOTE: At any level of staffing for the nonsurgical, endoscopic procedure described above, if an LPN or UAP is the assigned staff providing assistance, in addition to such LPN or UAP assigned staff in the operating/procedure room, an RN shall be immediately available in the ASC to provide emergency assistance. That RN shall not be assigned to a non-interruptible task during the duration of the procedure.

13. Post-Surgical Care Area. There shall be an RN whose sole responsibility is the post-surgical care of the patient. There shall be at least one other member of the nursing staff in the post-surgical care area(s) onsite and continually available to assist the post-surgical care RN until all patients have been discharged from the ASC.

E. General Personnel Requirements

1. All physicians and ASC employees, including contracted personnel and personnel practicing under a use agreement, shall meet and comply with these personnel requirements.

2. All physicians and ASC employees, including contracted personnel and personnel practicing under a use

agreement, prior to and at the time of employment and annually thereafter, shall be verified to be free of tuberculosis in a communicable state in accordance with the ASC's policies and procedures and current Centers for Disease Control (CDC) and OPH recommendations.

3. All unlicensed staff involved in direct patient care and/or services shall be supervised by a qualified professional employee or staff member.

4. A personnel file shall be maintained within the ASC on every employee, including contracted employees and personnel providing services under a use agreement. Policies and procedures shall be developed to determine the contents of each personnel file. At a minimum, all personnel files shall include the following:

a. an application;

b. current verification of professional licensure;

c. health care screenings as defined by the ASC;

d. orientation and competency verification;

e. annual performance evaluations;

f. criminal background checks for UAPs, prior to offer of direct or contract employment after the effective date of this Rule, as applicable and in accordance with state law. The criminal background check shall be conducted by the Louisiana State Police or its authorized agent; and

g. any other screenings required of new applicants by state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1747 (September 2017).

§4569. Medical Records

A. Each ASC shall make provisions for securing medical records of all media types, whether stored electronically or in paper form. The identified area or equipment shall be secured to maintain confidentiality of records and shall be restricted to staff movement and remote from treatment and public areas.

B. All records shall be protected from loss or damage.

C. The ASC shall have a designated area located within the ASC which shall provide for the proper storage, protection and security for all medical records and documents.

D. The ASC shall develop a unique medical record for each patient. Records may exist in hard copy, electronic format or a combination thereof.

E. ASCs that enter into a use agreement shall integrate the medical records of patients into the medical records of the ASC and shall comply with all requirements of this Section.

F. The ASC shall ensure the confidentiality of patient records, including information in a computerized medical record system, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations and any state laws, rules and regulations.

1. If computerized records are used, the ASC shall develop:

a. a back-up system for retrieval of critical medical records;

b. safeguards/firewalls to prevent unauthorized use and access to information; and

c. safeguards/firewalls to prevent alterations of electronic records.

G. A unique medical record shall be maintained for every patient admitted and/or treated.

H. The medical record cannot become part of any other medical record associated with another entity.

I. The following data shall be documented and included as part of each patient's basic medical record:

1. unique patient identification;

2. admission and discharge date(s) and times;

3. medical and social history;

4. physical examination notes in accordance with medical staff bylaws, policies and procedures;

5. chief complaint or diagnosis;

6. physician's orders;

7. clinical laboratory report(s);

8. pathology report(s), when appropriate;

9. radiological report(s), when appropriate;

10. consultation report(s), when appropriate;

11. medical and surgical treatment regimen;

12. physician progress notes;

13. nurses' records of care provided and medications administered;

14. authorizations, consents or releases;

15. operative report;

16. anesthesia record to include, but not limited to:

a. type of anesthesia used;

b. medication administered;

c. person administering the anesthesia; and

d. post-anesthesia report;

17. name of the treating physician(s), names of surgical assistants, and nursing personnel (scrub and circulator(s));

18. start and end time of the surgery/procedure;

19. a current informed consent for surgery/procedure and anesthesia that includes the following:

a. name of the patient;

b. patient identification number;

c. name of the procedure or operation being performed;

d. reasonable and foreseeable risks and benefits;

e. name of the licensed medical practitioner(s) who will perform the procedure or operation;

f. signature of patient or legal guardian or individual designated as having power of attorney for medical decisions on behalf of the patient;

g. date and time the consent was obtained; and

h. signature and professional discipline of the person witnessing the consent;

20. special procedures report(s);

21. patient education and discharge instructions;

22. a discharge summary, including:

a. physician progress notes and discharge notes; and

23. a copy of the death certificate and autopsy findings, when appropriate.

J. The medical records shall be under the custody of the ASC and maintained in its original, electronic, microfilmed or similarly reproduced form for a minimum period of 10 years from the date a patient is discharged, pursuant to R.S. 40:2144(F)(1). The ASC shall provide a means to view or reproduce the record in whatever format it is stored.

K. Medical records may be removed from the premises for computerized scanning for the purpose of storage. Contracts entered into, for the specific purpose of scanning at a location other than the ASC, shall include provisions addressing how:

1. the medical record shall be secured from loss or theft or destruction by water, fire, etc.; and

2. confidentiality shall be maintained.

L. Medical records may be stored off-site provided:

1. the confidentiality and security of the medical records are maintained; and

2. a 12-month period has lapsed since the patient was last treated in the ASC.

M. Each clinical entry and all orders shall be signed by the physician, and shall include the date and time. Clinical entries and any observations made by nursing personnel shall be signed by the licensed nurse and shall include the date and time.

1. If electronic signatures are used, the ASC shall develop a procedure to assure the confidentiality of each electronic signature, and shall prohibit the improper or unauthorized use of any computer-generated signature.

2. Signature stamps shall not be used.

N. All pertinent observations, treatments and medications given to a patient shall be entered in the nurses' notes as part of the medical record. All other notes relative to specific instructions from the physician shall be recorded.

O. Completion of the medical record shall be the responsibility of the admitting physician within 30 days of patient discharge.

P. All hardcopy entries into the medical record shall be legible and accurately written in ink. The recording person shall sign the entry to the record and include the date and time of entry. If a computerized medical records system is used, all entries shall be authenticated, dated and timed, complete, properly filed and retained, accessible and reproducible.

Q. Written orders signed by a member of the medical staff shall be required for all medications and treatments administered to patients, and shall include the date and time ordered. Verbal orders shall include read-back verification. All verbal orders shall be authenticated by the ordering physician within 48 hours to include the signature of the ordering physician, date and time.

R. The use of standing orders shall be approved by the medical staff, and the standing orders shall be individualized for each patient. Standing orders shall be approved for use by the medical staff on a yearly basis. If standing orders are utilized, the standing orders shall become part of the medical record and include the patient's name, date of surgery and shall be authenticated by the ordering physician's signature, date and time. Any changes to the pre-printed orders shall be initialed by the physician making the entry or change to the pre-printed form. The changes shall be legible, noted in ink (if hard copy), and shall include the date and time.

1. Range orders are prohibited.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1750 (September 2017).

§4571. Other Records and Reports

A. The following indexes, records and registers shall be required of the licensed ASC, including any individual or entity that enters into a use agreement:

1. a patient's register;

2. an operating/procedure room register;

3. a death register;

4. a daily census report of admissions and discharges;

5. records of reportable diseases as required by state and/or federal regulations;

6. a laboratory log denoting laboratory specimens that are sent to pathology:

a. the laboratory log shall include, at a minimum, the following information:

i. the patient's name;

ii. the specimen site; and

iii. the date the specimen was sent for pathology interpretation; and

7. an implant log, when appropriate.

B. Other statistical information shall be maintained to expedite data gathering for specialized studies and audits.

C. Nothing in this Chapter is intended to preclude the use of automated or centralized computer systems or any other techniques provided the regulations stated herein are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1751 (September 2017).

§4573. Quality Assurance and Performance Improvement

A. The governing body shall ensure that there is an implemented, maintained, effective, written, data-driven and ongoing program designed to assess and improve the quality of patient care. This program shall include all services, provided directly or through contract, and those services provided under a use agreement, where applicable.

B. The governing body shall ensure that it allocates sufficient staff, time, information systems and training to implement the Quality Assurance and Performance Improvement (QAPI) Program.

C. The ASC shall ensure there is a written quality assurance plan for assessing and improving quality of care that is focused on high risk, high volume and problem-prone areas, and which specifies the intervals that the ASC shall actively collect data related to the quality indicators. Performance improvement activities shall consider incidence, prevalence and severity of problems and those that can affect health outcomes, patient safety and quality of care. The plan shall describe the system for overseeing and analyzing the effectiveness of monitoring, evaluation and sustained improvement activities. All services related to patient care, including services furnished by a contractor or under a use agreement, shall be evaluated.

D. Nosocomial infections, patient care outcomes, surgical services and other invasive procedures performed in the ASC shall be evaluated as they relate to appropriateness of diagnosis and treatment.

E. The services provided by each licensed practitioner with ASC privileges shall be periodically evaluated to determine whether they are of an acceptable level of quality and appropriateness and in accordance with medical staff bylaws/rules and regulations.

F. Quality assurance and performance improvement shall include monitoring of in-line gases.

G. The QAPI program shall monitor, identify and develop a plan for elimination of medication errors and adverse patient events.

H. Corrective actions to problems identified through the QAPI program with on-going monitoring for sustained corrective action shall be documented. All QAPI data shall be documented and remain within the ASC. Staff education and training related to the correction of problems shall be documented.

I. The number and scope of distinct QAPI improvement projects conducted annually shall reflect the scope and complexity of the ASC's services and operations.

J. The ASC shall document the projects that are being conducted. The documentation, at a minimum, shall include:

1. the reason(s) for implementing the project; and

2. a description of the project's results.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1751 (September 2017).

Subchapter F. Safety, Sanitization and Emergency Preparedness

§4575. General Provisions

A. The ASC shall have policies and procedures, approved and implemented by the medical staff and governing body, that address provisions for:

1. sanitizing, disinfecting and sterilizing supplies, equipment and utensils; and

2. the safe use of cleaning supplies and solutions that are to be used and the directions for use, including:

a. terminal cleaning of the OR/procedure rooms; and

b. cleaning of the OR/procedure rooms between surgical and nonsurgical procedures.

B. Policies and procedures shall be developed, implemented and approved by the ASC's governing body for the types and numbers of sterilizing equipment and autoclaves sufficient to meet the surgical sterilization needs of the ASC.

1. Procedures for the proper use of sterilizing equipment for the processing of various materials and supplies shall be in writing, according to manufacturer's recommendations, and readily available to personnel responsible for the sterilizing process.

2. All sterilization monitoring logs shall be maintained within the ASC for a minimum of 18 months.

C. All steam sterilizing equipment shall have live bacteriological spore monitoring performed at a frequency according to the manufacturer's instructions.

1. If tests are positive, a system shall be in place to recall supplies that have tested substandard in accordance with the ASC's policies and procedures set forth by the ASC's governing body.

D. All ethylene oxide sterilizing equipment shall have live bacteriological spore monitoring performed with each load and according to manufacturer's recommendation. There shall be ventilation of the room used for this sterilization to the outside atmosphere. There shall be a system in place to monitor trace gases of ethylene oxide with a working alert system which is tested and documented daily.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1752 (September 2017).

§4577. Infection Control

A. The ASC shall maintain an infection control program that minimizes infections and communicable diseases through prevention, investigation and reporting of infections. This program shall include all contracted services and those services provided under a use agreement.

B. The ASC shall provide a functional and sanitary environment for the provision of surgical or endoscopy services, if provided, by adopting and adhering to professionally accepted standards of practice. The ASC shall have documentation that the infection control program was considered, selected and implemented based on nationally recognized infection control guidelines.

C. The infection control program shall be under the direction of a designated and qualified professional. The ASC shall determine that the individual selected to lead the infection control program has had documented training in the principles and methods of infection control. The individual shall maintain his/her qualifications through ongoing education and training, which can be demonstrated by participation in infection control courses or in local and national meetings organized by a nationally recognized professional infection control society.

D. The ASC shall develop, with the approval of the medical director and the governing body, policies and procedures for preventing, identifying, reporting, investigating, controlling and immediately implementing corrective actions relative to infections and communicable diseases of patients and personnel. At a minimum, the policies shall address:

1. hand sanitizers and hand hygiene;
2. use of all types of gloves;
3. surgical scrub procedures;
4. linen cleaning and reuse;
5. waste management;
6. environmental cleaning;
7. reporting, investigating and monitoring of surgical infections;
8. sterilization and cleaning procedures and processes;
9. single use devices;
10. disinfecting procedures and processes;
11. breaches of infection control practices; and
12. utilization of clean and dirty utility areas.

E. The ASC shall have policies and procedures developed and implemented which require immediate reporting, according to the latest criteria established by the Centers for Disease Control, Office of Public Health and the Occupational Safety and Health Administration (OSHA), of the suspected or confirmed diagnosis of a communicable disease.

F. The ASC shall maintain an infection control log of incidents related to infections. The log is to be maintained within the ASC for a minimum of 18 months.

G. Any employee with a personal potentially contagious/ or infectious illness shall report to his/her immediate supervisor and/or director of nursing for possible reassignment or other appropriate action to prevent the disease or illness from spreading to other patients or personnel.

1. Employees with symptoms of illness that have the potential of being potentially contagious or infectious (i.e. diarrhea, skin lesions, respiratory symptoms, infections, etc.) shall be either evaluated by a physician and/or restricted from working with patients during the infectious stage.

H. Provisions for isolation of patients with a communicable or contagious disease shall be developed and implemented according to ASC policy and procedure.

I. Provisions for transfer of patients from the ASC shall be developed and implemented according to ASC policy and procedure.

J. The ASC shall develop a system by which potential complications/infections that develop after discharge of a patient from the ASC are reported, investigated and monitored by the infection control officer.

K. Procedures for isolation techniques shall be written and implemented when applicable.

L. The ASC shall have a written and implemented waste management program that identifies and controls wastes and hazardous materials to prevent contamination and the spread of infection within the ASC. The program shall comply with all applicable laws and regulations governing wastes and hazardous materials and the safe handling of these materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1752 (September 2017).

§4579. Laundry Handling and Sanitation

A. The ASC shall be responsible for ensuring the proper handling, cleaning, sanitizing and storage of linen and other washable goods whether provided by the ASC or provided by a contracted vendor. All linen used in the ASC shall be of sufficient quantity to meet the needs of the patients.

B. Laundry services shall be provided either in-house or through a contracted commercial laundry service in accordance with the ASC's policies and procedures as set forth by the governing body.

1. Contracted Laundry Service

a. If laundry service is contracted, the ASC shall assess the cleaning and sanitizing processes that are used by the commercial laundry service.

2. In-House Laundry Service

a. If laundry services are provided in-house, policies and procedures shall be developed which follow manufacturer's recommended guidelines for water temperature, the method for cleaning and sanitizing reusable laundry and the type of cleaning products utilized to prevent the transmission of infection through the ASC's multi-use of these washable goods.

b. The water temperature shall be monitored and documented on a daily use log and maintained for a minimum of 18 months.

C. Procedures shall be developed for the proper handling and distribution of linens to minimize microbial contamination from surface contact or airborne deposition.

D. Cross contamination of clean and dirty linen shall be prevented. Provisions shall be made for the separation of clean and soiled linen. All contaminated laundry shall be handled according to the ASC's written protocols in accordance with current applicable OSHA and CDC guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1753 (September 2017).

§4581. Emergency Preparedness and Emergency Procedures

A. Disaster and emergency plans shall be developed by the governing body, and updated annually, which are based on a risk assessment using an all hazards approach for both internal and external occurrences. Disaster and emergency plans shall include provisions for persons with disabilities.

B. The ASC shall develop and implement policies and procedures based on the emergency plan, risk assessment and communication plan which shall be reviewed and updated at least annually. Such policies shall include a system to track on duty staff and sheltered patients, if any, during the emergency.

C. The ASC shall develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Patient care shall be well-coordinated within the ASC, across health care providers and with state and local public health departments and emergency systems.

D. The ASC shall develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of emergency procedures. Such training shall be provided at least annually.

E. Additional Requirements

1. Each ASC shall post exit signs and diagrams conspicuously through the facility.

2. Flash lights or battery operated lamps for emergency use shall be available for ASC personnel and kept in operational condition.

3. The ASC shall ensure that emergency equipment is:

a. immediately available for use during emergency situations;

b. appropriate for the ASC's patient population; and

c. maintained by appropriate personnel.

4. The ASC shall have written policies and procedures that address the availability and relevant use of the following emergency equipment in the ASC's operating/procedure rooms sufficient in number to handle multiple simultaneous emergencies:

a. emergency call system;

b. oxygen;

c. mechanical ventilatory assistance equipment, including:

i. airways;

ii. manual breathing bag; and

iii. ventilator;

d. cardiac defibrillator;

e. cardiac monitoring equipment;

f. tracheostomy set;

g. laryngoscope and endotracheal tubes;

h. suction equipment; and

i. any other emergency medical equipment and supplies specified by the medical staff and approved by the governing body for treatment of all age groups serviced in the ASC.

5. The ASC shall have an operable backup generator of sufficient size to support and maintain necessary life-sustaining medical equipment.

a. A sufficient amount of fuel shall be maintained to ensure the operation of the generator for at least four hours to maintain:

i. temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;

ii. emergency lighting; and

iii. fire detection, extinguishing and alarm systems.

6. The ASC is responsible for:

a. developing and implementing policies and procedures for the safe emergency transfer of patients from the ASC in the event that an emergency impacts the ASC's ability to provide services;

b. developing policies that address what types of emergency procedures, equipment and medications shall be available; and

c. providing trained staff to sustain the life of the patient prior to the transfer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1753 (September 2017).

§4583. Inactivation of License due to a Declared Disaster or Emergency

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

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

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

b. the ASC intends to resume operation as an ASC in the same service area;

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

2. the ASC resumes operating in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

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

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

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

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

1. The ASC shall submit a written license reinstatement request to HSS 60 days prior to the anticipated date of reopening.

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

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

c. The ASC shall submit the following:

i. a copy of the approval letter of the architectural facility plans from the Office of the State Fire Marshal (OSFM) and any other office/entity designated by the department to review and approve the facility's architectural plans;

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

iii. a copy of the on-site health inspection report with approval of occupancy from OPH.

2. The ASC resumes operating in the same service area within one year.

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

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

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

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the ASC license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1754 (September 2017).

§4585. Inactivation of License due to a Non-Declared Emergency or Disaster

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

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

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

b. the facility intends to resume operation as an ASC in the same service area;

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

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

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

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

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

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

C. Upon the ASC's receipt of the department's approval of request to inactivate the license, the ASC shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the ASC to OSFM and OPH as required.

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

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

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

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

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

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

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

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

H. The provisions of this Section shall not apply to an ASC which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the ASC license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1754 (September 2017).

Subchapter G. Physical Environment

§4587. General Requirements

A. The standards in this Subchapter shall apply to any ASC constructed after the effective date of this rule, or an ASC that makes alterations, additions or substantial rehabilitation to an existing ASC or adaptation of an existing building to create an ASC. Cosmetic changes to the ASC such as painting, flooring replacement or minor repairs shall not be considered an alteration or substantial rehabilitation.

Exception: For those applicants for ASC licensure who received plan review approval from the OSFM before the effective date of the promulgation of this Rule, or who have begun construction or renovation of an existing building before the effective date of the promulgation of this Rule, the physical environment requirements of §4587 shall not apply.

B. An applicant for an ASC license shall furnish one complete set of architectural plans and specifications to the entity/office designated by the department to review and approve the facility's architectural plans and the Office of State Fire Marshal.

1. The office designated by the department to review and approve architectural drawings and specifications and the Office of State Fire Marshal shall review and approve the

Life Safety Code plans before construction is allowed to begin.

2. When the plans and specifications have been reviewed and all inspections and investigations have been made, the applicant will be notified whether the plans for the proposed ASC have been approved.

C. No alterations, other than minor alternations, shall be made to existing facilities without the prior written approval of, and in accordance with, architectural plans and specifications approved in advance by the department, or its designee, and the Office of State Fire Marshal.

D. All new construction, additions and renovations, other than minor alterations, shall be in accordance with the specific requirements of the Office of State Fire Marshal and the department, or its designee, who shall be responsible for the review and approval of architectural plans. Plans and specifications submitted to these offices shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer and shall include scaled architectural plans stamped by an architect.

E. All designs and construction shall be in accordance with the provisions of LAC Title 51, *Public Health—Sanitary Code*.

F. Facility within a Facility

1. If more than one health care provider occupies the same building, premises or physical location, all treatment facilities and administrative offices for each health care facility shall be clearly separated from the other by a clearly defined and recognizable boundary.

2. There shall be clearly identifiable and distinguishable signs posted inside the building as well as signs posted on the outside of the building for public identity of the ASC. Compliance with the provisions of R.S. 40:2007 shall be required.

3. An ASC that is located within a building that is also occupied by one or more other businesses and/or other healthcare facilities shall have all licensed spaces and rooms of the ASC contiguous to each other and defined by cognizable boundaries.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1755 (September 2017).

§4589. General Appearance and Space Requirements

A. The ASC shall be constructed, arranged and maintained to ensure the safety and well-being of the patients and the general public it serves.

B. The ASC shall have a minimum of two operating and/or procedure rooms and a minimum of one post-anesthesia recovery room to meet the needs of the patients being served. In addition to the operating and/or procedure rooms and post-anesthesia recovery rooms, the ASC may also have one or more treatment rooms.

C. The location of the operating and procedure rooms within the ASC, and the access to it, shall conform to professionally-accepted standards of practice, particularly for infection control, with respect to the movement of people, equipment and supplies in and out of the operating or procedure rooms.

1. The operating and procedure rooms' temperature and humidity shall be monitored and maintained in accordance with accepted standards of practice and documented on a daily use log that is maintained for a minimum of 18 months.

D. The ASC shall have a separate waiting area sufficient in size to provide adequate seating space for family members and/or guests of the patient.

E. The ASC shall meet the following requirements including, but not limited to:

1. a sign shall be posted on the exterior of the ASC that can be viewed by the public which shall contain, at a minimum, the "doing business as" name that is on the ASC's license issued by the department;

2. signs or notices shall be prominently posted in the ASC stipulating that smoking is prohibited in all areas of the ASC;

3. policies and procedures shall be developed for maintaining a clean and sanitary environment at all times;

4. there shall be sufficient storage space for all supplies and equipment. Storage space shall be located away from foot traffic, provide for the safe separation of items, and prevent overhead and floor contamination;

5. all patient care equipment shall be clean and in working order. Appropriate inspections of patient care equipment shall be maintained according to manufacturer's recommendations and ASC policies and procedures;

6. designated staff areas shall be provided for surgical and other personnel to include, but not be limited to:

a. dressing rooms;

b. toilet and lavatory facilities including soap and towels; and

c. closets or lockers to secure the personal belongings of the staff;

7. adequate toilet facilities shall be provided for patients and/or family which maintain proper ventilation, properly functioning toilet(s) in each toilet facility, hot and cold water in all lavatories, soap and towels;

8. a private area shall be provided for patients to change from street clothing into hospital gowns and to prepare for surgery;

9. provisions shall be made for securing patients' personal effects;

10. all doors to the outside shall open outward and be provided with self-closing devices;

11. all stairways, ramps and elevators shall be provided with non-skid floor surfaces and all stairways shall have handrails on both sides;

12. an effective and on-going pest control program shall be maintained to ensure the ASC is free of insects and rodents;

13. proper ventilation, lighting and temperature controls shall be maintained in all areas of the ASC;

14. waste products shall be stored in covered containers of a capacity and type approved by the Office of Public Health, and disposal of such wastes shall be in a manner approved by the Office of Public Health;

15. each ASC shall provide for a covered entrance, well-marked, and illuminated for drop off and/or pick up of patients before and after surgery. The covered entrance shall extend to provide full overhead coverage of the entire transporting automobile and/or ambulance to permit protected transfer of patients. Vehicles in the loading area should not block or restrict movement of other vehicles in the drive or parking areas immediately adjacent to the ASC;

16. the ASC shall provide a separate room for meetings to ensure privacy between medical staff and family members;

17. patient and family parking spaces shall be provided adjacent to the ASC that are in proportion to the number of pre- and post-operative stations;

18. adequate staff and physician parking spaces shall be available.

F. Surgical Area

1. The surgical area shall be comprised of a minimum of two operating rooms. In new construction and renovation, each operating room shall have a minimum clear floor area of 250 square feet with a minimum clear area of 15 feet between fixed cabinets and built-in shelves.

2. The surgical/ procedure room area shall be located in a segregated and restricted section of the ASC and be removed from general lines of traffic of both visitors and other ASC personnel, and from other departments so as to prevent traffic through them.

3. The surgical/procedure room area shall be defined by the following unrestricted, semi-restricted and restricted areas.

a. Unrestricted Area. This area shall include a central control point established to monitor the entrance of patients, personnel and materials into the restricted areas. Street clothes are permitted in this area, and traffic is not limited.

b. Semi-Restricted Area. This area shall include the peripheral support areas of the surgical center which includes storage areas for clean and sterile supplies, work areas for storage and processing of instruments and corridors leading to the restricted areas of the surgical center. Staff attire appropriate for the semi-restricted area shall be defined in policy. Traffic in this area is limited to authorized personnel and patients.

c. Restricted Area. This area shall include operating and procedure rooms, the clean core and scrub sink areas. Surgical attire, including hair coverings and masks, shall be required in accordance with professionally accepted standards.

4. The operating/procedure room(s) shall be appropriately equipped to safely provide for the needs of the patient and in accordance with accepted clinical practices. The operating/procedure room(s) shall consist of a clear and unobstructed floor area to accommodate the equipment and personnel required, allowing for aseptic technique. Only one surgical case or procedure can be performed in an operating/procedure room at a time.

5. There shall be scrub-up facilities in the surgical center which provide hot and cold running water and that are equipped with knee, foot or elbow faucet controls.

6. Space for supply and storage of medical gases, including space for reserve cylinders shall be provided. Provisions shall be made for the secure storage of all medical gas cylinders to prevent tipping and falling. Policies and procedures shall be developed for testing of medical gases.

7. Equipment storage room(s) shall be provided for equipment and supplies used in the operating/procedure room(s). Equipment storage room(s) shall be located within the semi-restricted area.

a. Stretchers shall be stored in an area that is convenient for use, out of the direct line of traffic and shall not create an obstacle for egress.

8. There shall be emergency resuscitation equipment and supplies including a defibrillator and tracheostomy set available to both surgery and post-anesthesia recovery areas.

a. The numbers of crash carts (emergency medical supply carts) in the ASC should be based on current professionally accepted standards of practice adopted from a national association or organization and defined in policies and procedures, and shall be immediately available to both surgery and post-anesthesia recovery areas.

G. Post-Anesthesia Recovery Area

1. Rooms for post-anesthesia recovery in an ASC shall be provided in accordance with the functional program and sufficient in size and equipment to efficiently and safely provide for the needs of the staff and patients. There shall be at least one separate post-anesthesia recovery area within the ASC.

2. Provisions to ensure patient privacy such as cubicle curtains shall be made.

3. The post-anesthesia recovery area shall be accessible directly from the semi-restricted area and adjacent to the operating/procedure rooms.

4. A nurse's station(s) shall be located within the post-anesthesia recovery area and shall be centrally located with complete visualization of all patients in the post-anesthesia recovery area.

a. Each nurse's station or nursing care area shall be equipped to perform nursing functions to include:

i. desk space;

ii. chart racks and/or electronic medical record equipment;

iii. telephone(s) or other communication equipment; and

iv. lockable cupboard, closet or room designed for the storage and preparation of patient medications.

b. A double-locked storage shall be provided for controlled substances. Separate areas shall be provided for the separation of internal and external drugs and medications. This area shall be well lighted with temperature controls and accessible only to authorized personnel. A separate refrigerator for pharmaceuticals shall be provided and monitored regularly for documented compliance with temperature controls. A sink with running hot and cold water and sufficient work area shall also be provided in the area of drug preparation.

5. Hand washing station(s) shall be available in the post-anesthesia recovery area.

6. The post-anesthesia recovery area shall have a minimum of 80 square feet provided for each patient in a lounge chair/stretcher.

H. There shall be sufficient space between and around lounge chairs/stretchers and between fixed surfaces and lounge chairs/stretchers to allow for nursing and physician access to each patient.

I. General and individual office(s) for business transactions, records and administrative and professional staff shall be provided within the ASC. Space for private patient interviews relating to admission shall be provided within the ASC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1755 (September 2017).

Chapter 46. Health Care Facility Sanctions

Subchapter A. General Provisions

§4601. Introduction

A. The purpose of this Chapter is to:

1. provide for the development, establishment and enforcement of statewide standards for the imposition of sanctions pursuant to state statutes against health care facilities in the state of Louisiana which have violations of federal or state law or statutes, licensure standards and requirements, certification requirements, or Medicaid requirements;

2. specify criteria as to when and how each sanction is to be applied;

3. specify the severity of the sanctions to be used in the imposition of such sanctions;

4. develop the procedure and requirements for applying each sanction;

5. provide for an administrative reconsideration process as well as an appeal procedure, including judicial review; and

6. provide for the administration of the Nursing Home Residents' Trust Fund and the Health Care Facility Fund.

B. This Chapter shall not apply to any individual health care provider who is licensed or certified by one of the boards under the Department of Health and Hospitals. These boards include, but are not limited to:

1. Board of Pharmacy;

2. Board of Physical Therapy;

3. Board of Licensed Medical Examiners;

4. Board of Dentistry;

5. Board of Podiatry; and

6. Board of Optometrists.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3077 (November 2013).

§4603. Definitions

Administrative Reconsideration—for purposes of this Chapter, also known as informal reconsiderations.

Class A Violation—a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to a client. Examples of *class A violations* include, but are not limited to:

1. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in the death of a client; or

2. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in serious harm to a client.

Class B Violation—a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created which results in the substantial probability of death or serious physical or mental harm to a client. Examples of *class B violations* include, but are not limited to:

1. medications or treatments improperly administered or withheld;

2. lack of functioning equipment necessary to care for a patient or client;

3. failure to maintain emergency equipment in working order;

4. failure to employ a sufficient number of adequately trained staff to care for clients; or

5. failure to implement adequate infection control measures.

Class C Violation—a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client. Examples of *class C violations* include, but are not limited to:

1. failure to perform treatments as ordered by the physician, including the administration of medications;

2. improper storage of poisonous substances;

3. failure to notify the physician and family of changes in the condition of a patient or client;

4. failure to maintain equipment in working order;

5. inadequate supply of needed equipment;

6. lack of adequately trained staff necessary to meet a patient's or client's needs; or

7. failure to protect patients or clients from personal exploitation including, but not limited to, sexual conduct involving facility staff and a patient or client.

Class D Violation—a violation of a rule or regulation related to administrative and reporting requirements that do not directly threaten the health, safety, rights, or welfare of a client. Examples of *class D violations* include, but are not limited to:

1. failure to submit written reports of accidents;

2. failure to timely submit a plan of correction;

3. falsification of a record; or

4. failure to maintain a patient's or client's financial records as required by rules and regulations.

Class E Violation—a violation that occurs when a facility fails to submit a statistical or financial report in a timely manner as required by rule or regulation.

Client–an individual receiving services from a health care facility.

CMS—the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Department or *DHH*—the Louisiana Department of Health and Hospitals.

Desk Review—Health Standards Section's (HSS) procedure for conducting administrative reconsiderations of sanctions in which a panel of HSS employees, who were not involved in the decisions to cite the deficiencies that were the basis of the sanction or impose the sanction, reviews the documentation submitted by the facility and the information on which the sanction was based and determines whether the sanction was appropriate. Oral presentations are not scheduled unless requested.

Devolutive Appeal—an appeal that does not suspend the execution of the administrative sanction pending the outcome of the appeal.

Division of Administrative Law (DAL)—the Louisiana Department of State Civil Service, *Division of Administrative Law*, or its successor.

Health Care Facility or *Facility*—any health care provider or entity licensed or certified by DHH. In other laws, statues and regulations, this entity may be referred to as a provider, agency, clinic, residential unit, or home. A *health care facility* shall include, but not be limited to a/an:

1. abortion clinic;

2. adult brain injury facility;

3. adult day health care agency;

4. adult residential care provider (ARCP);

5. ambulatory surgical center;

6. case management agency;

7. behavioral health service provider;

8. crisis receiving center;

9. emergency medical services provider;

10. end stage renal disease (ESRD) treatment facility;

11. forensic supervised transitional residential and aftercare facility;

12. supplier of portable x-ray services;

13. home and community-based services (HCBS) provider;

14. home health agency;

15. hospice agency;

16. hospital;

17. intermediate care facility for persons with developmental disabilities (ICF-DD);

18. mental health clinic;

19. mental health center;

20. mental health rehabilitation agency;

21. non-emergency medical transportation agency;

22. nursing facility;

23. rural health clinic;

24. pain management clinic;

25. pediatric day health care (PDHC) facility;

26. psychiatric rehabilitation treatment facility (PRTF);

27. substance abuse/addiction treatment facility; and

28. therapeutic group home (TGH).

HSS—the Department of Health and Hospitals, Office of Management and Finance, Health Standards Section.

Licensee—the person, partnership, company, corporation, association, organization, professional entity, or other entity to whom a license is granted by the licensing agency, and upon whom rests the ultimate responsibility and authority for the conduct of, and services provided by the facility.

Louisiana Administrative Procedure Act (APA)—R.S. 49:950 et seq.

New Admission—any individual admitted to a facility or a new client receiving services from the facility after the facility receives notice of the sanction and on or after the effective date of the sanction as listed in the sanction notice. A client who was admitted prior to the effective date of the sanction and taking temporary leave before, on or after the effective date of the sanction is not considered a *new admission* upon return to the facility.

Repeat Violation—either of the following:

1. the existence of the violation is established as of a particular date and it is one that may be reasonably expected to continue until corrective action is taken. The department may elect to treat the cited continuing violation as a *repeat violation* subject to appropriate sanction for each day following the date on which the initial violation is established until such time as there is evidence that the violation has been corrected; or

2. the existence of a violation is established and another violation that is the same or substantially similar to the cited violation occurs within 18 months. The second and all similar violations occurring within an 18-month time period will be considered as repeat violations and sanctioned accordingly.

Sanction—any adverse action imposed on a facility by the department pursuant to its statutory or regulatory authority for a violation of a statute, law, rule or regulation. For purposes of this Rule, *sanction* does not include the following:

1. any adverse action that may be applied to a facility by the statewide management organization of the Louisiana Behavioral Health Partnership or its successor, or by a contracted coordinated care network with the Bayou Health program or its successor;

2. any adverse action that may be applied to a facility by an agency of the federal government or another state agency;

3. a deficiency; or

4. an immediate jeopardy determination.

Secretary—the *secretary* of DHH or his/her designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3077 (November 2013).

Subchapter B. Sanctions and Standards for the Imposition of Sanctions

§4611. General Provisions

A. Any health care facility found to be in violation of any state or federal statute, regulation, or any department rule, adopted in accordance with the APA, governing the administration and operation of the facility may be sanctioned as provided in this Chapter.

B. Unless otherwise prohibited by federal law or regulation, the department may impose one or more of the following sanctions:

1. civil fine(s);

2. denial of Medicaid payment with respect to any individual admitted to, or provided services by, a facility;

3. denial of new admissions into the facility or by the provider;

4. removal from the freedom of choice list;

5. transfer of clients receiving services;

6. suspension of license;

7. monitoring;

8. special staffing requirements;

9. temporary management;

10. revocation of license;

11. denial of license renewal; or

12. any and all sanctions allowed under federal or state law or regulations, including but not limited to:

a. sanctions authorized under the medical assistance programs integrity law (MAPIL), pursuant to R.S. 46:437.1 et seq.;

b. the surveillance and utilization review systems (SURS) rule, pursuant to LAC 50:I, Chapter 41; or

c. any successor statutes or rules.

C. Considerations. When determining whether to impose a sanction, the department may consider some or all of the following factors:

1. whether the violations pose an immediate threat to the health or safety of the client(s);

2. the duration of the violation(s);

3. whether the violation, or one that is substantially similar, has previously occurred during the last three consecutive surveys;

4. the facility's history of survey compliance;

5. the sanction most likely to cause the facility to come into compliance in the shortest amount of time;

6. the severity of the violation if it does not pose an immediate threat to health and safety;

7. the "good faith" exercised by the facility in attempting to stay in compliance;

8. the financial benefit to the facility of committing or continuing the violation;

9. whether the violation is a repeat violation;

10. whether the facility interfered or hindered the department's investigation or survey process;

11. whether the facility has the governance or institutional control to maintain compliance; and

12. such other factors as the department deems appropriate.

D. The department shall determine whether a violation is a repeat violation and sanction the provider accordingly.

E. The department reserves the right to issue more than one sanction for each violation committed by a facility.

F. Any facility sanctioned under this Rule and found to have a violation that poses a threat to the health, safety, rights, or welfare of a client may have additional actions, such as criminal charges, brought against it under another applicable law, statute or regulation.

G. Unless otherwise provided for in state law or statute, if the secretary determines that the violations committed by the facility pose an imminent or immediate threat to the health, welfare or safety of any client receiving services, the imposition of the sanction may be immediate and may be enforced during the pendency of the administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3078 (November 2013).

§4613. Civil Fines

A. Class A Violations

1. Civil fines for class A violations shall not exceed $2,500 for the first violation and shall not exceed $5,000 per day for repeat violations.

2. The aggregate fines assessed for class A repeat violations shall not exceed $20,000 in any one calendar month.

B. Class B Violations

1. Civil fines for class B violations shall not exceed $1,500 for the first violation and shall not exceed $3,000 per day for repeat violations.

2. The aggregate fines assessed for class B repeat violations shall not exceed $15,000 in any one calendar month.

C. Class C Violations

1. Civil fines for class C violations shall not exceed $1,000 for the first violation and shall not exceed $2,000 per day for repeat violations.

2. A facility may elect to pay 50 percent of the civil fine imposed for a class C violation in exchange for waiving its right to an administrative reconsideration and appeal if it submits, and HSS receives, the following within 30 days of the facility's receipt of the civil fine notice:

a. payment of 50 percent of the civil fine imposed; and

b. the facility's written waiver of the right to an administrative reconsideration and appeal on the form provided by DHH.

D. Class D Violations

1. Civil fines for class D violations shall not exceed $100 per day for the first violation and shall not exceed $250 per day for repeat violations.

E. Class E Violations

1. Civil fines for class E violations shall not exceed $50 for the first violation and shall not exceed $100 for repeat violations.

F. Determination of the Amount of Civil Fines

1. In establishing the amount of civil fines to be imposed against the provider, the department may consider:

a. all relevant aggravating circumstances, including, but not limited to:

i. whether the violation resulted from intentional or reckless conduct by the provider;

ii. the pervasiveness of the violation;

iii. the duration of the violation; and/or

iv. the extent of actual or potential harm to clients; and

b. all relevant mitigating circumstances, including, but not limited to:

i. whether the provider had taken steps to prevent the violation; and/or

ii. whether the provider had implemented an effective corporate compliance program prior to the violation.

2. The aggregate fines assessed for any class C, D and E violations shall not exceed $5,000 in any one calendar month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3079 (November 2013).

§4615. Denial of Medicaid Payment

A. The department may impose the sanction of "denial of Medicaid payment" with respect to any individual admitted to or provided services by a facility for any violation of statute, rule or regulation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to a resident, patient or client;

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death or serious physical or mental harm to a resident, patient or client will result from the violation;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client; or

4. more than two substantiated complaint surveys in two years.

B. This sanction shall remain in effect until:

1. the department determines that the facility is in compliance with the requirements; and

2. the department has provided notice to the facility of its compliance and the lifting of the sanction.

C. The department has the discretion to apply this sanction to new admissions only.

D. The facility shall notify all clients and all potential new clients of the imposition of this sanction.

E. The facility is prohibited from seeking reimbursement from a Medicaid recipient for services provided during the imposition of this sanction.

F. This sanction may be used in conjunction with other sanctions including, but not limited to, removal from the freedom of choice list and transfer of clients to another facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3079 (November 2013).

§4617. Denial of New Admissions

A. The department may impose the sanction of "denial of new admissions." Denial of new admissions prohibits a new client from being admitted to a facility or any new client from receiving services from a facility during the term of the sanction.

B. The department may impose the sanction of denial of new admission for any violation of statute, rule or regulation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to a resident, patient or client;

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death or serious physical or mental harm to a resident, patient or client will result from the violation;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client; or

4. more than two substantiated complaint surveys in two years.

C. The facility must provide notice of the imposition of the sanction and its effective date to all potential new admissions and to health care providers who have transferred, or it reasonably believes may transfer, a client into the sanctioned facility.

D. The sanction shall remain in effect until:

1. the department determines that the facility is in compliance with the requirements; and

2. the facility has received notice of its compliance and the lifting of the sanction.

E. This sanction may be used in conjunction with other sanctions, including removal from the freedom of choice list.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3080 (November 2013).

§4619. Removal from the Freedom of Choice List

A. The department may impose the sanction of "removal from the freedom of choice list" to a facility placed on a freedom of choice list. DHH may impose this sanction for any violation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to a resident, patient or client;

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death or serious physical or mental harm to a resident, patient or client;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client; or

4. more than two substantiated complaint surveys in two years.

B. The sanction of removal from the freedom of choice list shall remain in effect until:

1. the department determines that the facility is in compliance with the requirements; and

2. the facility has received notice of its compliance and the lifting of the sanction.

C. This sanction may be used in conjunction with another sanction, including denial of new admissions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3080 (November 2013).

§4621. Transfer of Clients Receiving Services

A. The department may impose the sanction of "transfer of clients receiving services" provided by a facility. This sanction may be imposed for any violation of statute, rule or regulation including but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to a resident, patient or client;

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death, serious physical harm or mental harm to a resident, patient or client;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client;

4. when there is an imminent threat to the health, safety and welfare of the facility's clients; or

5. more than two substantiated complaint surveys in two years.

B. This sanction may be imposed in conjunction with any other sanctions including, but not limited to, the following:

1. license suspension;

2. monitoring;

3. license revocation; and/or

4. denial of Medicaid payment with respect to any individual admitted to or provided services by a facility.

C. The sanction of transfer of clients shall remain in effect until:

1. the department determines that the facility is in compliance with the requirements; and

2. the facility has received notice of its compliance and the lifting of the sanction from the department.

D. The facility shall:

1. assist in the safe and orderly transfer of its clients to other facilities;

2. prohibit any action(s) that would prevent or impede the transfer of its clients;

3. maintain the needs of its clients until the transfer is complete; and

4. update the client's treatment plan and other records as necessary in preparation for the transfer or discharge of its client.

E. The facility, with assistance from the department, shall notify the clients of the transfer sanction and the transfer procedures. The department will identify similar facilities in close proximity to accommodate the clients being transferred.

F. At a minimum, the facility shall provide, at the facility's expense:

1. a copy of the current active treatment plan;

2. current orders; and

3. any other pertinent medical records to the facility accepting its transferred clients in an effort to achieve the seamless continuum of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3080 (November 2013).

§4623. License Suspension

A. Unless otherwise provided by federal or state law, the department may impose a suspension of a license if the department determines that the violations committed by the facility pose an imminent or immediate threat to the health, welfare or safety of its clients.

B. The sanction of license suspension shall remain in effect until the department determines that the facility is in compliance with the requirements, and has provided notice of compliance and the lifting of the suspension to the facility.

C. The imposition or lifting of the suspension does not affect the imposition of other sanctions.

D. If the license suspension is reversed during the appeal process, the facility's license will be re-instated or granted upon the payment of any licensing fees, outstanding sanctions or other fees due to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3081 (November 2013).

§4625. Monitoring

A. The department may impose the sanction of monitoring. The facility is responsible for the cost of the monitoring.

B. Monitoring may be imposed:

1. when the facility is noncompliant with any law, statute, rule or regulation and is in the process of correcting deficiencies to achieve such compliance;

2. when the facility was previously found to be noncompliant with any law, statute, rule or regulation, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

3. when the department has reason to question the compliance of the facility with any law, statute, rule or regulation;

4. while a facility is instituting improvements; or

5. while a facility is in the process of closing.

C. Monitoring may include:

1. periodic unannounced visits by a surveyor;

2. on-site full time monitoring by surveyors to observe all phases of the facility's operations; or

3. on-site visits as deemed necessary by the department.

D. The department may maintain and utilize a specialized team of professionals, such as an attorney, auditor or health care professional, for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against facilities being monitored.

E. The sanction of monitoring shall remain in effect until:

1. the department determines that the facility is in compliance with the requirements and will remain in compliance with such requirements; and

2. the facility has received notice of compliance and the lifting of the sanction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3081 (November 2013).

§4627. Special Staffing Requirements

A. The department may require special staffing for the facility.

B. Special staffing may include, but is not limited to:

1. a consultant on client assessments or care planning;

2. an additional licensed nurse to provide treatments;

3. a consultant dietician;

4. a consultant pharmacist; or

5. medical records practitioner.

C. The department may impose the sanction of special staffing for any violation of statute, rule or regulation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to a resident, patient or client;

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death or serious physical or mental harm to a resident, patient or client will result from the violation;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/ or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client;

4. at the discretion of the department, 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 the deficiencies; or

5. when there is an imminent threat to the health, safety and welfare of the facility's clients.

D. Any special staffing shall meet the requirements outlined in the letter from the department and be:

1. in addition to the staff already hired;

2. time limited;

3. compensated by the facility; and

4. approved by the department.

E. The sanction shall remain in effect until the department determines the facility:

1. is in compliance with requirements; and

2. has received notice of its compliance and the lifting of the sanction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3081 (November 2013).

§4629. Temporary Management

A. The department may require the immediate appointment of a temporary manager, at the facility's expense, to:

1. oversee the operation of the facility; and

2. assure the health and safety of the facility's clients.

B. Temporary management may be imposed for any violation of statute, rule or regulation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or

operation of a facility which results in death or serious harm to a resident, patient or client;

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death, serious physical harm or mental harm to a resident, patient or client;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, rights, or welfare of a client;

4. 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 the deficiencies;

5. when a licensee or its management has abandoned its clients;

6. when a licensee or its management has abandoned the facility which jeopardizes the health, safety and/or welfare of the facility's clients; or

7. when a facility is closing within 30 calendar days and the department has reasonable cause to believe that inadequate arrangements have been made to relocate the clients and may result in adverse effects to the clients.

C. This sanction shall be enforced and in effect during the pendency of the facility's administrative reconsideration and/or appeal.

D. Cost of Temporary Management

1. The facility shall be responsible for all costs of temporary management.

2. The department shall undertake any means to recover the payment of temporary management including, but not limited to, withholding or recouping from the facility's Medicaid reimbursement.

3. Failure to reimburse the department for the cost of temporary management shall result in the facility's owners, managers, officers, directors and administrator being prohibited from operating, managing, directing or owning a licensed health care facility for a period of two years from the latter of the date the sanction is lifted or the date the sanction is upheld through the appeal process.

E. Powers and Duties of the Temporary Manager

1. The facility must provide the temporary manager with sufficient power and duties to address, correct and/or ameliorate the deficiencies that led to the imposition of the temporary management sanction.

2. The temporary manager's powers and duties are subject to the approval of the department.

F. Qualifications and Compensation of a Temporary Manager. The facility shall appoint a temporary manager who is:

1. qualified by education and experience to perform the duties required of the temporary management;

2. subject to the approval of the department; and

3. adequately compensated by the facility for the performance of his/her duties as temporary manager.

G. The department may end the temporary management of a facility when it determines that the facility is in compliance with the laws, rules or regulations for a sufficient time period as determined by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3082 (November 2013).

§4631. Denial of Renewal License and Revocation of License

A. The department may deny an application to renew a license or may revoke a license pursuant to the process and procedures contained in the department's statutory and promulgated licensing standards applicable to each facility.

B. Voluntary Non-Renewal

1. If a facility fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered.

2. There are no appeal rights for a voluntary surrender as this is a voluntary action on the part of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3082 (November 2013).

Subchapter C. Notice and Appeals

§4641. Notice of Sanctions and Appeals

A. Unless otherwise provided in the licensing standards or other promulgated state rule or regulation, the following notice and appeal procedures are applicable to all sanctions imposed by the department pursuant to a Louisiana state statute or regulation.

B. Notice to Facility of Sanctions. The department shall provide written notice to a health care facility of the imposition of a sanction. The notice shall contain the following information:

1. the nature of the violation(s) and whether the violation is a repeat violation;

2. the legal authority for the violation(s);

3. the sanction assessed for each violation and the effective date of the sanction;

4. notification that the facility has 10 calendar days from receipt of the notice within which to request an administrative reconsideration of the proposed sanction;

5. notification of the administrative reconsideration and/or administrative appeal procedures and the deadlines for each; and

6. notification that the department's decision becomes final and no administrative or judicial review may be obtained if the facility fails to timely request an administrative reconsideration and/or administrative appeal.

C. Waivers. When a civil fine for a class C violation is imposed, the facility may choose to waive its right to an administrative reconsideration and appeal hearing in exchange for paying 50 percent of the fine by submitting the waiver and payment to HSS within 30 days of receipt of the notice imposing the civil fine.

D. Administrative Reconsideration. The facility may request an administrative reconsideration of the department's decision to impose a sanction.

1. The facility's request for an administrative reconsideration must:

a. be in writing;

b. be received by HSS within 10 calendar days of the provider's receipt of the notice of the imposition of the sanction; and

c. include any documentation that demonstrates that the sanction was in error.

2. A reconsideration shall be conducted by designated employees of the department who did not participate in the initial decision to recommend imposition of the sanction.

3. Correction of the deficiency or violation cited for imposition of the sanction shall not be the basis for an administrative reconsideration.

4. A reconsideration shall be conducted as a desk review unless the facility elects to make an oral presentation. The facility may request an oral presentation by notifying HSS within the deadline provided in the notice scheduling the administrative reconsideration.

5. A sanction may be confirmed, reduced or rescinded as a result of the administrative reconsideration. A deficiency may not be altered or rescinded as a result of the administrative reconsideration, except a deficiency may be altered or rescinded in an administrative reconsideration of a revocation, denial of renewal or suspension.

6. A reconsideration decision shall be based upon all documents and the oral presentation furnished by the provider to the department at the time of the administrative reconsideration.

7. A reconsideration decision is final unless the facility timely requests an administrative appeal.

E. Administrative Appeal

1. The provider may request an administrative appeal of the department's decision to impose a sanction.

2. The issue that may be adjudicated in the appeal is the appropriateness of the sanction, including the classification of the violation(s).

3. A deficiency and its underlying facts may not be altered or rescinded as a result of the administrative appeal, except a state deficiency and its underlying facts may be altered or rescinded in an administrative appeal of a revocation, denial of renewal or suspension. For example, in an appeal of a fine due to a Class A violation, the DAL, after hearing the evidence, may decide to reduce the violation to a Class B and reduce the fine accordingly. However, the DAL may not reduce or alter the underlying deficiency on the survey report.

4. The facility's appeal request shall:

a. be in writing;

b. be received by the DAL within 30 days of the provider's receipt of the notice of the imposition of the sanction when no administrative reconsideration is requested, or when an administrative reconsideration is requested, within 30 days of the receipt of the notice of the results of the administrative reconsideration;

c. state what the facility contests and the specific reasons for the disagreement; and

d. shall include any documentation that demonstrates that the sanction was imposed in error.

5. In an appeal contesting a civil fine, the facility shall either post an appeal bond with the DAL as provided in R.S. 40:2009.11 for nursing facilities or R.S. 40:2199(D) for all other facilities, or the facility may choose to pay the fine and file a devolutive appeal.

6. Correction of the deficiency or violation cited for the imposition of the sanction will not be considered as a basis for the appeal.

7. The administrative hearing shall be limited to those issues specifically contested.

8. Except as hereinafter provided, when an administrative appeal is requested in a timely and proper manner, the DAL shall provide an administrative hearing in accordance with the provisions of the APA.

E. Judicial Review. The facility may request judicial review of the administrative appeal decision in the Nineteenth Judicial District Court in accordance with the APA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3083 (November 2013).

§4643. Administrative Appeal Process

A. Any party may appear and be heard at an appeal proceeding through an attorney at law or designated representative. A designated representative must file a written notice of appearance on behalf of the facility identifying him/herself by name, address and telephone number, and identifying the party represented in addition to written authorization to appear on behalf of the facility.

B. The administrative appeal hearing shall be conducted by an administrative law judge (ALJ) or his or her successor from the DAL.

C. Preliminary Conferences

1. The ALJ may schedule a preliminary conference.

2. The purposes of a preliminary conference, if scheduled, include, but are not limited to the following:

a. clarification, formulation and simplification of issues(s);

b. resolution of matters in controversy;

c. exchange of documents and information;

d. stipulations of fact so as to avoid unnecessary introduction of evidence at the formal review;

e. the identification of witnesses; and

f. such other matters that may aid in the disposition of the issues.

3. When the ALJ schedules a preliminary conference, all parties shall be notified in writing. The notice shall direct any parties and their attorneys to appear at a specified date, time and place.

4. Where the preliminary conference resolves all or some matters in controversy, a summary of the findings agreed to at the conference shall be provided to all parties.

5. Where the preliminary conference does not resolve all matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy.

D. Hearings

1. When an administrative hearing is scheduled, the facility and/or its attorney and the agency representative, shall be notified in writing of the date, time and place of the hearing.

2. Evidence. The taking of evidence shall be controlled in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the issues shall be explained, and the order in which the evidence will be received shall be explained.

a. Testimony shall be taken only on oath, affirmation or penalty of perjury.

b. Each party shall have the right to:

i. call and examine witnesses;

ii. introduce exhibits;

iii. question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination; and

iv. impeach any witness regardless of which party first called him to testify; and

v. rebut the evidence against him.

c. The ALJ may question any party or witness and may admit any relevant and material evidence.

d. Each party shall arrange for the presence of their witnesses at the hearing.

e. A subpoena to compel the attendance of a witness may be issued by the ALJ upon written request by a party and showing the need therefore, or by the ALJ on his own motion.

f. An application for a subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda, or other records shall be:

i. in writing to the ALJ;

ii. give the name and address of the person or entity upon whom the subpoena is to be served;

iii. precisely describe the material that is desired to be produced;

iv. state the materiality thereof to the issue involved in the proceeding; and

v. include a statement indicating that to the best of the applicant's knowledge, the witness has such items in his possession or under his control.

3. The facility has the burden to prove that the imposition of a sanction was erroneous.

4. An audio 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 a copy of the transcript.

5. At the conclusion of the hearing, the ALJ may take the matter under submission.

6. Specific written findings as to each issue contested by the facility shall be made.

7. The ALJ has the authority to affirm, reverse, or modify the sanction(s) imposed by the department.

8. The ALJ does not have the authority to:

a. rescind or amend any violation of federal law, statute or regulation found by DHH on behalf of CMS; or

b. amend or rescind any violation of state law, statute, rule or manual in an appeal of a civil fine or of any other sanction, except license revocation, suspension and non-renewal.

9. Such findings shall be submitted in writing to the facility at its last known address and to the department and other affected parties.

E. Continuances

1. A hearing may be continued to another time or place, or a further hearing may be ordered by the ALJ on his own motion or upon showing of good cause, at the request of any party.

2. Where the ALJ determines that additional evidence is necessary for the proper determination of the case, he/she may, at his/her 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.

3. Any evidence so submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

4. Written notice of the time and place of a continued or further hearing shall be provided to each party, 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.

F. If a facility representative fails to appear at a hearing, the appeal may be dismissed and the departmental findings made final. A copy of the decision shall be mailed to each party.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3083 (November 2013).

Subchapter D. Enforcement of Sanctions

§4651. Enforcement of Sanctions/Collection of Fines

A. The decision to impose a sanction(s), except those classified as immediate, is final when:

1. an administrative appeal is not requested within the specified time limit;

2. the facility agrees to pay the fine or to comply with the sanction;

3. the administrative appeal affirms the department's fine or sanction and the time for seeking judicial review has expired; or

4. the judicial review or appeal affirms the fine or sanction and the deadline for seeking further review expires.

B. Civil Fines. When a fine becomes final, the facility shall do one of the following:

1. make payment in full within 10 days of the date the fine becomes final; or

2. request a payment schedule, in light of a documented hardship, within 10 calendar days of the fine becoming final.

C. Interest shall begin to accrue, at the current judicial rate, on the day following the date on which any fine becomes due and payable.

D. Failure to Make Payment of Assessed Fines. When the assessed fine is not received within the prescribed time period and the facility has not arranged for a payment schedule, the department may:

1. deduct the full amount with accrued interest from funds otherwise due to a Medicaid provider as Medicaid reimbursement; or

2. institute civil action as necessary to collect the fines due if the provider is not a Medicaid provider.

E. The facility is prohibited from:

1. claiming imposed fines and/or interest as reimbursable costs to Medicaid or Medicare; and

2. increasing charges to clients as a result of civil fines and/or interest imposed by DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3085 (November 2013).

Subchapter E. Funds

§4661. Nursing Home Residents' Trust Fund

A. The department shall deposit civil fines and the interest collected from nursing homes into the Nursing Home Residents' Trust Fund, hereafter referred to as trust fund.

B. The secretary shall administer the trust fund.

C. The monies in the trust fund shall be subject to annual appropriation and shall be used solely as mandated by the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) for any of the following purposes:

1. to protect the health or property of residents of nursing homes which the department finds deficient;

2. to pay for the costs of relocation of residents to other facilities;

3. to maintain operation of a facility pending correction of deficiencies or closure;

4. to reimburse residents for personal funds lost;

5. to allow the department to use the funds for education to improve the health and welfare of residents;

6. to reimburse a nursing home(s) for evacuation expenses, subject to approval by the federal government; and

7. any other purpose approved by CMS.

D. Request for monies from the trust fund shall be made in writing to the department. All expenditures are subject to the approval of CMS.

E. Monies from the trust fund shall be utilized only to the extent that private or public funds, including funds available under title XVIII and title XIX of the Social Security Act, are not available or are not sufficient to meet the expenses of the facility.

F. The department is hereby authorized to enter into cooperative endeavor agreements with public and private entities for the approved expenditure of monies in the trust fund that achieve the purpose of the fund.

G. 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.

H. The department has the discretion to require repayment of a disbursement from the trust fund.

1. If required, the terms of repayment of monies disbursed shall be determined by the secretary and may, where appropriate, be set forth in a contract signed by the secretary and the applicant or other party responsible for repayment.

2. Failure to repay the funds according to the established terms of repayment shall preclude future disbursements to the applicant from the trust fund until all monies are repaid.

3. Monies due and owing to reimburse the trust fund shall accrue interest at the current judicial interest rate.

4. If a nursing home fails to repay the funds according to the established terms of repayment, the department may recoup the amount of disbursement not repaid by a nursing home from the nursing home's Medicaid payments or from any other payments owed to the nursing home from the department.

5. All monies collected pursuant to a repayment agreement or by recoupment shall be treated in the same manner as a collected civil fine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3085 (November 2013).

§4663. Health Care Facility Fund

A. The civil fines and interest collected from health care facilities, other than nursing homes, shall be deposited into the Health Care Facility Fund, hereafter referred to as trust fund.

B. The department has the exclusive use of the funds contained in the trust fund.

C. The monies in the trust fund shall be subject to annual appropriation by the legislature and shall be used exclusively for the following purposes:

1. the protection of health, welfare, rights or property of those receiving services from health care facilities;

2 the enforcement of sanctions against health care facilities;

3. the education, employment and training of employees, staff or other personnel of health care facilities; and/or

4. programs designed to improve the quality of care in health care facilities.

D. The Health Care Facility Fund may not be used to fund re-occurring programs.

E. The department is hereby authorized to enter into cooperative endeavor agreements with public and private entities for the approved expenditure of monies in the trust fund that achieve the purpose of the fund.

F. The department has the discretion to require repayment of a disbursement from the trust fund.

1. If required, the terms of repayment of monies disbursed shall be determined by the secretary and may, where appropriate, be set forth in a contract signed by the secretary and the applicant or other party responsible for repayment.

2. Failure to repay the funds according to the established terms of repayment shall prevent future disbursements to the applicant from the trust fund until all monies are repaid.

3. Monies due and owing according to the established terms of repayment shall accrue interest at the current judicial interest rate.

4. If a facility fails to repay the funds according to the established terms of repayment, the department may recoup the amount of disbursement not repaid by a facility from the facility's Medicaid payments or from any other payments owed to the facility from the department.

5. All monies collected pursuant to a repayment agreement or by recoupment shall be treated in the same manner as a collected civil fine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3085 (November 2013).

Chapter 47. Family Violence Shelter

§4701. General Requirements

A. A provider shall have a written policy on client civil rights. This policy shall give assurances that:

1. The provider will not discriminate in the rendering of services to individuals because of race, color, religion, sex, age, national origin, handicap, veteran status or any other non-merit factor.

B. A provider shall allow representatives of DHHR in the performance of their mandated duties to inspect all aspects of the program's functioning which impact on clients and to interview any staff member or client.

1. A provider shall make any information which the provider is required to have under the present requirements and any information related to assessment of compliance with these requirements available to DHHR.

C. The provider shall comply with all relevant standards, regulations, and requirements established by federal, state, local, and municipal regulatory bodies including:

1. the Division of Licensing and Certification;

2. the Office of Preventative and Public Health Services;

3. the Office of the State Fire Marshal;

4. the Office of the City Fire Marshal;

5. the applicable local governing authority;

6. fiscal and program review agencies with DHHR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4703. Governing Body

A. A provider shall have an identifiable governing body whose responsibility for and authority over the policies and activities of the provider.

1. A provider shall have documents identifying all members of the governing body; their addresses; their terms of membership; officers of the governing body; and terms of office of all officers.

2. When the governing body of the provider is composed of more than one person, the governing body shall hold formal meetings at least twice a year.

3. When the governing body is composed of more than one person, a provider shall have written minutes of all formal meetings of the governing body and the by-laws specifying frequency of meetings and quorum requirements.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4705. Responsibilities of a Governing Body

A. The governing body of a provider shall:

1. ensure the provider's compliance and conformity with provider's charter;

2. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

3. ensure that the provider is adequately funded and fiscally sound;

4. review and approve the provider's annual budget;

5. ensure that the provider is housed, maintained, staffed and equipped appropriately considering the nature of the provider's program;

6. designate a person to act as chief administrator and delegate sufficient authority to this person to manage the provider.

7. formulate and annually review, in consultation with the chief administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

8. annually evaluate the chief administrator's performance;9. have the authority to dismiss the chief administrator;

10. meet with designated representatives of DHHR whenever required to do so;

11. inform designated representatives of DHHR prior to initiating any substantial changes in the program, services or physical plant of the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4707. Accessibility of Executive

A. The chief administrator or a person authorized to act on behalf of the chief administrator shall be accessible to provider staff or designated representatives of DHHR at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4709. Documentation of Authority to Operate

A. A private provider shall have documentation of its authority to operate under state law.

1. A privately owned provider shall have documents identifying the names and addresses of owners.

2. A corporation, partnership or association shall identify the names and addresses of its members and officers and shall, where applicable, have a charter, partnership agreement, constitution, articles of association or by-laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4711. Program Description

A. A provider shall have a written program description describing:

1. the overall philosophy of the provider;

2. the long-term and short-term goals of the provider;

3. the types of clients to be served by the provider;

4. the services provided directly by the provider;

5. services available to the client from resources external to the provider;

6. a schedule for any fees for services;

7. the provider's approach to service planning.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4713. Accounting and Recordkeeping

A. A provider shall establish a system of business management and staffing to maintain separate and complete accounts, books, and records. Fiscal records will be maintained according to generally accepted accounting procedures, sufficient to reflect properly all direct and indirect costs incurred.

1. All transactions and events must be recorded, classified and summarized in appropriate journals; providing chronological records of transaction having a common origin and ledgers of accounts to receive and consolidate transaction amounts related to a given classification.

2. Expenditures must be kept in the following cost categories: Salaries, Fringe, Travel, Operating Services, Supplies, Equipment, Other. The provider will submit a monthly operating statement to the state detailing monthly expenditures by cost category.

3. All records shall be maintained in an accessible, standardized order and format and shall be subject at all reasonable times to inspection and audit by the state agency and the legislative auditor.

4. A provider shall not permit public funds to be paid, or committed to be paid, to any person to which any of the members of the governing body, administrative personnel, or members of the immediate families of members of the governing body, or administrative personnel have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the provider. The provider shall have written disclosure of any financial transaction with the facility in which a member of the governing body, administrative personnel, or his/her immediate family is involved.

5. All books, records and other documents relevant to the expenditure of state funds must be retained for six years after final payments.

6. A provider shall have sufficient space, facilities and supplies for providing effective recordkeeping services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4715. Confidentiality and Security of Files

A. A provider shall have written procedures for the maintenance and security of records and to whom records may be released. Records shall be the property of the provider and the provider, as custodian, shall secure records against loss, tampering, or unauthorized use.

B. A provider shall maintain the confidentiality of all clients' case records. Employees for the provider shall not disclose or knowingly permit the disclosure of any information concerning the client or his/her family, directly or indirectly, to any unauthorized person.

C. When the client is of majority age and noninterdicted, a provider shall obtain the client's written, informed permission prior to releasing any information concerning the client.

D. When the client is a minor or is interdicted, the provider shall obtain written, informed consent from the parent(s), or legally responsible person prior to releasing any information concerning the client.

E. A provider shall, upon written request, make available information in the case record to the client, the legally responsible person, or legal counsel of the client. If, in the professional judgement of the administration of the provider, it is felt that information contained in the record would be damaging to the client, that information my be withheld from the client except under court order.

F. A provider may use material from case records for research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, provided that names are deleted and other identifying information is disguised or deleted.

G. A provider shall not release a personnel file without the employee's permission except in accordance with state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4717. Administrative File

A. A provider shall have an administrative file including:

1. documents identifying the governing body;

2. list of members and officers of the governing body and their addresses and terms of membership, if applicable;

3. by-laws of the governing body and minutes of formal meetings, if applicable;

4. documentation of the provider's authority to operate under state law;

5. organizational chart of the provider;

6. all leases, contracts and purchase-of-service agreements to which the provider is a party;

7. insurance policies;

8. annual budgets and audit reports;

9. master list of all social service providers used by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4719. Client's Case Record

A. A provider shall have written record for each client including the following information:

1. basic demographic data;

2. client's history including, where applicable, family data, medical history, educational background, employment history, etc.;

3. statement of presenting problem as seen by the client;

4. client's current situation;

5. assessment and service plan (including client's goals and objectives);

6. the findings made in periodic review of the service plan and recording of the client's progress as measured by objective indicators;

7. a departure summary;

8. any follow-up contacts made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4721. Personnel File

A. A provider shall have a personnel file for each employee which shall contain:

1. the application for employment and/or resume;

2. reference letters from former employer(s) and personal references or phone notes on such references;

3. any required medical examinations;

4. evidence of applicable professional credentials/certifications according to state law;

5. annual performance evaluations;

6. personnel actions, other appropriate materials, reports and notes relating to the individual's employment with the facility;

7. employee's starting and termination dates;

8. the staff member shall have reasonable access to his/her file and shall be allowed to add any written statement he/she wishes to make to the file at any time.

B. A provider shall retain the personnel file of an employee for at least five years after the employee's termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4723. Fundraising and Publicity

A. A provider shall have a policy regarding participation of clients in activities related to fundraising and publicity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4731. Staff Plan

A. A provider shall have written plan for recruitment, screening, orientation, on-going training, development, supervision and performance evaluation of staff members.

AUTHORITY NOTE: Promulgated in accordance with R . S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4733. Recruitment

A. A provider shall employ qualified people representative of cultural and racial groups served by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4735. Screening

A. A provider's screening procedures shall address the prospective employee's qualifications, ability, related experience, health, character, emotional stability and social skills as related to the appropriate job description.

B. Prior to employing any person, a provider shall obtain written references or phone notes on oral references.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4737. Orientation

A. A provider's orientation program shall provide at least 16 hours of training for all direct care staff within 30 working days of the date of employment. Orientation training shall include instruction in safety and emergency procedures and in the specific responsibilities of the employee's job.

B. New employees shall be accompanied by experienced staff at all times and shall not be given the sole responsibility

for supervising clients until orientation training is completed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4739. Training

A. A provider shall ensure that each direct service worker participates in at least 40 hours of in-service training each year. Orientation training and activities related to routine supervision of the employee's tasks shall not be considered for the purpose of this requirement.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4741. Evaluation

A. A provider shall undertake an annual performance evaluation of all staff members.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4743. Personnel Practices

A. A provider shall have written personnel policies and written job descriptions for each staff position.

B. A provider shall have a written employee grievance procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4745. Number and Qualifications of Staff

A. A provider shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the responsibilities the provider undertakes are carried out, and to adequately perform the following functions:

1. administrative functions;
2. fiscal functions;
3. clerical functions;
4. direct client service functions;
5. supervisory functions;
6. recordkeeping and reporting functions;
7. social service functions;
8. ancillary service functions.

B. A provider shall not knowingly hire, or continue to employ, any person whose health, educational achievement, emotional or psychological make-up impairs his/her ability to properly protect the health and safety of the clients, or is such that it would endanger the physical or psychological well-being of the clients. This requirement is not to be interpreted to exclude continued employment in other than direct service capacities of persons undergoing temporary medical or emotional problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4747. External Professional Services

A. A provider shall obtain any required professional services not available from employees of the provider and shall have documentation of access to such services either in the form of a written agreement with an appropriately qualified professional, or written agreements with the state for required resources.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4749. Volunteers/Student Interns

A. A provider which utilizes volunteers or student interns on a regular basis, shall have a written plan for using such resources. This plan shall be given to all volunteers and interns. The plan shall indicate that all volunteers and interns shall:

1. be directly supervised by a paid staff member;
2. be oriented and trained in the philosophy of the facility and the needs of clients, and methods of meeting those needs;
3. be subject to character and reference checks similar to those performed for employment applicants;
4. be aware of and be briefed on any special needs or problems of clients.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4751. Staff Communications

A. A provider shall establish procedures to assure adequate communication among staff to provide continuity of services to the client. This system of communication shall include:

1. a regular review of individual and aggregate problems of clients including actions taken to resolve these problems;

2. sharing of daily information noting unusual circumstances and other information requiring continued action by staff;

3. records maintained of all accidents, personal injuries and pertinent incidents related to implementation of client's individual service plans.

B. Any employee of a provider working directly with clients in care shall have access to information from client's case records that is necessary for effective performance of the employee's assigned tasks.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4753. Physical Environment

A. Accessibility

1. A provider's building, parking lots and facilities shall be accessible to and functional for clients and staff members.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4755. Exterior Space

A. A provider shall ensure that all structures on the grounds of the facility accessible to clients are maintained in good repair and are free from any excessive hazard to health and safety.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4757. Interior Space

A. A provider shall have adequate space to serve as an administrative office for records, secretarial work and bookkeeping.

B. A provider shall have a designated space to allow private discussions and counseling sessions between individual clients and staff.

C. A provider shall ensure that there is evidence of routine maintenance and cleaning in all areas of the facility.

D. A provider shall replace or repair broken, run-down or defective furnishings and equipment promptly.

1. Outside doors, windows and other features of the structure necessary for safety and comfort of clients shall be repaired within 24 hours of being found to be in a state of disrepair.

E. A provider shall ensure that all electrical equipment, wiring, switches, sockets and outlets are maintained in good order and safe condition.

F. A provider shall ensure that any room, corridor or stairway within a facility shall be sufficiently illuminated.

G. A provider shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of clients.

H. A provider shall maintain the spaces used by clients at temperatures in accordance with federal and state laws.

I. A provider shall not use open-flame heating equipment.

J. A provider shall ensure that hot water accessible to clients must be regulated to a temperature not to exceed 110 degrees fahrenheit.

K. A provider shall not utilize any excessively rough surface or finish where this surface or finish may present a safety hazard to clients.

L. A provider shall not have walls or ceilings surfaced with materials containing asbestos.

M. A provider shall not use lead paint for any purpose within the facility or on the exterior or grounds of the facility, nor shall the provider purchase any equipment, furnishings or decoration surfaced with lead paint.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4759. General Safety Practices

A. A provider shall not maintain any firearm or chemical weapon in the office or facility.

B. A provider shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers labeled as to contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of clients, staff, and visitors.

C. A provider shall ensure that an appropriately equipped first-aid kit is available in the provider's buildings and in all vehicles used to transport clients.

D. A provider shall have access to 24-hour telephone service. The provider shall have either posted telephone numbers of emergency services, including fire department, police, medical services, poison control and ambulance, or else show evidence of an alternate means of immediate access to these services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4761. Transportation

A. The provider shall ensure that each client is provided with the transportation necessary for implementing the client's service plan.

B. The provider shall have means of transporting clients in cases of emergency.

C. Any vehicle used in transporting clients in care of the provider, whether such vehicle is operated by a staff member or any other person acting on behalf of the provider, shall be properly licensed and inspected in accordance with state law.

D. Any staff member of the provider or other person acting on behalf of the provider operating a vehicle for the purpose of transporting clients shall be properly licensed to operate that class of vehicle according to state law.

E. The provider shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats in the vehicle.

F. All vehicles used for the transportation of clients shall be maintained in a safe condition and be in conformity with all applicable motor vehicle laws.

G. The provider shall ascertain the nature of any need or problem of a client which might cause difficulties during transportation, such as seizures, a tendency towards motion sickness or a disability. The provider shall communicate such information to the operator of any vehicle transporting clients in care.

H. Every required exit, exit access and exit discharge in a provider's building shall be continuously maintained free of all obstructions or impediments to immediate use in the case of fire or other emergency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4763. Organization and Administration

A. Capacity. A provider shall not exceed the maximum capacity determined by the fire marshal's office.

1. Other Jurisdictional Approvals. A provider shall be licensed by the Department of Health and Human Resources, Division of Licensing and Certification.

C. Staff Coverage

1. During waking hours, a provider shall have at least one direct service worker on duty at all times.

2. During sleeping hours, a staff member shall be present and easily accessible to clients.

3. A provider shall make sufficient provisions for housekeeping and maintenance to ensure that direct service staff are able to adequately perform direct care functions.

4. A provider utilizing live-in staff shall have sufficient relief staff to ensure adequate off-duty time for live-in staff.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4765. Quality of Life

A. Communication.

1. A provider shall have a written description of rules and procedures concerning:

a. telephone communication by clients;

b. visits from a client's family and friends.

B. Routines

1. A provider shall have a written set of daily routines for clients designed to provide for reasonable consistency and timeliness in daily activities, in the delivery of services to clients, and in the provision of adequate periods of recreation, privacy, and sleep.

C. Work

1. A provider shall assign as unpaid work for clients only housekeeping tasks similar to those performed in a normal home.

D. Recreation

1. A provider shall have a written plan for ensuring that a range of indoor and outdoor recreational and leisure opportunities are provided for clients. Such opportunities shall be based on both the individual interests and needs of the clients and the composition of the living group.

2. A provider shall utilize the recreational resources of the community whenever appropriate. The provider shall arrange the transportation and supervision required for maximum usage of community resources.

E. Religion and Culture

1. Every client shall be permitted to attend religious services in accordance with his/her faith.

2. Clients shall not be forced to attend religious services.

F. Clothing

1. If a client is admitted without adequate clothing, a provider shall ensure that the client is provided with clean, well-fitting clothing appropriate to the season and to the client's age, sex and individual needs.

a. Clothing shall be maintained in good repair.

b. All clothing provided to a client shall go with the client at discharge.

c. Clothing shall belong to the individual client and not be shared in common.

G. Food Services

1. A provider shall ensure that a client is, on a daily basis, provided with food of such quality and in such quantity as to meet the recommended daily dietary allowances adjusted for age, gender and activity of the Food Nutrition Board of the National Research Council.

2. A person designated by the chief administrator shall be responsible for the total food service of the provider. If this person is not a professionally qualified dietitian, regularly scheduled consultations with a professionally qualified dietitian shall be obtained.

3. A provider shall ensure that a client is provided at least three meals or their equivalent available daily at regular times with not more than 14 hours between the evening meal and breakfast of the following day. Between meal snacks of nourishing quality shall be offered. Meal times shall be comparable to those in a normal home.

a. The provider shall ensure that the food provided to a client is in accord with his/her religious beliefs.

b. A provider shall develop written menus at least one week in advance.

c. Written menus shall be maintained on file for 30 days. Menus shall provide for a sufficient variety of foods and shall vary from week to week.

d. No client shall be denied a meal for any reason except according to a doctor's order.

4. When meals are provided to staff, a provider shall ensure that staff members eat substantially the same food served to clients in care, unless age differences or special dietary requirements dictate differences in diet.

5. A provider shall purchase and provide to clients only food and drink of safe quality and the storage, preparation and serving techniques shall ensure that nutrients are retained and spoilage is prevented.

a. Milk and milk products shall be Grade A and pasteurized.

b. Dry or staple food items shall be stored at least twelve inches above the floor, in a ventilated room not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents, or vermin.

c. Perishable foods shall be stored at the proper temperatures to conserve nutritive values.

6. A provider shall show evidence of effective procedures for cleaning all equipment and work areas.

a. Handwashing facilities, including hot and cold water, soap, and paper towels, shall be provided adjacent to food service work areas.

H. Medical Care

1. A provider shall ensure the availability of a comprehensive program of emergency medical and dental care, as appropriate, for all clients. The provider shall have a written plan for providing such care. This plan shall include:

a. approaches that ensure that any medical treatment administered will be explained to the client in language suitable to his/her age and understanding;

b. an on-going relationship with a licensed physician and dentist to advise the provider concerning medical and dental care;

c. availability of a physician on a 24-hour a day, seven days a week basis;

d. the provider shall show evidence of access to the resources outlined in this plan.

2. A provider shall have access to psychiatric and psychological resources, on both an emergency and on-going basis, as appropriate to the needs of clients.

3. A provider must ensure that a client receives timely, competent medical care, in keeping with community standards of medical practice when he/she is ill or injured.

4. A provider shall ensure that no medication is given to any client except in accordance with the written order of a physician.

5. A provider shall ensure that medications are either self-administered or administered by qualified persons according to state law.

a. A medication shall not be administered to any client for whom the medication has not been ordered.

H. Reports on Critical Incidents

1. A provider shall have written procedures for the reporting and documentation of deaths of clients, injuries, fights or physical confrontations, suspected incidents of abuse or neglect, unusual incidents and other situations or circumstances affecting the health, safety or well-being of a client or clients.

a. Such procedures shall ensure timely verbal and written reports to the governing body of the provider.

2. When an incident involves abuse or neglect of a client, death of a client, or entails any serious threat to the client's health, safety or wellbeing, a provider shall:

a. ensure immediate verbal reporting to the governing body by the chief administrator or his/her designee and a preliminary written report within 24 hours of the incident;

b. ensure immediate notification of designated representatives of DHHR or other appropriate authorities, according to state law;

c. ensure immediate attempts to notify other involved agencies and parties, as appropriate;

d. ensure immediate notification of the appropriate law enforcement authority whenever warranted;

e. ensure follow-up written reports to all appropriate persons and agencies.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4767. Direct Services Management

A. Admission Policies

1. A provider shall have a written description of admissions policies and criteria which shall include the following information:

a. policies and procedures related to intake;

b. the age and sex of clients in care;

c. the needs, problems, situations or patterns best addressed by the provider's program;

d. any other criterion for admission;

e. maximum allowable length of stay;

f. any preplacement requirements on the client;

g. the written description of admissions policies and criteria shall be provided to DHHR and available to the client.

2. A provider shall not admit more clients into care than the number specified on the provider's license.

3. A provider shall not accept any client for placement whose needs cannot be adequately met by the provider's program.

B. Intake Evaluation

1. The provider shall accept a client into care only when a current comprehensive intake evaluation has been completed, including social, health and family history; and, medical, social, educational, psychological and, as appropriate, developmental or vocational assessment.

2. In emergency situations necessitating immediate placement into care, the provider shall gather as much information as possible about the client to be admitted and the circumstances requiring shelter; formalize this in an "emergency admission note" within two days of admission; and then proceed with an intake evaluation as quickly as possible.

C. Clarification of Expectations to Client

1. The provider shall, consistent with the client's maturity and ability to understand, make clear its expectations and requirements for behavior, and provide the client with an explanation of the services provided by the program.

2. A provider shall not admit any client into care whose presence will be seriously damaging to the on-going functioning of the provider or to clients already in care.

D. Individual Service Plan

1. A provider shall develop a comprehensive, time-limited, goal oriented individual service plan with the client addressing the client's needs.

a. A provider shall ensure that all persons working directly with the client are appropriately informed of the service plan.

E. Departure and Follow-Up

1. When a client leaves the shelter, the provider shall prepare a departure summary for the client's record which shall include:

a. the client's destination;

b. the client's forwarding address and telephone number;

c. client's permission to be contacted by the provider by phone and/or mail for follow-up purposes;

d. services provided to client during the shelter stay;

e. services to be provided on a non-residential basis;

f. summary client assessment by provider staff.

F. Client Contract

1. Provider shall have a clearly written list of rules and regulations governing conduct for clients in care of the provider. These rules and regulations shall be made available to each staff member and each client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4769. Physical Environment

A. Exterior Space

1. A provider shall maintain the grounds of the facility in an acceptable manner and shall ensure that the grounds are free from any hazard to health or safety.

a. Garbage and rubbish which is stored outside shall be stored securely in non-combustible, covered containers and shall be removed on a regular basis.

b. Trash collection receptacles and incinerators shall be separate from play area and be located as to avoid being a nuisance to neighbors.

c. Fences shall be in good repair.

d. Areas determined to be unsafe, including steep grades, cliffs, open pits, swimming pools, high voltage boosters, or high speed roads, shall be fenced off or have natural barriers to protect clients.

e. Playground equipment shall be so located, installed and maintained as to ensure the safety of clients.

2. A provider shall have access to outdoor recreational space and suitable recreational equipment.

3. A provider shall provide adequate lighting of exterior areas to ensure the safety of clients and staff during the night.

B. Interior Space

1. Each living unit shall contain a space for the free and informal use of clients. This space shall be constructed and equipped in a manner consonant with the programmatic goals of the provider.

C. Dining Areas

1. A provider shall provide dining areas which permit children, staff and guests to eat together in small groups.

2. A provider shall provide dining areas which are clean, well-lighted, ventilated and attractively furnished.

D. Sleeping Accommodations

1. A provider shall ensure that sheets, pillow, bedspread and blankets are provided for each client.

a. Sheets and pillow cases shall be changed at least weekly, but shall be changed more frequently, if necessary.

2. A provider shall provide clients with solidly constructed beds. Cots or other portable beds are not to be used on a routine basis.

3. A provider shall ensure that the uppermost mattress of any bunk bed in use shall be far enough from the ceiling to allow the occupant to sit up in bed.

4. A provider shall provide each client in care with his/her own dresser or other adequate storage space for private use, and designated space for hanging clothing in proximity to the bedroom occupied by the client.

5. Each client in care of a provider shall have his/her own designated areas for rest and sleep.

E. Bathrooms

1. A provider shall provide toilets and baths or showers which allow for individual privacy unless clients in care require assistance.

a. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene unless clients are individually given such items.

b. Tubs and showers shall have slip-proof surfaces.

2. A provider shall ensure that bathrooms have a safe and adequate supply of hot and cold running water. This water shall be potable.

3. A provider shall ensure that bathrooms contain mirrors secured to the walls at convenient heights and other furnishings necessary to meet the clients' basic hygienic needs.

4. A provider shall ensure that bathrooms are equipped to facilitate maximum self-help by clients. Bathroom shall be large enough to permit staff assistance of children, if necessary.

5. Toilets, wash basins, and other plumbing or sanitary facilities in a facility shall, at all times, be maintained in good operating condition, and shall be kept free of any materials that might clog or otherwise impair their operation.

F. Kitchens

1. Kitchens used for meal preparation shall be provided with the necessary equipment for the preparation, storage, serving and clean up of all meals for all of the clients and staff regularly served by such kitchen. All equipment shall be maintained in working order.

2. A provider shall not use disposable dinnerware at meals on a regular basis unless the facility documents that such dinnerware is necessary to protect the health or safety of clients in care.

3. A provider shall ensure that all dishes, cups and glasses used by clients in care are free from chips, cracks or other defects.

a. All reusable eating and drinking utensils shall be sanitized after a thorough washing and rinsing.

4. Animals shall not be permitted in food storage, preparation, and dining areas.

G. Furnishings

1. A provider shall have comfortable customary furniture as appropriate for all living areas. Furniture for the use of clients shall be appropriately designed to suit the size and capabilities of these clients.

a. A provider shall ensure that there is evidence of routine maintenance and cleaning programs in all areas of the provider.

H. Laundry Space

1. A provider shall have a laundry space with washer and dryer.

I. Storage

1. A provider shall ensure that there are sufficient and appropriate storage facilities.

2. A provider shall have securely locked storage space for all potentially harmful materials. Keys to such storage spaces shall only be available to authorized staff members.

a. Poisonous or toxic materials shall be stored in storage.

J. Electrical Systems

1. A provider shall provide adequate lighting of exterior areas to ensure the safety of clients and staff during the night.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4771. Emergency and Safety

A. Emergency and Safety Plan

1. A provider shall have a written overall plan of emergency and safety procedures.

2. The plan shall provide for the evacuation of clients to safe or sheltered areas.

3. The plan shall include provisions for training staff and, as appropriate, clients in preventing, reporting and responding to fires and other emergencies.

4. The plan shall provide means for an on-going safety program including continuous inspection of the provider for possible hazards, continuous monitoring of safety equipment, and investigation of all accidents or emergencies.

5. A provider shall prohibit the use of candles in sleeping areas of the clients.

6. Power driven equipment used by a provider shall be kept in safe and good repair. Such equipment shall be used by clients only under the direct supervision of a staff member and according to state law.

7. A provider shall have procedures to prevent infestation.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:2125.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

Chapter 49. Case Management

§4901. Personnel Standards

A. Staff Qualifications

1. Case managers hired or promoted on or after August 20, 1994 must meet the following criteria for education and experience:

a. bachelor's degree in a human services related field including but not limited to psychology, education, rehabilitation counseling, or counseling from an accredited institution; and one year of paid experience in a human services field providing direct consumer services or case management or

b. a licensed registered nurse; and one year of paid experience as a registered nurse in public health or a human services related field providing direct consumer services or case management; or

c. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education;

d. thirty hours of graduate level course credit in a human services related field may be substituted for the one year of required paid experience. Experience may be obtained before or after completion of the degree or obtaining licensure;

e. all case managers must be employees of the provider. Contracting for case managers is prohibited.

2. Case management supervisors hired or promoted on or after August 20, 1994 must meet the following qualifications for education and experience:

a. a master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education with certification in special education, occupational therapy, speech or physical therapy from an accredited institution; and two years of paid post-degree experience in a human services related field providing direct consumer services or case management; and one year of this experience must be in providing direct consumer services to the targeted population to be served; or

b. a bachelor's degree in social work from a social work program accredited by the Council on Social Work Education; and three years of paid post-degree experience in a human services related field providing direct consumer services or case management. Two years of this experience must be in providing direct consumer services to the targeted population to be served; or

c. a licensed registered nurse; and three years of paid post-licensure experience as a registered nurse in public health or a human services related field providing direct consumer services or case management. Two years of this experience must be in providing direct consumer services or case management to the target population to be served; or

d. a bachelor's degree in a human services field including but not limited to psychology, education, rehabilitation counseling, or counseling from an accredited institution; and four years of paid post-degree experience in a human services related field providing direct consumer services or case management. Two years of this experience must be in providing direct consumer services to the targeted population to be served;

e. thirty hours of graduate level course credit in the human services field may be substituted for one year of experience.

B. Training. Case managers must receive necessary orientation and periodic training on the provision of case management services arranged or provided through their agency.

1. Orientation of at least 16 hours shall be provided by the agency to all staff, volunteers and students within five working days of employment which shall include, at a minimum:

a. policies and procedures of the provider;

b. confidentiality;

c. documentation in case records;

d. consumer rights protection and reporting of violations;

e. abuse and neglect policies and procedures;

f. professional ethics;

g. emergency and safety procedures;

h. infection control including universal precautions.

2. For newly hired or promoted case managers who will provide services primarily to a specific population or sub-group, a minimum of eight hours of the orientation training must cover orientation to each target population to be served including but not limited to specific service needs and resources.

3. Routine supervision cannot be considered training.

4. In addition to the minimum 16 hours of orientation, all case managers must receive a minimum of 16 hours of training during the first 90 calendar days of employment which is related to the target population to be served and specific knowledge, skills and techniques necessary to provide case management to the target population. This training must be provided by an individual with demonstrated knowledge of the training topic and the target population. This 16 hours of training must include, at a minimum:

a. assessment techniques;

b. service planning;

c. resource identification;

d. interviewing techniques;

e. data management and record keeping;

f. communication skills.

5. No new case manager employee can be given sole responsibility for a consumer until this training is satisfactorily completed and the employee possesses adequate abilities, skills and knowledge of case management.

6. A case manager must complete a minimum of 40 hours of training per calendar year. For new employees, the orientation training cannot be counted toward the 40 hour minimum annual training requirement. The 16 hours of training for new case managers required in the first 90 days of employment may be counted toward the 40-hour minimum annual training requirement. Appropriate updates of topics covered in orientation and training for a new case manager must be included in the required 40 hours of annual training. The following is a list of suggested additional topics for annual training:

a. the nature of the illness or disability, including symptoms and behavior;

b. pharmacology;

c. potential array of services for the population/ available local resources;

d. building natural support systems;

e. family dynamics;

f. developmental life stages;

g. crisis management;

h. first aid/CPR;

i. signs and symptoms of mental illness, alcohol and drug addiction, and mental retardation/ developmental disabilities, head injuries and/or HIV;

j. recognition of illegal substances;

k. monitoring techniques;

l. advocacy;

m. behavior management techniques;

n. developmental life stages;

o. value clarification/goals and objectives;

p. stress management/time management;

q. accessing special education services;

r. cultural diversity;

s. pregnancy and prenatal care;

t. health management;

u. team building/interagency collaboration;

v. transition/closure;

w. age-appropriate preventive health care;

x. facilitating team meetings;

y. computer skills;

z. legal issues.

7. A case management supervisor must satisfactorily complete 40 hours of training per year. A new supervisor must satisfactorily complete a minimum of 16 hours on all of the following topics prior to assuming case management supervisory responsibilities:

a. professional identification/ethics;

b. process for interviewing, screening, and hiring staff;

c. orientation/inservice training of staff;

d. evaluating staff;

e. approaches to supervision;

f. managing caseload size;

g. conflict resolution;

h. documentation.

8. Documentation of all training must be placed in the individual's personnel file. Documentation must include an agenda and the name, title, agency affiliation of the training presenter(s) and other sources of training.

C. Supervision

1. Each case management provider must have and implement a written plan for supervision of all case management staff. Supervision must occur at least once per week per case manager. Supervisors must review at least 10 percent of each case manager's case records each month for completeness, compliance with these standards, and quality of service delivery.

2. Supervision of individual case managers must include the following:

a. direct review, assessment, problem solving, and feedback regarding the delivery of case management services;

b. teaching and monitoring of the application of consumer centered case management principles and practices;

c. assuring quality delivery of services;

d. managing assignment of caseloads;

e. arranging for or providing training as appropriate.

3. Supervision must be accomplished by a combination of more than one of the following means:

a. individual, face to face sessions with staff to review cases, assess performance and give feedback;

b. sessions in which the supervisor accompanies an individual staff member to meet with consumers. The supervisor assesses, teaches and gives feedback regarding the staff member's performance related to the particular consumer;

c. group face to face sessions with all case management staff to problem solve, provide feedback and support to case managers.

4. Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a weekly basis. The file on the case manager must include, at a minimum:

a. date and content of the supervisory sessions; and

b. results of the supervisory case review which shall address, at a minimum, completeness and adequacy of records, compliance with standards, and effectiveness of services.

5. Case managers must be evaluated at least annually by their supervisor according to written policy of the provider on evaluating their performance.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:885 (August 1994).

§4903. Caseload Size Standards

A. Each full-time case manager may only have a maximum of 60 consumers in a caseload unless a lower ratio exists in DHH or other applicable controlling state or federal regulations.

B. Each case management supervisor may only have a maximum of five full-time case managers or a combination of full-time case managers and other human service staff under their direct supervision.

C. A supervisor may carry one-fifth of a caseload for each case manager supervised less than five. For example, a supervisor of three case managers may carry two-fifths of the maximum caseload.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:887 (August 1994).

§4905. Standards on Protecting Client Rights, Health, and Safety

A. All DHHR and private disability agency case managers shall conform to applicable state laws and Department of Health and Human Resources policies and procedures relative to client rights, including but not limited to those concerning confidentiality of client information and grievance procedures and client's right to appeal department decisions on service eligibility, planning, and delivery.

B. All DHHR and private disability agency case managers, if utilized, shall conform to applicable state laws and Department of Health and Human Resources policies and procedures regarding client health and safety including but not limited to those concerning transporting clients and abuse/neglect reporting.

C. Case manager initiated contact with clients shall be as specified in each client's individual plan and shall not be less frequent than 90 days.

1. A program office shall allow (if requested) surveyors of the DHHR Division of Licensing and Certification to inspect all aspects of the case management/service coordination client care (if the client agrees to the interview).

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4907. Application Procedure

A. The applicant shall submit a copy of a request for licensure to the Department of Health and Hospitals, Health Standards Section, P. O. Box 3767, Bin #27, Baton Rouge, Louisiana 70821-3767. The request shall include descriptions of:

1. the target populations to be served;

2. geographical areas (regions) to be served;

3. address(es) of the office site(s) to be used;

4. administrative file as described under §4943;

5. the provider's policies and procedures manual;

6. the requested program and services to be provided as outlined in §4953;

7. the provider's plan for staffing as outlined in §4959.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by

the Department of Health and Hospitals, Office of the Secretary, LR 20:887 (August 1994).

§4909. Review of Applications

A. The complete application request with the required fee must be received by the Health Standard Section at least 60 days prior to the date for which licensing is sought. A written response will be provided to the applicant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4910. Types of Licenses and Expiration Dates

A. A license must be issued to an agency by geographical location (DHH region) where records and minutes of formal meetings are maintained and staff reports. When an agency has three or more staff providing case management services in another region, the agency must establish an office site in that region and request a separate license for that geographical location (unless these services are provided in parishes contiguous to the region where the agency is licensed).

B. Temporary licenses may be issued to new providers, providers who have substantially changed–either in ownership or in the services offered or in the location of the office site, or to a provider who has an identified licensing deficiency and the provider's license is expiring within 60 days. Temporary licenses expire on the date specified on the license.

C. Regular licenses expire on the date specified on the license, which will be one calendar year from the date of issue.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:308-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 August 1994).

§4911. Issuance of a License

A. The agency will not be recognized by DHH until the applicant's enrollment by geographical location (region) is approved by DHH Health Standards Section

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4913. Types of Licenses and Expiration Dates

A. New providers or providers which have substantially changed—either in the services offered or in the physical plant—are issued temporary licenses. Temporary licenses expire on the date specified on the license. Regular licenses expire on the date specified on the license which is one year or more from the date of issue. Provisional licenses are granted when the provider has deficiencies which are not a danger to the health and welfare of clients. Provisional licenses are issued for a period not to exceed 90 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4915. Reapplication

A. When a provider changes its ownership or makes any substantial changes in the services offered as outlined in §4910 or changes the location of the licensed agency, the provider must reapply for a license, beginning with a request for licensure. In the event of a change of ownership, the old license must be immediately returned to the DHH Health Standards Section. If no such changes have occurred, the regular annual reapplication must be made at least 60 days prior to the expiration of the current license. The application must be on a form prescribed by the DHH Health Standards Section and must be accompanied by the required fee. A license cannot be transferred to any location or provider other than those specified in the license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4917. Refusal, Revocation and Fair Hearing

A. A license may be revoked or refused when applicable licensing requirements are not met, as determined by the DHH Health Standards Section. Licensing decisions are subject to appeal and fair hearing in accordance with state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4919. Terms of the Licensure

A. If the provider is in compliance with the requirements of these standards, a license as a client care case management provider will be issued by the DHH Health Standards Section along with a letter enumerating that the agency is permitted to provide case management/service coordination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 12:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4921. Services for Different Handicaps

A. A provider will not be licensed to serve more than one program office type of handicapped client until the provider has been in operation and has consistently met applicable requirements for one year.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4923. Quarterly Staffing Report

A. A provider will report quarterly to the Division of Licensing and Certification, P.0. Box 3767, Baton Rouge, LA 70821 the following: The name, social security number, position and hours worked for a random seven-day period of all the staff employed by the provider. State owned and operated providers are exempt from this requirement as there are already state checks on their personnel.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4925. Licensing Inspections

A. Licensing inspections must generally be completed annually, but may occur at any time. No advance notice may be given. Licensor must be given access to the provider office site, staff members or consumers, and all relevant files and records. Licensor must explain the licensing process in an initial interview and must report orally on any deficiencies found during the inspection prior to leaving the agency. A written report of findings must be forwarded to the provider. The provider must respond to the deficiencies cited with a plan of corrective action acceptable to the secretary within 15 working days of receipt.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4927. New Construction, Renovations of Existing Facilities and Conversion of any Residential or Commercial Building for Residential Care

A. The building site shall be approved by the Division of Licensing and Certification prior to beginning of any construction. The site shall have good drainage and not subject to flooding. The site shall not be located in an area that would present a hazard to those being served. Plans and specifications must be prepared by a licensed architect or engineer. Three sets of complete plans and specifications must be submitted for approval to the Division of Licensing and Certification. The Division of Licensing and Certification will forward one set to the Office of Preventive and Public Health Services, and one set to the Office of State Fire Marshal.

B. The third set will be reviewed by the Division of Licensing and Certification. All three agencies must issue an approval of the plans and specifications prior to beginning construction. The Division of Licensing and Certification will issue the letter authorizing the start of construction after receiving approval from the Office of Preventive and Public Health Services, the Office of State Fire Marshal.

C. The Division of Licensing and Certification, the Office of Preventive and Public Health Services, and the Office of State Fire Marshal, shall have the authority to inspect the project at any stage to insure that the approved plans and specifications are being followed. Final approval of the building must be obtained from these agencies after the building is completed and before it is occupied. A license shall issued by the Division of Licensing and Certification only after these final approvals have been obtained.

D. It shall be the responsibility of the provider to obtain any approvals from local authorities (such as zoning, building, fire, etc.) that may be needed in the particular city or parish.

E. All providers must be in conformity with the ASNI standards for the handicapped.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4929. General Waiver

A. The Office of the Secretary of DHH (the secretary) must determine the adequacy of quality and protection in accordance with the provisions of these standards.

B. If, in the judgment of the secretary, application of the requirements stated in these standards would be impractical in a specified case, such requirements may be modified by the secretary to allow alternative arrangements that will secure as nearly equivalent provision of services as is practical. In no case will the modification afford less quality or protection, in the judgment of the secretary, than that which would be provided with compliance of the provisions contained in these standards.

C. At the time of each subsequent revisit, such requirement modification must be reviewed by the secretary and either continued or cancelled.

D. DHH Office of Aging and Adult Services Case Management

1. Agencies that provide case management and/or support coordination services to the DHH Office of Aging and Adult Services (OAAS) waiver programs recipients shall be exempt from licensure as a case management agency for the provision of case management services. This licensure exemption shall only be to the extent that the agency uses only DHH/OAAS trained and certified case managers to provide case management services to OAAS waiver programs in lieu of DHH licensure. Such agencies serving other populations and programs, in addition to those waiver

programs operated by OAAS, shall obtain and maintain DHH licensure.

2. OAAS certification requirements shall ensure:

a. the quality of services and the care, well-being, and protection of the clients receiving services; and

b. that the delivery of case management services does not afford less quality or protection than the licensing provisions of this Chapter.

3. OAAS shall provide an attestation of meeting these requirements on an annual basis or as required by the DHH Health Standards Section.

4. OAAS case management and support coordination services will still be subject to the support coordination standards of participation rule for OAAS waiver programs, the program integrity/SURS (fraud/abuse) rules, and other applicable Medicaid rules and regulations.

E. Department of Children and Family Services Case Management

1. The Department of Children and Family Services (DCFS) shall be exempt from licensure as a case management agency for the provision of targeted case management services rendered by foster care and family services workers. The licensure exemption shall only be to the extent that DCFS uses trained and certified employees to provide case management services in lieu of DHH licensure.

2. DCFS certification requirements shall ensure:

a. the quality of services and the care, well-being, and protection of the clients receiving services; and

b. that the delivery of case management services does not afford less quality or protection than the licensing provisions of this Chapter.

3. DCFS shall provide an attestation of meeting these requirements on an annual basis.

4. DCFS case management services will still be subject to the Medicaid targeted case management rules, the program integrity/SURS (fraud/abuse) rules and other applicable Medicaid rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2152 (October 2015).

§4931. Case Management/Service Coordination Services

A. Case management must consist of services to assist consumers in gaining access to the full range of needed services, including medical, social, educational and other support services. These must be ongoing services which must be accomplished through the following activities.

1. Intake, which must include determination of a consumer's eligibility for case management services as part of a targeted group of consumers and the determination of need for case management services. All consumers must be interviewed within 14 calendar days of referral to the provider.

2. Assessment/reassessment, which must include the collection and integration of formal/professional and informal information concerning a consumer's social, familial, medical, developmental, legal, educational, vocational, psychiatric and economic status, as appropriate, to assist in the formulation of a comprehensive, individualized written service plan.

a. The assessment process must include input from the consumer/guardian, and may include input from family members, friends, professionals, and service providers, as appropriate.

b. The assessment must focus on the individual's strengths and needs. The case manager must make a face-to-face contact with the consumer as part of the assessment process.

c. The consumer's status must be reassessed on an ongoing basis.

3. Service planning, which must include the development of a comprehensive, individualized written plan based on the needs and strengths of the consumer identified during the assessment process.

a. The consumer/guardian must actively participate with the case manager in development of the service plan with input from family members, professionals and service providers, as needed.

b. The objective of service planning must be to promote consistent, coordinated, timely and quality service provision.

c. The service plan must include, at a minimum: consumer strengths and needs; specific measurable goals and objectives with anticipated time-frames.

d. The service plan must be completed within 45 calendar days of the intake interview for case management services.

e. The written service plan must be reviewed at least 90 days to assure goals and services are appropriate to the consumer's needs identified in the assessment/reassessment process.

D. Linkage, which must assure that the consumer has access to and is receiving the most appropriate services available to meet needs as outlined in the service plan. Linkage must include, but is not limited to:

1. contacting the individual's support network including family, neighbors and friends to mobilize assistance for the individual; and

2. locating or assisting the consumer in locating formal and informal service providers;

3. advocacy, which may occur on behalf of the consumer when needed to assure the consumer has access to and receives appropriate services.

E. Monitoring/follow-up, which must include ongoing interaction with the consumer/guardian, family members and professionals (as appropriate), and service providers to ensure that the agreed upon services are provided in a coordinated and integrated manner and are adequate to meet the needs and stated goals of the service plan. The case manager must make at least monthly face-to-face contacts with the consumer/guardian as part of the linkage and monitoring/follow-up process.

F. Transition/closure, which must be a joint decision made by the case manager, consumer and/or family member, when appropriate. Closure must occur upon completion of all case management goals identified on the service plan except when case management is a required component of a service or a required service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4933. General Requirements

A. The provider must allow representatives of the state licensing authority, in the performance of their mandated duties, to inspect all aspects of the provider's functioning which impact on consumers and families and to interview any staff member or consumer (if the consumer or family agrees to said interview).

B. The provider must make available to the state licensing authority any information which the provider is required to have under the present requirements and any information reasonably related to assessment of compliance with these requirements.

C. The provider must make available to DHH any information required by law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:888 (August 1994).

§4935. Governing Body

A. The provider must have an identifiable governing body with responsibility for and authority over the policies and activities of the agency.

B. The provider must document, in writing, all members of the governing body; their addresses; their terms of membership; officers of the governing body; and terms of office of any officers.

C. When the governing body does not include consumer and family representation, written policy and procedures must be implemented to ensure consumer and family input.

D. When the governing body is comprised of more than one person, the governing body must hold formal meetings at least semi-annually to discuss agency operations, including programmatic operations.

E. When the governing body is composed of more than one person, the provider must have written minutes of all formal meetings of the governing body and bylaws specifying frequency of meetings and quorum requirements.

AUTHORITY NOTE: Promulgated in accordance with R . S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:889 (August 1994).).

§4937. Governing Body Responsibilities

A. The governing body must:

1. ensure the provider's compliance and conformity with its articles of incorporation or charter;

2. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

3. ensure that the provider shall be adequately funded and fiscally sound;

4. review and approve the provider's annual budget;

5. ensure the review and approval of an annual external audit;

6. designate a person to act as chief administrator and delegate sufficient authority to this person to manage the agency;

7. formulate and annually review, in consultation with the chief administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

8. annually evaluate the chief administrator's performance, including evaluation in the areas of quality assurance and disposition of grievances;

9. have the authority to dismiss the chief administrator;

10. notify the designated representatives of DHH prior to initiating any substantial changes in the services provided;

11. ensure that a continuous written Quality Improvement Program is in effect;

12. ensure that services are provided in a culturally sensitive manner as evidenced by staff trained in cultural awareness and related policies and procedures;

13. ensure that all business practices and staff activities conforms to the *Code of Governmental Ethics*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:889 (August 1994).

§4939. Accessibility of Executive

A. The chief administrator or a person authorized to act on behalf of the chief administrator must be accessible to staff or designated representatives of DHH during agency hours of operation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4941. Documentation of Authority to Operate

A. A provider shall have documentation of its authority to operate under state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4943. Administrative Files

A. The provider's administrative files must include at a minimum:

1. documents identifying the governing body;

2. list of members and officers of the governing body, their addresses and terms of membership;

3. minutes of formal meetings and bylaws of the governing body, if applicable;

4. documentation of the provider's authority to operate under state law;

5. functional organizational chart which depicts lines of authority;

6. all leases, contracts and purchase-of-service agreements to which the provider is a party;

7. insurance policies;

8. annual budgets and audit reports;

9. master list of all service providers used by the provider;

10. the provider's policies and procedures

11. Documentation of corrective action taken as a result of external or internal reviews.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4945. Organizational Communication

A. The provider must establish procedures to assure adequate communication among staff to provide continuity of services to the consumer.

B. The provider must establish procedures which facilitates participation and feedback from staff, consumers, families, and when appropriate, the community at large. This will be used in areas such as policy-making, planning, and program development.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4947. Financial Management

A. The provider must establish a system of financial management and staffing to assure maintenance of complete and accurate accounts, books and records in keeping with generally accepted accounting principles.

B. The provider must demonstrate fiscal accountability through regular recording of its finances and an annual external audit conducted by a certified public accountant.

C. The provider must not permit public funds to be paid, or committed to be paid, to any person to which any of the members of the governing body, administrative personnel, or members of the immediate families of members of the governing body or administrative personnel have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the provider. The provider shall have a written disclosure of any financial transaction with the provider in which a member of the governing body, administrative personnel, or his/her immediate family is involved.

D. The provider must be capable of reporting fiscal data from July 1 through June 30.

E. The provider must have adequate and appropriate general liability insurance for the protection of its consumers, staff, facilities, and the general public.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4949. Confidentiality and Security of Records

A. A provider must have written procedures for the maintenance, security, and confidentiality of records. This must include specifying who must supervise the maintenance of records, and who must have custody of records. This procedure must also state to whom records can be released and the procedure for doing so. Records, including consumer as well as administrative, must be the property of the provider and the provider, as custodian, must secure records against loss, tampering, or unauthorized use.

B. Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the agency, the consumers or his/her family, directly or indirectly, to any unauthorized person.

C. The provider must safeguard the confidentiality of any information from which the consumer or his/her family might be identified, releasing such information only under the following conditions:

1. by court order;

2. by the consumer's written, informed consent for release of information;

a. when the consumer has been declared legally incompetent, the individual to whom the consumer's rights have devolved provides written consent.

b. when the consumer is a minor, the parent or legal guardian provides written consent.

c. in compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

D. A provider must, upon request, make available information in the case records to the consumer or legally responsible person. If, in the professional judgement of the administration of the agency, it is felt that information contained in the record would be damaging to a consumer, that information (only) may be withheld from the consumer except under court order. The provider may charge a reasonable fee for providing the above records.

E. A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge or the provider's services, or similar educational purposes, provided that names are deleted and other similar identifying information is disguised or deleted.

F. A system must be maintained that provides for the control/location of all consumer records. Consumer records must be located at the licensed site.

G. A system must be maintained that secures all records from unauthorized access and provides reasonable protection against fire, water damage, tampering, and other hazards.

H. A designated staff member must be responsible for the storage and protection of consumer records.

I. There must be a written process by which the consumer may gain access to his/her own records and receive copies upon written request.

J. Consumer records must be available to appropriate state and federal personnel at all reasonable times.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:890 (August 1994).

§4951. Records—Administrative and Consumer

A. All provider records must be maintained in an accessible, standardized order and format and must be retained and disposed of in accordance with state laws.

B. A provider must have sufficient space, facilities and supplies for providing effective record keeping services.

C. Upon agency closure, all provider records must be maintained according to applicable laws, rules and regulations.

D. A provider must have a written record for each consumer which must minimally include:

1. identifying data recorded on a standardized form including the following:

a. name;

b. home address;

c. home telephone number;

d. date of birth;

e. sex;

f. race or ethnic origin;

g. closest living relative;

h. education;

i. marital status;

j. name and address of current employment, school, or day program, as appropriate;

k. date of initial contact;

l. court and/or legal status, including relevant legal documents;

m. names, addresses, and phone numbers of other persons or providers involved with the consumer’s service plan. This shall include the consumer's physician;

n. other identifying data as indicated;

o. date the information was gathered;

p. signature of the staff member gathering the information.

2. Interdiction Status. A notation on the inside of the front cover that the consumer has been interdicted if this information is known.

3. Limited health records including a description of any serious or life threatening medical condition of the consumer. This must include a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies.

E. A provider must ensure that all entries in records are legible, signed by the person making the entry and accompanied by the date on which the entry was made.

F. Entries must be made in consumer records when services are provided to and/or on behalf of consumer in accordance with the following:

1. All entries and forms in the consumer's record that are completed by the provider must be in ink, are legible, be dated, be signed and shall include the functional title of the person making the entry.

2. An error in the consumer's record made by staff must be corrected by drawing a line through the erroneous information. The word "error" must be written beside the correction, and the correction must be initialed.

3. Correction fluid must never be used in a consumer's record.

G. Consumer record material must be organized in a manner which encourages staff to use it as a communication tool.

1. The location of documents within the record must be consistent among all the provider's records.

2. The record must be appropriately thinned so that current material shall be easily located in the record.

H. Each record must document the need for case management services and the following, at a minimum:

1. medical, social, psychiatric, psychological and other pertinent information regarding the consumer's disability, illness, or condition which will document eligibility for case management services for the targeted population;

2. necessary assessments and other information concerning the consumer's medical, social, familial, cultural, developmental, legal, educational, vocational, psychiatric and economic status, as appropriate, to support the initial service plan, and modifications in the service plan;

3. documentation of the need for ongoing case management and other identified services;

4. written service plan signed and dated by the case manager and the consumer and/or guardian shall be placed in the consumer's record;

5. description of all contacts, services delivered and/or action taken identifying the persons involved in service delivery, the date and place of service, the content of service delivery and the duration of the contact;

6. progress notes written at least monthly to document progress towards specified goals;

7. summary of services provided and progress towards goals, as well as the reason for the closure of the case at the time of termination; and,

8. any joint agreement with the consumer for closure.

I. The provider must utilize the tracking and/or data system for the Program Office of the targeted population being served or a comparable system which tracks the same data elements and allows reporting of data to the program office.

J. The provider must sign an agreement with the appropriate Program Office regarding the exchange of consumer-related data.

K. The record must contain at least six months of current information.

L. Information older than six months may be kept in storage but shall be available for review.

M. The records are maintained until audited and all audit questions answered or for three years from the time of payment, whichever is longer.

N. When a consumer transfers to another provider, at a minimum, copies of the following information must be sent to the requesting provider upon receipt of a release of information signed by the consumer:

1. most current service plan;

2. current assessments upon which service plan is based;

3. number of services used in the calendar year; and

4. last quarter's progress notes;

O. A nonredisclosure clause must accompany all information released to the requesting provider on all Office of Alcohol and Drug Abuse consumers;

P. The receiving provider must bear the cost of copying which shall not to exceed the community's competitive copying rate.

Q. A written policy must govern the disposal of consumer records and confidentiality of consumer information must be protected at the time of disposal.

R. A provider must have a written record for each employee which includes:

1. the application for employment and/or resume'

2. references

3. any required medical examinations

4. all required documentation of appropriate status which includes:

a. valid driver's license for operating provider vehicles or transporting consumers.

b. verification of professional credentials/certification required to hold the position including the following:

i. current licensure

ii. relevant licensure

iii. relevant education

iv. relevant training

v. relevant experience

5. periodic, at least annual, performance evaluations.

6. employee's starting and terminations dates along with salary paid.

S. An employee must have reasonable access to his/her personnel file and must be allowed to add any written statement he/she wishes to make to the file at any time.

T. A provider must not release a personnel file without the employee's written permission except in accordance with state law.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:891 (August 1994).

§4953. Program Description

A. The provider must have a clear, concise written program description, available to the public, detailing:

1. the overall philosophy of the program;

2. the long and short term goals of the program;

3. the types of consumers to be served;

4. the intake and closure criteria;

5. there must be written eligibility criteria for each of the services/programs provided;

6. the services to be provided;

7. a schedule of any fees for service which will be charged to the consumer;

8. a method of obtaining feedback from the consumer regarding consumer satisfaction with services;

9. an inventory of existing resources (both formal and informal) has been completed that identifies services within the geographic area to address the unique needs of the population to be served. This inventory must be updated at least annually;

10. demonstrated evidence that the program coincides with or is in agreement with existing state, regional, and local comprehensive service coordination and planning for the target population.

B. The provider must make every effort to ensure that service and planning for each consumer must be a comprehensive process involving appropriate staff, representatives of other agencies, the consumer, and where appropriate, the legally responsible person, and any other person(s) significantly involved in the consumer's care on an ongoing basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:891 (August 1994).

§4955. Transportation

A. The provider must ensure that any vehicle used by the agency staff to transport consumers must be properly maintained, inspected, and licensed according to state laws and carries a sufficient amount of liability insurance.

B. Any staff member using a vehicle to transport consumers must be properly licensed to operate that vehicle according to state laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:891 (August 1994), amended LR 20:893 (August 1994).

§4957. External Professional Service

A. A provider shall, when necessary, give assistance to clients in obtaining any required professional services not available from employees of the provider facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4959. Staff Plan and Staff Coverage

A. A provider must have a written plan for recruitment, screening orientation, ongoing training, development and supervision and performance evaluation of staff members.

B. Sufficient staffing must be provided to ensure a safe environment and adequacy of programming with consideration given to the geography of the setting, the number and needs of individuals served, the intensity of services needed. Staff coverage must be documented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4961. Nondiscrimination

A. A provider must have a written policy to prevent discrimination and must comply with all state and federal employment practices, laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4963. Recruitment

A. A provider must actively recruit and, whenever possible, employ qualified persons of both sexes representative of the cultural and racial groups served by the provider. This must include the hiring of qualified persons with disabilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4965. Screening

A. A provider shall have at least three written personal and/or prior work references for each employee or telephone notes from contact with said references.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4967. Orientation

A. A provider's orientation shall provide at least 16 hours of training for all direct care staff within one week of the date of employment.

1. All new employees working directly with clients shall receive orientation training on the provider's emergency and safety procedures and the requirements of state law and facility policy concerning client abuse. This training shall occur on or prior to the first day of employment and the staff member shall sign a statement of understanding certifying that such training has occurred.

2. A new employee shall not be given sole responsibility for the implementation of a client's program plan until this training is completed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4969. Training

A. A provider shall ensure that each direct service worker completes at least 40 hours of training per year. Orientation and normal supervision shall not be considered for meeting this requirement.

B. Employee training shall be documented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§4971. Program Evaluation

A. The provider must develop and implement a continuous Quality Improvement Plan that is designed to objectively assess and improve the quality of services for consumers which includes the following components:

1. the capability to identify, assess, and correct problems, a time line for correction of deficiency and follow-up on the results of corrective action;

2. procedures to allow immediate response to identified problems.

B. Pertinent findings of quality improvement activities must be reported to the governing body, executive/provider director.

C. The chief administrator must have the responsibility for the implementation and coordination of the quality improvement process. Duties must be specified.

D. Administrative review and any required corrective action must be conducted as required.

E. The Quality Improvement Plan and process must be reviewed at least annually to determine the need for and the mechanisms for improving the plan.

F. A program evaluation system must be maintained to identify the results of services and the effects of services on the consumer which meets the following criteria:

1. measures outcomes of programs and services;

2. regularly measures the progress of the consumers in relation to the program goals; and

3. evaluates post-discharge information, if applicable;

4. information gained from the system must be used to improve the program.

5. there must be a means to determine when performance is less than acceptable which includes the following:

a. the reasons must be identified when performance falls below the acceptable level;

b. management must take prompt action to improve program performance to an acceptable level; and

c. follow-up and monitoring of corrective actions must be performed at specific times with results documented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4973. Personnel Practices

A. The provider must have written employment and personnel policies which include:

1. job descriptions for all positions, including volunteers and students, that specify duties, qualifications, and competencies;

2. a description of hiring practices, which includes a policy against discrimination based on race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status or any other nonmerit factor; and

3. a description of procedures for: employee evaluation, promotion, disciplinary action, termination, and hearing of employee grievances.

B. There must be a written grievance procedure that allows employees to make complaints without fear of retaliation.

C. Grievances must be periodically reviewed by the governing body in an effort to promote improvement in these areas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4975. Abuse Reporting

A. A provider must have abuse reporting procedures which require all employees to report any incidents of abuse or mistreatment be that abuse or mistreatment is done by another staff member or professional, family member, the consumer, or any other person.

B. There must be written policies and procedures regarding abuse and neglect as defined by state and federal law.

1. The requirement that such action, as defined, must be strictly prohibited

2. Reporting Procedures

a. Every agency employee, consultant or contractor who witnesses, learns of, is informed of, or otherwise has reason to suspect that an incident of abuse or neglect has occurred must report such incident in accordance with state Child Protection laws and Adult Protection laws and fully cooperate with the investigation of the incident.

b. Proper authorities in the agency, community, and state must be identified.

c. Every employee must be informed of his or her reporting responsibilities and trained in the procedures for reporting.

3. Any allegations of abuse and neglect by agency personnel must be investigated internally.

a. Individuals under investigation must not be part of the investigation.

b. The Agency takes appropriate disciplinary action in the case of validated abuse.

c. The results of such investigations must be reviewed at an appropriate higher level and reported to the governing body.

d. Appropriate measures must be taken to assure that the individual is protected from further abuse.

4. Every employee, consultant, and contractor must be given a written copy of the agency's policies and procedures on consumer abuse and neglect.

a. Documentation of policy review by each employee must be maintained in the employee's personnel file.

b. Policies and procedures must be made available to others upon request.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:893 (August 1994).

§4977. Basic Rights

A. All case managers must conform to applicable state laws and DHH policies and procedures relative to consumer rights, including but not limited to those concerning confidentiality of consumer information and grievance procedures and consumer's right to appeal department decisions on service eligibility, planning, and delivery.

B. All case managers must conform to applicable state laws and DHH policies and procedures regarding consumer health and safety including but not limited to those concerning transporting consumers and abuse/neglect reporting.

C. There must be written policies and procedures that protect the consumer's welfare including the means by which the protections will be implemented and enforced.

D. The consumer, consumer's family or legal guardian, where appropriate, must be informed of their rights both verbally and in writing in language the consumer is able to understand.

E. The written policies and procedures, at a minimum, must address the following protections and rights:

1. to human dignity;

2. to acceptance of chosen life style;

3. to impartial access to treatment regardless of race, religion, sex, ethnicity, age or handicap;

4. cultural access is evidenced through provision of:

a. interpretive services

b. translated material

c. use of native language and staff when possible

d. staff trained in cultural awareness

5. access to persons with special needs is evidenced through sign language interpretation and mechanical aids and devices that assist those persons in achieving maximum benefit from services;

6. to privacy;

7. to confidentiality and access to consumer records including:

a. requirement for the consumer's written, informed consent for release of information

b. emergency unauthorized release

c. internal access to consumer records

d. external access to consumer records

e. conditions for consumer access to his/her records

8. to a complete explanation of the nature of services and procedures to be received including risks, benefits and available alternative services;

9. to participate, actively, in services including assessment/reassessment, service plan development, and transition/closure;

10. to refuse specific services;

11. to complaint/grievance procedures;

12. to be informed of the financial aspects of services;

13. to be informed of the need for parental or guardian consent for treatment or services, if appropriate;

14. to manage, personally, financial affairs unless legally determined otherwise;

15. to give informed written consent prior to being involved in research projects;

16. to refuse to participate in any research project without compromising access to services;

17. to protection from harm including any form of abuse, neglect, or mistreatment;

18. to receive services in a safe and humane environment;

19. to receive the least intrusive services appropriate and available;

20. to contact any advocacy resources as needed, especially during grievance procedures;

21. to be informed of the right to freely choose providers from those available.

F. A provider must ensure that consumers are provided all rights available to them be they interdicted or not.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:894 (August 1994).

§4979. Self-Advocacy

A. A provider must make every effort to ensure that a consumer understands his/her rights in matters such as access to services, appeal, grievances, and protection from abuse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:894 (August 1994).

§4981. Advocacy

A. A provider must ensure that an advocate is provided to the consumer whenever the consumer rights or desires may be in conflict or jeopardy with the provider.

AUTHORITY NOTE: Promulgated in accordance with R. S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:895 (August 1994).

§4983. Grievance Procedures for Consumers

A. A provider must have a written grievance procedure for consumers designed to allow consumers to make complaints without fear of retaliation.

B. Grievances must be periodically reviewed by the governing body in an effort to promote improvement in these areas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:380-451.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 20:895 (August 1994).

Chapter 50. Home and Community-Based Services Providers Licensing Standards

Subchapter A. General Provisions

§5001. Introduction

A. Pursuant to R.S. 40:2120.2, the Department of Health (LDH) has established the minimum licensing standards for home and community-based services (HCBS) providers. These licensing provisions contain the core requirements for HCBS providers as well as the module-specific requirements, depending upon the services rendered by the HCBS provider. These regulations are separate and apart from Medicaid standards of participation or any other requirements established by the Medicaid Program for reimbursement purposes.

B. Any person or entity applying for an HCBS provider license or who is operating as a provider of home and community-based services shall meet all of the core licensing requirements contained in this Chapter, as well as the module-specific requirements, unless otherwise specifically noted within these provisions.

C. Providers of the following services shall be licensed under the HCBS license:

1. adult day care (ADC);

2. family support;

3. personal care attendant (PCA);

4. respite;

5. substitute family care (SFC);

6. supervised independent living (SIL), including the shared living conversion services in a waiver home;

7. supported employment; and

8. monitored in-home caregiving (MIHC).

D. The following entities shall be exempt from the licensure requirements for HCBS providers:

1. any person, agency, institution, society, corporation, or group that solely:

a. prepares and delivers meals;

b. provides sitter services;

c. provides housekeeping services;

d. provides home modifications/environmental accessibility adaptations and/or assessments; or

e. provides personal emergency response system/assistive technology/devices;

2. any person, agency, institution, society, corporation, or group that provides gratuitous home and community-based services;

3. any individual licensed practical nurse (LPN) or registered nurse (RN) who has a current Louisiana license in good standing;

4. staffing agencies that supply contract workers to a health care provider licensed by the department;

5. any person who is employed as part of a departmentally authorized self-direction program; and

a. for purposes of these provisions, a self-direction program shall be defined as a service delivery option based upon the principle of self-determination. The program enables clients and/or their authorized representative(s) to become the employer of the people they choose to hire to provide supports to them;

6. any agency that provides residential orientation and adjustment programs for blind persons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:63 (January 2012), amended LR 38:1410 (June 2012), LR 40:1007 (May 2014), LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2498 (December 2017).

§5003. Definitions

Accredited—the process of review and acceptance by an accreditation body such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation (COA).

Activities of Daily Living (*ADLs*)—the functions or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living may include, but are not limited to, bathing, dressing, eating, grooming, walking, transferring and/or toileting.

Adult Day Care Services—structured and comprehensive services provided in a group setting that are designed to meet the individual needs of adults with functional impairments. This program provides a variety of health, social and related support services in a protective setting for a portion of a 24-hour day.

Assistance with Activities of Daily Living—services that provide assistance with activities of daily living. Such assistance may be the actual performance of the tasks for the individual, hands-on assistance with the performance of the tasks, or supervision and prompting to allow the individual to self-perform such tasks.

Branch—an office from which in-home services such as personal care attendant (PCA), supervised independent living (SIL) and respite are provided within the same LDH region served by the parent agency. The branch office shares administration and supervision.

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

Change in Health Status—a significant decline in the client's health that will not normally resolve itself without further assessment and/or intervention by staff or licensed medical practitioners.

Client—an individual who is receiving services from a home and community-based service provider.

Department—the Louisiana Department of Health (LDH) or any of its sections, bureaus, offices or its contracted designee.

Developmental Disability—a severe, chronic condition as defined in the Developmental Disabilities Law of 2005, R.S. 28:451.l-455.2.

Employed—performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is hired for a staff position.

Family Support Services—advocacy services, family counseling, including genetic counseling, family subsidy programs, parent-to-parent outreach, legal assistance, income maintenance, parent training, homemaker services, minor home renovations, marriage and family education, and other related programs.

Geographic Location—the LDH region in which the primary business location of the provider agency operates from.

Health Standards Section (*HSS*)—the licensing and certification section of the Department of Health.

Home and Community-Based Service Provider—an agency, institution, society, corporation, person(s) or any other group licensed by the department to provide one or more home and community-based services as defined in R.S. 40:2120.2 or these licensing provisions.

Incident—a death, serious illness, allegation of abuse, neglect or exploitation or an event involving law enforcement or behavioral event which causes serious injury to the client or others.

Individual Service Plan—a service plan, person centered and developed for each client, that is based on a comprehensive assessment which identifies the individual's strengths and needs in order to establish goals and objectives so that outcomes to service delivery can be measured.

NOTE: For those clients receiving Medicaid reimbursed home and community-based services, a comprehensive plan of care prepared in accordance with policies and procedures established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan.

Individuals with Disabilities Education Act (*IDEA*)—the law ensuring services to children with disabilities through the U.S. Department of Education which may include vocational training.

Instrumental Activities of Daily Living (*IADLs*)—the functions or tasks that are not necessary for fundamental functioning but assist an individual to be able to live in a community setting. These are activities such as light house-keeping, food preparation and storage, grocery shopping, laundry, reminders to take medication, scheduling medical appointments, arranging transportation to medical appointments and assistance attending medical appointments if needed.

LDH Region—the geographic administrative regions designated by the Department of Health.

Line of Credit—a credit arrangement with a federally insured, licensed lending institution which is established to assure that the provider has available funds as needed to continue the operations of the agency and the provision of services to clients. The line of credit shall be issued to the licensed entity and shall be specific to the geographic location shown on the license. For purposes of HCBS licensure, the line of credit shall not be a loan, credit card or a bank balance.

Mental Abuse—includes, but is not limited to abuse that is facilitated or caused by taking or using photographs or recordings in any manner that would demean or humiliate a client using any type of equipment (e.g., cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media sites.

1. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the client to experience humiliation, intimidation, fear, shame, agitation, or degradation, regardless of whether the client provided consent and regardless of the client's cognitive status. This may include, but is not limited to:

a. photographs and recordings of clients that contain nudity;

b. sexual and intimate relations;

c. bathing, showering or toileting;

d. providing perineal care such as after an incontinence episode;

e. agitating a client to solicit a response;

f. derogatory statements directed to the resident;

g. showing a body part without the client's face, whether it is the chest, limbs or back;

h. labeling a client's pictures and/or providing comments in a demeaning manner;

i. directing a client to use inappropriate language; and/or

j. showing a client in a compromised position.

Monitored In-Home Caregiving—services provided by a principal caregiver to a client who lives in a private unlicensed residence. The principal caregiver shall reside with the client, and shall be contracted by the licensed HCBS provider having a MIHC service module.

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

Personal Care Attendant Services—services required for a person with a disability to become physically independent to maintain physical function or to remain in, or return to, the community.

Respite Care—an intermittent service designed to provide temporary relief to unpaid, informal caregivers of the elderly and/or persons with disabilities.

Satellite—an alternate location from which center-based respite or adult day care services are provided within the same LDH region served by the parent agency. The satellite office shares administration and supervision.

Service Area—the LDH administrative region in which the provider's geographic business location is located and for which the license is issued.

Sitter Services—

1. services provided by a person who:

a. spends time with an individual;

b. accompanies such individual on trips and outings;

c. prepares and delivers meals to such individual; or

d. provides housekeeping services.

2. Any person who provides sitter services shall not provide hands-on personal care attendant service with respect to ADLs to the individual.

Sub-License—any satellite or branch office operating at a different physical geographic address.

Substitute Family Care Caregiver—a single or dual parent family living in a home setting which has been certified through a home study assessment as adequate and appropriate to provide care to the client by the SFC provider. At least one family member will be designated as a principal SFC caregiver.

Substitute Family Care Services—provide 24-hour personal care, supportive services and supervision to adults who meet the criteria for having a developmental disability.

Supervised Independent Living via a Shared Living Conversion Model—a home and community-based shared living model for up to six persons, chosen by clients of the Residential Options Waiver (ROW), or any successor waiver, as their living option.

Supervised Independent Living Services—necessary training, social skills and medical services to enable a person who has mental illness or a developmental disability, and who is living in congregate, individual homes or individual apartments, to live as independently as possible in the community.

Supported Employment—a system of supports for people with disabilities in regards to ongoing employment in integrated settings. Supported employment can provide assistance in a variety of areas including:

1. job development;

2. job coaches;

3. job retention;

4. transportation;

5. assistive technology;

6. specialized job training; and

7. individually tailored supervision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:64 (January 2012), amended LR 40:1007 (May 2014), LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2499 (December 2017).

§5005. Licensure Requirements

A. All HCBS providers shall be licensed by the Department of Health. It shall be unlawful to operate as a home and community-based service provider without a license issued by the department. LDH is the only licensing authority for HCBS providers in Louisiana.

B. An HCBS license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the HCBS provider to which it is issued and only for the specific geographic address of that provider, including any sub-license;

3. designate which home and community-based services the provider can provide;

4. enable the provider to render delineated home and community-based services within an LDH region;

5. be valid for one year from the date of issuance, unless revoked, suspended, modified or terminated prior to that date, or unless a provisional license is issued;

6. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the HCBS provider;

7. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

8. be posted in a conspicuous place on the licensed premises at all times.

C. An HCBS provider shall provide only those home and community-based services or modules:

1. specified on its license; and

2. only to clients residing in the provider's designated service area, LDH region, or at the provider's licensed location.

D. An HCBS provider may apply for a waiver from the Health Standards Section (HSS) to provide services to a client residing outside of the provider's designated service area or LDH region only under the following conditions.

1. A waiver may be granted by the department if there is no other HCBS provider in the client's service area or LDH region that is licensed and that has the capacity to provide the required services to the client, or for other good cause shown by the HCBS provider and client.

2. The provider shall submit a written waiver request to HSS prior to providing services to the client residing outside of the designated service area or LDH region.

3. The written waiver request shall be specific to one client and shall include the reasons for which the waiver is requested.

E. In order for the HCBS provider to be considered operational and retain licensed status, the provider shall meet the following conditions.

1. Each HCBS provider shall have a business location which shall not be located in an occupied personal residence and shall be in accordance with the provisions of §5027 and §5031 of this Chapter.

a. The business location shall be part of the licensed location of the HCBS provider and shall be in the LDH region for which the license is issued.

b. The business location shall have at least one employee, either contracted or staff, on duty at the business location during the days and hours of operation as stated on the licensing application and business location signage.

c. An HCBS provider which provides ADC services or out of home (center-based) respite care services may have the business location at the ADC building or center-based respite building.

2. The ADC shall be open at least five hours on days of operation. Center-based respite facilities shall have the capacity to provide 24-hour services.

3. There shall be a sufficient number of trained direct care staff and professional services staff, either employed or contracted, available to be assigned to provide services to persons in their homes as per the plan of care. ADC services and center-based respite services should be sufficiently staffed during the facility's hours of operation.

4. Each HCBS provider shall have at least one published business telephone number. Calls shall be returned within one business day.

F. The licensed HCBS provider shall abide by and adhere to any state law, rule, policy, procedure, manual or memorandum pertaining to HCBS providers.

G. A separately licensed HCBS provider shall not use a name which is substantially the same as the name of another HCBS provider licensed by the department. An HCBS provider shall not use a name which is likely to mislead the client or family into believing it is owned, endorsed or operated by the State of Louisiana.

H. If applicable, each HCBS provider shall obtain facility need review approval prior to initial licensing.

1. If an existing licensed HCBS provider who is not currently providing PCA, respite, MIHC or SIL services wants to begin providing these services, the provider shall be required to apply for facility need review approval for each of the requested services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:65 (January 2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2500 (December 2017).

§5007. Initial Licensure Application Process

A. An initial application for licensing as an HCBS provider shall be obtained from the department. A completed initial license application packet for an HCBS provider shall be submitted to and approved by the department prior to an applicant providing HCBS services.

B. The initial licensing application packet shall include:

1. a completed HCBS licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural facility plans for the adult day care module and the center-based respite module from the Office of the State Fire Marshal and any other office/entity designated by the department to review and approve the facility's architectural plans;

3. a copy of the on-site inspection report for the adult day care module and the center-based respite module with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health for the adult day care module and the center-based respite module;

5. a copy of a statewide criminal background check, conducted by the Louisiana State Police, or its authorized agent, including sex offender registry status, on all owners and administrators:

a. each owner shall be at least aged 18 years;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000 that is:

i. current at the time of submission of the application for licensure; and

ii. issued to/in the name of the applicant at the geographic location shown on the application for licensure;

b. general and professional liability insurance in the amount of at least $300,000 that is current and in effect at the time of license application; and

c. worker's compensation insurance that is current and in effect at the time of license application;

NOTE: The LDH Health Standards Section shall specifically be identified as the certificate holder on these policies pursuant to §5007.B.6.a-c and any certificates of insurance issued as proof of insurance by the insurer or producer (agent). The policy shall have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

7. a completed disclosure of ownership form which includes any controlling interest or ownership in any other licensed agencies;

8. the days and hours of operation;

9. an organizational chart and names, including position titles, of key administrative personnel and governing body; and

10. any other documentation or information required by the department for licensure including, but not limited to, a copy of the facility need review approval letter.

C. A person convicted of one or more of the following felonies is prohibited from being the owner or the administrator of an HCBS provider agency. For purposes of these provisions, the licensing application shall be rejected by the department for any felony conviction relating to:

1. the violence, abuse, or negligence of a person;

2. the misappropriation of property belonging to another person;

3. cruelty, exploitation or the sexual battery of the infirmed;

4. a drug offense;

5. crimes of a sexual nature;

6. a firearm or deadly weapon;

7. Medicare or Medicaid fraud; or

8. fraud or misappropriation of federal or state funds.

D. If the initial licensing packet is incomplete, the applicant shall be notified of the missing information and shall have 90 days from receipt of the notification to submit the additional requested information.

1. If the additional requested information is not submitted to the department within 90 days, the application shall be closed.

2. If an initial licensing application is closed, an applicant who is still interested in becoming an HCBS provider shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process, subject to any facility need review approval.

E. Applicants for HCBS licensure shall be required to either attend a mandatory HCBS provider training class or complete the LDH online provider training when a completed initial licensing application packet has been received by the department.

F. Upon completion of the mandatory HCBS provider training class and written notification of satisfactory class completion from the department or upon submission of attestation of satisfactory completion of the LDH online provider training, an HCBS applicant shall be required to admit one client and contact the HSS field office to schedule an initial licensing survey.

1. Prior to scheduling the initial survey, applicants shall be:

a. fully operational;

b. in compliance with all licensing standards; and

c. providing care to only one client at the time of the initial survey.

2. If the applicant has not admitted one client or contacted the HSS field office to schedule an initial survey within 30 days of receipt of the written notification from the department, the application will be closed. If an applicant is still interested in becoming an HCBS provider, a new initial licensing packet with a new initial licensing fee shall be submitted to the department to start the initial licensing process, subject to any facility need review approval.

G. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the HCBS provider will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2500 (December 2017).

§5009. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial on-site licensing survey shall be conducted to ensure compliance with the licensing laws and standards.

B. In the event that the initial licensing survey finds that the HCBS provider is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

C. In the event that the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations that present a potential threat to the health, safety, or welfare of the clients, the department shall deny the initial license.

D. In the event that the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, but the department in its sole discretion determines that the noncompliance does not present a threat to the health, safety or welfare of the clients, the department may issue a provisional initial license for a period not to exceed six months. The provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

1. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license will be issued.

2. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a client are cited, the provisional license will expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and the appropriate licensing fee.

E. The initial licensing survey of an HCBS provider shall be an announced survey. Follow-up surveys to the initial licensing surveys are unannounced surveys.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2501 (December 2017).

§5011. Types of Licenses and Expiration Dates

A. The department shall have the authority to issue the following types of licenses:

1. Full Initial License. The department shall issue a full license to the HCBS provider when the initial licensing survey finds that the provider is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. The department may issue a provisional initial license to the HCBS provider when the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed HCBS provider who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

B. The department, in its sole discretion, may issue a provisional license to an existing licensed HCBS provider for a period not to exceed six months. The department will consider the following circumstances in making a determination to issue a provisional license:

1. compliance history of the provider to include areas of deficiencies cited;

2. the nature and severity of any substantiated complaints;

3. the existing HCBS provider has been issued a deficiency that involved placing a client at risk for serious harm or death;

4. the existing HCBS provider has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

5. the existing HCBS provider is not in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

C. When the department issues a provisional license to an existing licensed HCBS provider, the provider shall submit a plan of correction to LDH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct a follow-up survey, either on-site or by desk review, of the HCBS provider prior to the expiration of the provisional license.

1. If the follow-up survey determines that the HCBS provider has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the HCBS license.

2. If the follow-up survey determines that all non-compliance or deficiencies have not been corrected, or if new deficiencies that are a threat to the health, safety or welfare of a client are cited on the follow-up survey, the provisional license shall expire.

3. The department shall issue written notice to the provider of the results of the follow-up survey.

D. If an existing licensed HCBS provider has been issued a notice of license revocation or termination, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

1. If a timely administrative appeal has been filed by the provider regarding the license revocation, suspension, or termination, the administrative appeal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the administrative tribunal or department issues a decision on the license revocation, suspension, or termination.

2. If the secretary of the department determines that the violations of the HCBS provider pose an imminent or immediate threat to the health, welfare, or safety of a client, the imposition of such action may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the HCBS provider will be notified in writing.

3. The denial of the license renewal application does not affect in any manner the license revocation, suspension, or termination.

E. The renewal of a license does not in any manner affect any sanction, civil fine or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:67 January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2501 (December 2017).

§5012. Change in License by Addition or Deletion of a Service Module or Modules from the HCBS License

A. Addition of a Service Module or Modules to existing HCBS License

1. An HCBS provider with an active HCBS license, current and in good standing, may submit a request to add a service module or modules. The following information shall be submitted for consideration of this request:

a. a completed HCBS license application which has "Add a Service" clearly marked;

b. a facility need review approval letter, if seeking to add the PCA, SIL, MIHC, or respite service modules; and

c. applicable fee for issuance of the new HCBS license.

B. Deletion of a Service Module or Modules to existing HCBS License

1. An HCBS provider with an active HCBS license may submit a request to delete a service module or modules. The following information shall be submitted for consideration of this request:

a. a completed HCBS license application which has "Delete a Service" clearly marked; and

b. applicable fee for issuance of the new HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2501 (December 2017).

§5013. Changes in Licensee Information, Location, or Key Personnel

A. An HCBS license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any change regarding the HCBS provider's entity name, "doing business as" name, mailing address, telephone number or any combination thereof, shall be reported in writing to the Health Standards Section within five working days of the change.

C. Any change regarding the HCBS provider's key administrative personnel shall be reported in writing to the Health Standards Section within 10 working days subsequent to the change.

1. Key administrative personnel include the:

a. administrator;

b. director of nursing, if applicable; and

c. medical director, if applicable.

2. The HCBS provider's notice to the department shall include the individual's:

a. name;

b. address;

c. hire date; and

d. qualifications.

D. If the HCBS provider changes its name without a change in ownership, the HCBS provider shall report such change to the department in writing five days prior to the change. The change in the HCBS provider name requires a change in the HCBS provider license. Payment of the applicable fee is required to re-issue the license.

1. An HCBS provider that is under license revocation may not undergo a CHOW.

2. If the CHOW results in a change of geographic address, an on-site survey may be required prior to issuance of the new license.

E. Any request for a duplicate license shall be accompanied by the applicable fee.

F. If the HCBS provider changes the physical address of its geographic location without a change in ownership, the HCBS provider shall report such change to LDH in writing at least five days prior to the change. Because the license of an HCBS provider is valid only for the geographic location of that provider, and is not transferrable or assignable, the provider shall submit a new licensing application.

1. An on-site survey may be required prior to the issuance of the new license.

2. The change in the HCBS provider's physical address results in a new license renewal anniversary date and an additional full licensing fee shall be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2502 (December 2017).

§5014. Change of Ownership of an HCBS Provider

A. The license of an HCBS provider is not transferable or assignable and cannot be sold.

B. A change of ownership (CHOW) of the HCBS provider shall not be submitted at time of the annual renewal of the provider's license.

C. Before an initial license can be issued to the new owner, all licensing application requirements shall be:

1. completed by the applicant in accordance with the provisions of §5007; and

2. submitted to the department for approval.

D. The applicant shall submit the following licensing requirements to the department:

1. the completed HCBS license application and non-refundable fee;

2. disclosure of ownership documentation;

3. proof of financial viability to include:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000 that is current at the time of the application for licensure and is issued to/in the name of the applicant at the geographic location shown on the application for licensure;

b. general and professional liability insurance of at least $300,000 that is current and in effect at the time of application for licensure; and

c. worker's compensation insurance that is current and in effect at the time of application for licensure.

NOTE: The LDH Health Standards Section shall specifically be identified as the certificate holder on these policies pursuant to §5014.D.3.a-c and any certificates of insurance issued as proof of insurance by the insurer or producer (agent). The policy shall have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

4. If center-based services such as adult day care or center-based respite are also being acquired in the change of ownership, the prospective new owner shall be required to submit approvals for occupancy from OPH and the State Fire Marshal. Such approvals shall be issued under the name of the center as given by the new owner.

E. An HCBS provider may not undergo a CHOW if any of the following conditions exist:

1. licensure is provisional, under revocation or denial of renewal;

2. is in a settlement agreement with the department;

3. has been excluded from participation from the Medicaid program;

4. has ceased to operate and does not meet operational requirements to hold a license as defined by §5031, Business Location, and in accordance with §5026, Cessation of Business.

F. The department may deny approval of the CHOW for any of the reasons a license may be revoked or denied renewal pursuant to these licensing provisions.

G. If the CHOW results in a change of geographic address, an on-site survey may be required prior to issuance of the new license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2502 (December 2017).

§5015. Renewal of License

A. The HCBS provider shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the current license. The license renewal application packet shall include:

1. the license renewal application;

2. the days and hours of operation;

3. a current State Fire Marshal report for the adult day care module and the center-based respite module;

4. a current Office of Public Health inspection report for the adult day care module and the center-based respite module;

5. the non-refundable license renewal fee;

6. any other documentation required by the department; and

7. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000 that is current at the time of the application for license renewal and is issued to/in the name of the applicant at the geographic location shown on the application for license renewal;

b. general and professional liability insurance of at least $300,000 that is current and in effect at the time of application for license renewal and has been maintained and in effect throughout the term of the license; and

c. worker's compensation insurance that is current and in effect at the time of application for license renewal and has been maintained and in effect throughout the term of the license.

NOTE: The LDH Health Standards Section shall specifically be identified as the certificate holder on these policies pursuant to §5015.A.7.a-c and any certificates of insurance issued as proof of insurance by the insurer or producer (agent). The policy shall have a cancellation/change statement

requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the HCBS license.

NOTE: Upon expiration of the current license, the HCBS provider shall cease providing services in accordance with R.S. 40:2120.6 and shall meet the requirements of §5026 Cessation of Business.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2502 (December 2017).

§5016. Deemed Status through Accreditation

A. An HCBS provider may request deemed status from the department. The department may accept accreditation in lieu of a routine on-site resurvey provided that:

1. the accreditation is obtained through an organization approved by the department;

2. all services provided under the HCBS license shall be accredited; and

3. the provider forwards the accrediting body's findings to the Health Standards Section within 30 days of its accreditation.

B. The accreditation will be accepted as evidence of satisfactory compliance with all provisions of these requirements.

C. The following may cause the state agency to perform a full licensing survey on an accredited HCBS provider:

1. any substantiated complaints in the preceding 12-month period;

2. addition of service module or modules;

3. a change of ownership in the preceding 12-month period;

4. issuance of a provisional license in the preceding 12-month period;

5. serious violations of licensing standards or professional standards of practice that were cited in the preceding 12-month period that resulted in or had the potential for negative outcomes to clients served; or

6. allegations of inappropriate client treatment or services to a client resulting in death or serious injury.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:68 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2503 (December 2017).

§5017. Survey Activities

A. The department, or its designee, may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing HCBS providers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. The department shall also conduct complaint surveys. The complaint surveys shall be conducted in accordance with R.S. 40:2009.13 et seq.

C. The department shall require an acceptable plan of correction from a provider for any survey where deficiencies have been cited, regardless of whether the department takes other action against the facility for the deficiencies cited in the survey. The acceptable plan of correction shall be submitted within the prescribed timeframe to the department for approval.

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

E. The department may issue appropriate sanctions for noncompliance, deficiencies and violations of law, rules and regulations. Sanctions include, but are not limited to:

1. civil fines;

2. directed plans of correction;

3. license revocation; and/or

4. denial of license renewal.

F. LDH surveyors and staff shall be:

1. given access to all areas of the provider agency, and to all relevant administrative and/or clinical files during any survey as necessary or required to conduct the survey and/or investigation; and

2. allowed to interview any provider staff, client or other persons as necessary or required to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2503 (December 2017).

§5019. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to the HCBS provider shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to an HCBS provider shall be available for disclosure to the public 30 days after the provider submits an acceptable plan of correction to the deficiencies or 90 days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Unless otherwise provided in statute or in these licensing provisions, a provider shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

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

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

3. The request for informal reconsideration of the deficiencies shall be made to the department's Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement deficiencies.

4. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

NOTE: Informal reconsiderations of the results of a complaint investigation are conducted as desk reviews.

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

6. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided in these licensing provisions for initial license denials, revocations and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2503 (December 2017).

§5021. Denial of Initial Licensure, Revocation of License, Denial of License Renewal

A. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the provisions of the Administrative Procedure Act. These actions may be taken against the entire license or certain modules of the license.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the HCBS provider is noncompliant with any licensing laws or regulations, or any other required statutes or regulations that present a potential threat to the health, safety or welfare of the clients.

2. The department may deny an initial license for any of the reasons a license may be revoked or denied renewal pursuant to these licensing provisions.

3. If the department denies an initial license, the applicant for an HCBS provider license shall discharge the client(s) receiving services.

C. Voluntary Non-Renewal of a License. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

D. Revocation of License or Denial of License Renewal. An HCBS provider license may be revoked or denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the HCBS licensing laws, rules and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. failure to uphold client rights whereby deficient practices result in harm, injury or death of a client;

5. failure to protect a client from a harmful act of an employee, either contracted or staff, or by another client including, but not limited to:

a. mental or physical abuse, neglect, exploitation or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

6. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in §5021.D.5;

7. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, client records or provider records;

d. matters under investigation by the department or the Office of the Attorney General; or

e. information submitted for reimbursement from any payment source;

8. knowingly making a false statement or providing false, forged or altered information or documentation to LDH employees or to law enforcement agencies;

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

10. an owner, officer, member, manager, administrator, director or person designated to manage or supervise client care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court;

a. For purposes of these provisions, conviction of a felony involves any felony conviction relating to:

i. the violence, abuse, or negligence of a person;

ii. the misappropriation of property belonging to another person;

iii. cruelty, exploitation or the sexual battery of the infirmed;

iv. a drug offense;

v. crimes of a sexual nature;

vi. a firearm or deadly weapon;

vii. Medicare or Medicaid fraud; or

viii. fraud or misappropriation of federal or state funds;

11. failure to comply with all reporting requirements in a timely manner, as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview provider staff or clients;

13. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

14. failure to allow or refusal to allow access to provider, facility or client records by authorized departmental personnel;

15. bribery, harassment, intimidation or solicitation of any client designed to cause that client to use or retain the services of any particular HCBS provider;

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department; or

18. failure to maintain current, and in effect, required insurance policies in accordance with the provisions of this Chapter.

E. In the event an HCBS provider license is revoked, renewal is denied or the license is surrendered in lieu of an adverse action, any owner, board member, director or administrator, and any other person named on the license application of such HCBS provider is prohibited from owning, managing, directing or operating another HCBS agency for a period of two years from the date of the final disposition of the revocation, denial action or surrender.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:69 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2503 (December 2017).

§5023. Notice and Appeal of Initial License Denial, License Revocation and Denial of License Renewal

A. Notice of an initial license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The HCBS provider has a right to an administrative reconsideration of the initial license denial, license revocation or denial of license renewal. There is no right to an administrative reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The HCBS provider shall request the administrative reconsideration within 15 calendar days of the receipt of the notice of the initial license denial, license revocation or denial of license renewal. The request for administrative reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section. The request for administrative reconsideration shall be considered timely if received by the Health Standards Section within 15 days from the provider's receipt of the notice.

2. The request for administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received by HSS, an administrative reconsideration shall be scheduled and the provider will receive written notification of the date of the administrative reconsideration.

4. The provider shall have the right to appear in person at the administrative reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the initial license denial, revocation or denial of license renewal shall not be a basis for reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the administrative reconsideration.

C. The HCBS provider has a right to an administrative appeal of the initial license denial, license revocation or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The HCBS provider shall request the administrative appeal within 30 days of the receipt of the results of the administrative reconsideration.

a. The HCBS provider may forego its rights to an administrative reconsideration, and if so, shall request the administrative appeal within 30 calendar days of the receipt of the written notice of the initial license denial, revocation or denial of license renewal.

2. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor. The request shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the Division of Administrative Law, or its successor, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the provider pose an imminent or immediate threat to the health, welfare or safety of a client, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the provider will be notified in writing.

4. Correction of a violation or a deficiency which is the basis for the initial license denial, license revocation or denial of license renewal shall not be a basis for an administrative appeal.

D. If an existing licensed HCBS provider has been issued a notice of license revocation, and the provider's license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

E. If a timely administrative appeal has been filed by the provider on an initial license denial, denial of license renewal or license revocation, the Division of Administrative Law, or its successor, shall conduct the hearing in accordance with the Administrative Procedure Act.

1. If the final agency decision is to reverse the initial license denial, denial of license renewal or license revocation, the provider's license will be re-instated or granted upon the payment of any licensing fees, outstanding sanctions or other fees due to the department.

2. If the final agency decision is to affirm the denial of license renewal or license revocation, the provider shall discharge any and all clients receiving services according to the provisions of this Chapter.

a. Within 10 calendar days of the final agency decision, the provider shall notify HSS, in writing, of the secure and confidential location where the client records will be stored and the name and contact information of the person(s) responsible for the client records.

F. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new HCBS provider, or the issuance of a provisional license to an existing HCBS provider. A provider who has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license is not considered to be a denial of initial licensure, denial of license renewal or license revocation.

G. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal, solely as to the validity of the deficiencies.

1. The correction of a violation, noncompliance or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five calendar days of receipt of the written notice of the results of the follow-up survey from the department.

4. The provider shall request the administrative appeal within 15 calendar days of receipt of the written notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

5. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge clients unless the Division of Administrative Law, or its successor, issues a stay of the expiration.

a. The stay may be granted by the Division of Administrative Law, or its successor, upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing and only upon a showing

that there is no potential harm to the clients being served by the provider.

6. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired, or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Division of Administrative Law, or its successor, shall conduct the hearing in accordance with the Administrative Procedure Act.

a. If the final agency decision is to remove all deficiencies, the provider's license will be re-instated upon the payment of any outstanding sanctions and licensing or other fees due to the department.

b. If the final agency decision is to uphold the deficiencies thereby affirming the expiration of the provisional license, the provider shall ensure an orderly discharge and transition of any and all clients receiving services in accordance with the provisions of this Chapter.

i. Within 10 calendar days of the final agency decision, the provider shall notify HSS in writing of the secure and confidential location where the client records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:70 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2504 (December 2017).

§5024. Inactivation of License due to a Declared Disaster or Emergency [Formerly §5025]

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

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

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

b. the licensed HCBS provider intends to resume operation as an HCBS provider in the same service area;

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

d. includes an attestation that all clients have been properly discharged or transferred to another provider; and

e. provides a list of each client and where that client is discharged or transferred to;

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

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

4. the licensed HCBS provider continues to submit required documentation and information to the department.

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

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

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

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

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

2. The provider resumes operating as an HCBS provider in the same service area within one year.

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

1. The licensed capacity of the reinstated license shall not exceed the licensed capacity of the adult day care and center-based respite provider at the time of the request to inactivate the license.

E. No change of ownership in the HCBS provider shall occur until such HCBS provider has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as an HCBS provider.

F. The provisions of this Section shall not apply to an HCBS provider which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the HCBS

provider license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2505 (December 2017).

§5025. Inactivation of License due to a Non-Declared Disaster or Emergency

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

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

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

b. the licensed HCBS intends to resume operation as an HCBS provider in the same service area;

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

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

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

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

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

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

C. Upon the facility's receipt of the department's approval of request to inactivate the facility's license, the facility shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to the OSFM and the OPH as required.

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

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

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

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

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

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

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

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

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

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2506 (December 2017).

§5026. Cessation of Business

A. Except as provided in §5024 and §5025 of these licensing regulations, a license shall be immediately null and void if an HCBS provider becomes non-operational.

B. A cessation of business is deemed to be effective the date on which the HCBS provider ceased offering or providing services to the community and/or is considered non-operational in accordance with §5005.E.1.b.

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

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

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

1. give 30 days' advance written notice to:

a. each client or client's legal representative, if applicable;

b. each client's physician;

c. HSS;

d. OCDD;

e. OAAS;

f. support coordination agency for waiver participants;

g. state contractor for state plan LT-PCS services;

2. provide for a safe and orderly discharge and transition of all of the HCBS provider's clients.

F. In addition to the advance notice, the provider shall submit a written plan for the disposition of client services related records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's client services related records;

3. the name and contact information for the appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

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

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

H. Once any HCBS provider has ceased doing business, the provider shall not provide services until the provider has obtained a new initial HCBS license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2506 (December 2017).

Subchapter B. Administration and Organization

§5027. Governing Body

A. An HCBS provider shall have an identifiable governing body with responsibility for and authority over the policies and activities of the program/agency.

1. A provider shall have documents identifying all members of the governing body, their addresses, their terms of membership, officers of the governing body and terms of office of any officers.

2. The governing body shall be comprised of three or more persons and shall hold formal meetings at least twice a year.

3. There shall be written minutes of all formal meetings of the governing body and by-laws specifying frequency of meetings and quorum requirements.

B. The governing body of an HCBS provider shall:

1. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. ensure that the provider is adequately funded and fiscally sound;

3. review and approve the provider's annual budget;

4. designate a person to act as administrator and delegate sufficient authority to this person to manage the provider agency;

5. formulate and annually review, in consultation with the administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

6. annually evaluate the administrator's performance;

7. have the authority to dismiss the administrator;

8. meet with designated representatives of the department whenever required to do so;

9. ensure statewide criminal background checks on all unlicensed persons providing direct care and services to clients in accordance with R.S. 40:1203.2 or other applicable state law upon hire;

NOTE: Upon request of the employer with approval of the governing body, each applicant for employment may be fingerprinted in accordance with applicable state law to be used to obtain the criminal history record.

10. ensure that the provider does not hire unlicensed persons who have a conviction that bars employment in accordance with R.S. 40:1203.3 or other applicable state law;

a. the provider shall have documentation on the final disposition of all charges that bars employment pursuant to applicable state law; and

11. ensure that direct support staff comply with R.S. 40:1203.2 or other applicable state law.

NOTE: It is not acceptable for a provider to have a client, family member or legal representative sign a statement that they acknowledge the direct support worker has a conviction that bars employment but they still choose to have that individual as the worker. The provider is expected to be in compliance with statutory requirements at all times.

C. An HCBS provider shall maintain an administrative file that includes:

1. a list of members and officers of the governing body, along with their addresses and terms of membership;

2. minutes of formal meetings and by-laws of the governing body, if applicable;

3. a copy of the current license issued by HSS;

4. an organizational chart of the provider which clearly delineates the line of authority;

5. all leases, contracts and purchases-of-service agreements to which the provider is a party;

6. insurance policies;

7. annual budgets and audit reports; and

8. a master list of all the community resources used by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:72 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2507 (December 2017).

§5029. Policy and Procedures

A. The HCBS provider shall develop, implement and comply with provider-specific written policies and procedures related to compliance with this Chapter, including, but not limited to policies and procedures that:

1. conform to the department's rules and regulations;

2. meet the needs of the clients as identified and addressed in the ISP;

3. provide for the protection of clients' rights; and

4. promote the highest practicable social, physical and mental well-being of clients.

B. The HCBS provider shall have written policies and procedures approved by the owner or governing body, which shall be implemented and followed, that address at a minimum the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. personnel;

5. client rights;

6. grievance procedures;

7. client funds;

8. emergency preparedness;

9. abuse, neglect, exploitation and extortion;

10. incidents and accidents, including medical emergencies;

11. universal precautions;

12. documentation;

13. admission and discharge procedures; and

14. safety of the client while being transported by an agency employee, either contracted or directly employed, to include a process for evaluation of the employee's driver's license status inquiry report which may prohibit an employee from transporting clients.

C. The HCBS provider shall develop, implement and comply with written personnel policies that include the following:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members, that includes but is not limited to:

a. standards of conduct;

b. standards of attire to include having identification as an employee of the provider accessible when providing services to clients; and

c. standards of safety to include requirements for ensuring safe transportation of clients by employees, contracted or staff, who provide transportation;

2. written job descriptions for each staff position, including volunteers;

3. policies that shall, at a minimum, be consistent with Office of Public Health guidelines for services provided;

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees, either contracted or directly employed, to report any and all incidents of abuse or mistreatment or misappropriation of client funds, whether that abuse or mistreatment or misappropriation is done by another staff member, a family member, a client or any other person;

6. a written policy to prevent discrimination;

7. a written policy to assure that there is a final disposition of all charges that appear on the staff person's or contracted employee's criminal background check; and

8. a written policy to address prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restricted use of social media an include, at a minimum ensuring confidentiality of client information and

preservation of client dignity and respect, and protection of client privacy and personal and property rights.

D. The HCBS provider shall have written policies and procedures for client behavior management which:

1. prohibit:

a. corporeal punishment;

b. restraints of any kind;

c. psychological and verbal abuse;

d. seclusion;

e. forced exercise;

f. any cruelty to, or punishment of, a client; and

g. any act by a provider which denies:

i. food;

ii. drink;

iii. visits with family, friends or significant others; or

iv. use of restroom facilities;

NOTE: §5029.D.1.g.i-iv is not inclusive of medically prescribed procedures.

2. ensure that non-intrusive positive approaches to address the meaning/origins of behaviors are used prior to the development of a restrictive plan; and

3. cover any behavioral emergency and provide documentation of the event in an incident report format.

E. An HCBS provider shall comply with all federal state and local laws, rules and regulations in the development and implementation of its policies and procedures.

F. An HCBS provider shall ensure that all home and community-based waiver services are delivered in settings that are physically accessible to the client when the setting is controlled by the HCBS provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:73 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2507 (December 2017).

§5031. Business Location

A. All HCBS providers shall have a business location in the LDH region for which the license is issued. The business location shall be a part of the physical geographic licensed location and shall be where the provider:

1. maintains staff to perform administrative functions;

2. maintains and stores the provider's personnel records;

3. maintains and stores the provider's client service records;

4. holds itself out to the public as being a location for receipt of client referrals; and

5. after initial licensure, consistently provides services to at least two clients.

EXCEPTION: Adult Day Care shall have 10 or more clients pursuant to R.S. 40:2120.2(4)(e).

B. The business location shall have:

1. a separate entrance and exit from any other entity, business or trade;

2. signage that is easily viewable indicating the provider's legal or trade name, address and days and hours of business operation as stated in the provider's license application.

a. Any planned deviation of the provider's days and hours of operation shall be reported to the Health Standards Section within five business days.

b. Any unplanned deviation of provider's days and hours of operation shall be reported to the Health Standards Section within two business days.

C. The HCBS provider shall operate independently from any other business or entity, and shall not operate office space with any other business or entity.

1. The HCBS provider may share common areas with another business or entity. Common areas include foyers, kitchens, conference rooms, hallways, stairs, elevators or escalators when used to provide access to the provider's separate entrance.

2. Records or other confidential information shall not be stored in areas deemed to be common areas.

D. The business location shall:

1. be commercial office space or, if located in a residential area, be zoned for appropriate commercial use and shall be used solely for the operation of the business;

a. the business location shall not be located in an occupied personal residence;

2. have approval for occupancy from the Office of the State Fire Marshal and the Office of Public Health if located at the same address as an adult day care center or center-based respite;

3. have a published telephone number which is available and accessible 24 hours a day, 7 days a week, including holidays;

4. have a business fax number that is operational 24 hours a day, 7 days a week;

5. have internet access and a working e-mail address;

a. the e-mail address shall be provided to the department as well as any changes to the e-mail address within five working days to assure that the department has current contact information;

b. the e-mail address shall be monitored by the provider on an ongoing basis to receive communication from the department;

6. have space for storage of client records either electronically or in paper form or both in an area that is secure, safe from hazards and does not breach confidentiality of protected health information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:74 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2508 (December 2017).

§5032. Branch Offices and Satellites of HCBS Providers

A. HCBS providers with branch offices or satellite locations shall meet the following.

1. No branch office or satellite location may be opened without prior written approval from HSS. In order for a branch office or satellite location to be approved, the parent agency shall have maintained a full licensure for the previous 12-month period.

a. The number of any new branch or satellite locations for any provider within a geographic location may be limited at the discretion of HSS.

2. The department may consider the following in making a determination whether to approve a branch office or a satellite location:

a. compliance history of the provider to include the areas of non-compliance of the deficiencies cited within the last 12 months;

b. the nature and severity of any substantiated complaints within the last 12 months;

c. if the parent agency currently has a provisional license;

d. if the parent agency currently is in a settlement agreement with the department;

e. if the parent agency has previously been excluded from participation from the Medicaid program;

f. if the parent agency is currently under license revocation or denial of license renewal;

g. if the parent agency is currently undergoing a change of ownership; and

h. if any adverse action has been taken against the license of other agencies operated by the owner of the parent agency within the previous two-year period.

3. The branch office or satellite location shall be held out to the public as a branch, division, or satellite of the parent agency so that the public will be aware of the identity of the agency operating the branch or satellite.

a. Reference to the name of the parent agency shall be contained in any written documents, signs or other promotional materials relating to the branch or satellite.

4. Original personnel files shall not be maintained or stored at the branch office or satellite location.

5. A branch office or a satellite location is subject to survey, including complaint surveys, by the department at any time to determine compliance with minimum licensing standards.

6. A branch office or a satellite location shall:

a. serve as part of the geographic service area approved for the parent agency;

b. retain an original or a duplicate copy of all clinical records for its clients for a 12-month period at the branch or satellite location;

NOTE: If satellite or branch records are not maintained at the parent agency, such shall be made available as requested by the state surveyor without delaying the survey process;

c. maintain a copy of the agency's policies and procedures manual on-site for staff usage;

d. post and maintain regular office hours in accordance with §5031.B; and

e. staff the branch office or satellite location during regular office hours.

7. Each branch office or satellite location shall:

a. fall under the license of the parent agency and be located in the same LDH region as the parent agency;

b. be assessed the required fee, assessed at the time the license application is made and once a year thereafter for renewal of the branch or satellite license;

NOTE: This fee is non-refundable and is in addition to any other fees that may be assessed in accordance with applicable laws, rules, regulations and standards.

8. Existing branch office or satellite location approvals will be renewed at the time of the parent agency's license renewal, if the parent agency meets the requirements for licensure.

B. Branch Offices of HCBS Providers

1. An HCBS provider who currently provides in-home services such as PCA, respite, MIHC or SIL services may apply to the department for approval to operate a branch office to provide those same services.

a. HCBS providers are limited in the same LDH region as the parent agency at the discretion of HSS.

C. Satellite Locations of HCBS Providers

1. An HCBS provider who currently provides ADC services or provides center-based respite services may apply to the department for approval to operate a satellite location to provide additional ADC services or center-based respite services at that satellite location.

a. HCBS providers are limited in the same LDH region as the parent agency at the discretion of the HSS.

NOTE: The HSS may with good cause consider exceptions to the limit on numbers of satellite and/or branch locations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2509 (December 2017).

Subchapter C. Admission, Transfer and Discharge Criteria

§5033. Admissions

A. An HCBS provider shall have written admissions policies and criteria which shall include the following:

1. intake policy and procedures;

2. admission criteria and procedures;

3. admission criteria and procedures for minors;

4. legal status of the clients served;

5. the age of the populations served;

6. the services provided by the provider's program(s); and

7. criteria for discharge.

B. The written description of admissions policies and criteria shall be made available to the client and his/her legal representative.

C. An HCBS provider shall ensure that the client, the legal representative or other persons, where appropriate, are provided an opportunity to participate in the admission process.

1. Consents as necessary for care and services shall be obtained from the client or legal representative, if applicable, prior to admission.

2. Where such involvement of the client, the legal representative, where appropriate, or other persons as selected by the client is not possible or not desirable, the reasons for their exclusion shall be recorded.

D. When refusing admission, a provider shall provide a written statement as to the reason for the refusal. This shall be provided to designated representatives of the department or to a client upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2510 (December 2017).

§5035. Voluntary Transfers and Discharges

A. A client has the right to choose a provider. This right includes the right to be discharged from his current provider, be transferred to another provider and to discontinue all services.

B. Upon notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services or moves from the geographic region serviced by the provider, the HCBS provider shall have the responsibility of planning for a client's voluntary transfer or discharge.

C. The transfer or discharge responsibilities of the HCBS provider shall include:

1. holding a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are applicable, in order to facilitate an orderly transfer or discharge, unless the client or authorized representative declines such a meeting;

2. providing a current individual service plan (ISP). Upon written request and authorization by the client or authorized representative, a copy of the current ISP shall be provided to the client or receiving provider; and

3. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary on the health, developmental issues, behavioral issues, social issues, and nutritional status of the client. Upon written request and authorization by the client or authorized representative, a copy of the discharge summary shall be disclosed to the client or receiving provider.

D. The written discharge summary shall be completed within five working days of the notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services.

1. The provider's preparation of the discharge summary shall not impede or impair the client's right to be transferred or discharged immediately if the client so chooses.

E. The provider shall not coerce the client to stay with the provider agency or interfere in any way with the client's decision to transfer. Failure to cooperate with the client's decision to transfer to another provider may result in further investigation and action as deemed necessary by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2510 (December 2017).

§5037. Involuntary Transfers and Discharges

A. An HCBS provider shall not transfer or discharge the client from the provider except under the following circumstances. These situations will be considered involuntary transfers or discharges.

1. The client's health has improved sufficiently so that the client no longer requires the services rendered by the provider.

2. The safety or health of a client(s) or provider staff is endangered.

3. The client has failed to pay any past due amounts for services received from the provider for which he/she is liable within 15 days after receipt of written notice from the provider.

4. The provider ceases to operate.

5. The client or family refuses to cooperate or interferes with attaining the care objectives of the HCBS provider.

6. The HCBS provider closes a particular module so that certain services are no longer provided.

B. When the provider proposes to involuntarily transfer or discharge a client, compliance with the provisions of this Section shall be fully documented in the client's records.

C. An HCBS provider shall provide a written notice of the involuntary transfer or discharge to the client, a family member of the client, if known, to the authorized representative if known, and the support coordinator if applicable, at least 30 calendar days prior to the transfer or discharge.

1. The written notice shall be sent to the client or to the authorized representative via certified mail, return receipt requested.

2. When the safety or health of clients or provider staff is endangered, written notice shall be given as soon as practicable before the transfer or discharge.

3. When the client has failed to pay any outstanding amounts for services for which he/she has received from the provider and is liable, written notice may be given immediately. Payment is due within 15 days of receipt of written notice from the provider that an amount is due and owing.

4. The notice of involuntary discharge or transfer shall be in writing and in a language and manner that the client understands.

5. A copy of the notice of involuntary discharge or transfer shall be placed in the client's clinical record.

D. The written notice of involuntary transfer or discharge shall include:

1. a reason for the transfer or discharge;

2. the effective date of the transfer or discharge;

3. an explanation of a client's right to personal and/or third party representation at all stages of the transfer or discharge process;

4. contact information for the Advocacy Center;

5. names of provider personnel available to assist the client or authorized representative and family in decision making and transfer arrangements;

6. the date, time and place for the discharge planning conference;

7. a statement regarding the client's appeal rights;

8. the name of the director, current address and telephone number of the Division of Administrative Law, or its successor; and

9. a statement regarding the client's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

E. Appeal Rights for Involuntary Transfers or Discharges

1. If a timely appeal is filed by the client or authorized representative disputing the involuntary discharge, the provider shall not transfer or discharge the client pursuant to the provisions of this Section.

NOTE: The provider's failure to comply with these requirements may result in revocation of a provider's license.

2. If nonpayment is the basis of the involuntary transfer or discharge, the client shall have the right to pay the balance owed to the provider up to the date of the transfer or discharge and is then entitled to remain with the agency if outstanding balances are paid.

3. If a client files a timely appeal request, the Division of Administrative Law, or its successor, shall hold an appeal hearing at the agency or by telephone, if agreed upon by the appellant, within 30 days from the date the appeal is filed with the Division of Administrative Law, or its successor,.

a. If the basis of the involuntary discharge is due to endangerment of the health or safety of the staff or individuals, the provider may make a written request to the Division of Administrative Law, or its successor, to hold a pre-hearing conference.

i. If a pre-hearing conference request is received by the Division of Administrative Law, or its successor, the pre-hearing conference shall be held within 10 days of receipt of the written request from the provider.

4. The Division of Administrative Law, or its successor, shall issue a decision within 30 days from the date of the appeal hearing.

5. The burden of proof is on the provider to show, by a preponderance of the evidence, that the transfer or discharge of the client is justified pursuant to the provisions of the minimum licensing standards.

F. Client's Right to Remain with the Provider Pending the Appeal Process

1. If a client is given 30 calendar days written notice of the involuntary transfer or discharge and the client or authorized representative files a timely appeal, the client may remain with the provider and not be transferred or discharged until the Division of Administrative Law, or its successor, renders a decision on the appeal.

2. If a client is given less than 30 calendar days written notice and files a timely appeal of an involuntary transfer/discharge based on the health and safety of individuals or provider staff being endangered, the client

may remain with the provider and not be transferred or discharged until one of the following occurs:

a. the Division of Administrative Law, or its successor, holds a pre-hearing conference regarding the safety or health of the staff or individuals; or

b. the Division of Administrative Law, or its successor, renders a decision on the appeal.

3. If a client is given 15 days written notice and files a timely appeal of an involuntary transfer/discharge based on the client's failure to pay any outstanding amounts for services within the allotted time, the provider may discharge or transfer the client.

G. The transfer or discharge responsibilities of the HCBS provider shall include:

1. conducting a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate an orderly transfer or discharge;

2. development of discharge options that will provide reasonable assurance that the client will be transferred or discharged to a setting that can be expected to meet his/her needs;

3. preparing an updated ISP; and

4. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary of the health, developmental issues, behavioral issues, social issues and nutritional status of the client. Upon written request and authorization by the client or authorized representative, a copy of the discharge summary and/or updated ISP shall be disclosed to the client or receiving provider.

H. The agency shall provide all services required prior to discharge that are contained in the final update of the individual service plan and in the transfer or discharge plan.

1. The provider shall not be required to provide services if the discharge is due to the client moving out of the provider's geographic region. An HCBS provider is prohibited from providing services outside of its geographic region without the department's approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:75 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2510 (December 2017).

§5038. Provisions for Services to Clients Outside of Licensed Geographic Area in Event of a Gubernatorial Declared State of Emergency or Disaster

A. To ensure the health and safety of clients, and the coordination and continuation of services to clients, during a gubernatorial declared state of emergency or disaster in Louisiana, the department, through written notice sent electronically to licensed HCBS providers, may allow a licensed HCBS provider to operate and provide services to existing clients who are receiving personal care services and respite services and who have evacuated or temporarily relocated to another location in the state when the following apply:

1. the client has evacuated or temporarily relocated to a location outside of the provider's licensed region due to the declared state of emergency or disaster;

2. the client shall have been a client of the HCBS provider as of the date of the declared emergency or disaster, with an approved plan of care;

3. the client's existing caregiver(s) go with the client or provide services to the client at the client's temporary location;

4. the provider is responsible for ensuring that all essential care and services, in accordance with the plan of care, are provided to the client, and the provider shall have sufficient staff and back-up caregivers available to provide services; and

5. the provider shall not interfere with the client's right to choose a provider of his/her choice if the client elects a new HCBS provider in the area where the client relocates. The provider shall facilitate client's selection.

B. The provisions of this Section shall not apply to providers of center based respite services.

C. To ensure the health and safety of clients, and the coordination and continuation of services to clients, during a gubernatorial declared state of emergency or disaster in Louisiana, the department, through written notice sent electronically to licensed HCBS providers, may allow a licensed HCBS provider to operate and provide services to existing clients who are receiving supervised independent living services (SIL) and who have evacuated or temporarily relocated to another location in the state when the following apply:

1. the client has evacuated or temporarily relocated to a location outside of the provider's licensed region due to the declared state of emergency or disaster;

2. the client shall have been a client of the HCBS provider as of the declared state of emergency or disaster, with an approved plan of care;

3. the provider has sufficient and qualified staff to provide SIL services at the client's temporary location;

4. the provider is responsible for ensuring that all essential SIL services, in accordance with the plan of care, are provided to the client; and

5. the provider shall not interfere with the client's right to choose a provider of his/her choice if the client elects a new HCBS provider in the area where the client relocates. The provider shall facilitate client's selection.

D. Under the provisions of this Section, the department's initial written notice to licensed HCBS providers to

authorize these allowances shall be for a period not to exceed 45 days. The department may extend this initial period, not to exceed an additional 45 days, upon written notice sent electronically to the licensed HCBS providers.

E. Under the provisions of this Section, the department in its discretion may authorize these allowances statewide or to certain affected parishes.

F. An HCBS provider who wants to provide services to a client that has temporarily relocated out of state must contact that state's licensing/certification department to obtain any necessary licensing and/or certification before providing services in that state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 47:47 (January 2021).

Subchapter D. Service Delivery

§5039. General Provisions

A. The HCBS provider shall ensure that the client receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the client, in accordance with the comprehensive assessment and individual service plan.

B. Assessment of Needs

1. Prior to any service being rendered, an HCBS provider shall conduct a thorough assessment of the client's needs to identify where supports and services are needed and whether the provider has the capacity to provide such needed care and services.

2. The provider shall not admit a client for whom they do not have the capacity to safely provide required services.

3. The assessment shall identify potential risks to the client and shall address, at a minimum the following areas:

a. life safety, including, but not limited to:

i. the ability of the client to access emergency services;

ii. the ability of the client to access transportation in order to obtain necessary goods and services (i.e. medical appointments, medications and groceries); and

iii. the ability of the client to evacuate the home in an emergent event, such as a fire in the home, or in the event of a declared disaster;

b. living environment including, but not limited to:

i. presence of physical hazards (i.e. objects that could cause falls, hot water temperatures that could contribute to scalds);

ii. presence of functional utilities; and

iii. presence of environmental hazards (i.e. chemicals, foods not kept at acceptable temperatures);

c. health conditions including, but not limited to:

i. diagnoses;

ii. medications, including methods of administration; and

iii. current services and treatment regimen;

d. functional capacity including but not limited to:

i. activities of daily living;

ii. instrumental activities of daily living including money management, if applicable;

iii. communication skills;

iv. social skills; and

v. psychosocial skills including behavioral needs; and

e. client financial health including, but not limited to:

i. the client's independent ability to manage their own finances;

ii. the client's dependence on a family member or other legal representative to manage the client's finances; and

iii. the client's need for the provider's assistance to manage the client's finances to assure that bills such as rent and utilities are paid timely.

4. The assessment shall be conducted prior to admission and at least annually thereafter. The assessment shall be conducted more often as the client's needs change.

5. An HCBS comprehensive assessment performed for a client in accordance with policies, procedures, and timeframes established by Medicaid or by an LDH program office for reimbursement purposes can substitute for the assessment required under these provisions.

6. The provider shall be familiar with the health condition of clients served. If the client has an observable significant change in physical or mental status, the provider shall ensure that the change is immediately reported so that the client receives needed medical attention by a licensed medical practitioner in a timely manner.

C. Reserved.

D. Service Agreement

1. An HCBS provider shall ensure that a written service agreement is completed prior to admission of a client. A copy of the agreement, signed by all parties involved, shall be maintained in the client's record and shall be made available upon request by the department, the client and the legal representative, where appropriate.

2. The service agreement shall include:

a. a delineation of the respective roles and responsibilities of the provider;

b. specification of all of the services to be rendered by the provider;

c. the provider's expectations concerning the client; and

d. specification of the financial arrangements, including any fees to be paid by the client.

3. An HCBS plan of care or agreement to provide services signed by the provider or client in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes can substitute for the agreement required under these provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2511 (December 2017).

§5041. Individual Service Plan

A. Upon admission and prior to the initiation of care and services, an individual service plan shall be person centered and developed for each client, based upon a comprehensive assessment.

B. The client shall participate in the planning process. If the client is unable to participate in all or part of the planning, the provider shall document the parts or times and reasons why the client did not participate.

C. The agency shall document that they consulted with the client or legal representative regarding who should be involved in the planning process.

D. The agency shall document who attends the planning meeting.

E. The provider shall ensure that the ISP and any subsequent revisions are explained to the client receiving services and, where appropriate, the legal representative, in language that is understandable to them.

F. The ISP shall include the following components:

1. the findings of the comprehensive assessment;

2. a statement of goals to be achieved or worked towards for the person receiving services and their family or legal representative;

3. daily activities and specialized services that will be provided directly or arranged for;

4. target dates for completion or re-evaluation of the stated goals;

5. identification of all persons responsible for implementing or coordinating implementation of the plan; and

6. documentation of all setting options for services, including non-disability specific settings, which the provider offered to the client, including residential settings.

G. The provider shall ensure that all agency staff working directly with the person receiving services are appropriately informed of and trained on the ISP.

H. A comprehensive plan of care prepared in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan.

I. Each client's ISP shall be reviewed, revised, updated and amended no less than annually, and more often as necessary, or as designated by the department, to reflect changes in the client's needs, services and personal outcomes.

J. Coordination of Services

1. Client care goals and interventions shall be coordinated in conjunction with other providers rendering care and services and/or caregivers to ensure continuity of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2511 (December 2017).

§5043. Contract Services

A. A provider may enter into contracts or other agreements with other companies or individuals to provide services to a client. The provider is still responsible for the management of the client's care and for all services provided to the client by the contractor or its personnel.

B. When services are provided through contract, a written contract shall be established. The contract shall include all of the following items:

1. designation of the services that are being arranged for by contract;

2. specification of the period of time that the contract is to be in effect;

3. a statement that the services provided to the client are in accordance with the individual service plan;

4. a statement that the services are being provided within the scope and limitations set forth in the individual service plan and may not be altered in type, scope or duration by the contractor;

5. a statement that the contracted personnel shall meet the same qualifications and training requirements as an employee of an HCBS agency who holds the same position;

a. the provider shall be responsible for assuring the contractor's compliance with all personnel and agency policies required for HCBS providers during the contractual period;

6. assurance that the contractor completes the clinical record in the same timely manner as required by the staff of the provider;

7. payment of fees and terms; and

8. assurance that reporting requirements are met.

C. The provider and contractor shall document review of their contract on an annual basis.

D. The provider shall coordinate services with contract personnel to assure continuity of client care.

E. Any HCBS provider that employs contractors, including independent contractors, shall ensure that such utilization complies with all state and federal laws, rules and/or regulations, including those enforced by the United States Department of Labor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2511 (December 2017), LR 44:1445 (August 2018).

§5045. Transportation

A. An HCBS provider shall arrange for or provide transportation necessary for implementing the client's service plan.

B. Any vehicle owned by the agency or its employees, either contracted or staff, used to transport clients shall be:

1. properly licensed and inspected in accordance with state law;

2. maintained in an operational condition;

3. operated at an internal temperature that does not compromise the health, safety or needs of the client.

C. The provider shall have proof of liability insurance coverage in accordance with state law for any vehicle owned by the agency or its employees, either contracted or staff that are used to transport clients. The personal liability insurance of a provider's employee, either contracted or staff, shall not be substituted for the required vehicular insurance coverage.

D. Any staff member of the provider or other person acting on behalf of the provider, who is operating a vehicle owned by the agency or its employees, either contracted or staff, for the purpose of transporting clients shall be properly licensed to operate that class of vehicle in accordance with state law.

E. The provider shall have documentation of successful completion of a safe driving course for each staff or contract employee who transports clients. If the staff or contract employee does not transport clients, such shall be clearly documented in their personnel record.

1. Employees, either contracted or staff, who are required to transport clients as part of their assigned duties shall successfully complete a safe driving course within 90 days of hiring, every three years thereafter, and within 90 days of the provider's discovery of any moving violation.

F. Upon hire, and annually thereafter, the provider shall at a minimum, obtain a driver's license status inquiry report available on-line from the State Office of Motor Vehicles, for each employee, either contracted or directly employed, who is required to transport clients as part of their assigned duties.

G. The provider shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the transporting vehicle.

H. The provider shall ascertain the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff who will transport clients.

I. The following additional arrangements are required for transporting non-ambulatory clients who cannot otherwise be transferred to and from the vehicle.

1. A ramp device to permit entry and exit of a client from the vehicle shall be provided for vehicles.

a. A mechanical lift may be utilized, provided that a ramp is also available in case of emergency, unless the mechanical lift has a manual override.

2. Wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners.

3. The arrangement of the wheelchairs shall not impede access to the exit door of the vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:78 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2512 (December 2017).

Subchapter E. Client Protections

§5049. Client Rights

A. Unless adjudicated by a court of competent jurisdiction, clients served by HCBS providers shall have the same rights, benefits and privileges guaranteed by the constitution and the laws of the United States and Louisiana, including but not limited to the following:

1. human dignity;

2. impartial access to treatment regardless of:

a. race;

b. religion;

c. sex;

d. ethnicity;

e. age; or

f. disability;

3. cultural access as evidenced by:

a. interpretive services;

b. translated materials;

c. the use of native language when possible; and

d. staff trained in cultural awareness;

4. have sign language interpretation, allow for the use of service animals and/or mechanical aids and devices that assist those persons in achieving maximum service benefits when the person has special needs;

5. privacy;

6. confidentiality;

7. access his/her records upon the client's written consent for release of information;

8. a complete explanation of the nature of services and procedures to be received, including:

a. risks;

b. benefits; and

c. available alternative services;

9. actively participate in services, including:

a. assessment/reassessment;

b. service plan development; and

c. discharge;

10. refuse specific services or participate in any activity that is against their will and for which they have not given consent;

11. obtain copies of the provider's complaint or grievance procedures;

12. file a complaint or grievance without retribution, retaliation or discharge;

13. be informed of the financial aspect of services;

14. be informed of the need for parental or guardian consent for treatment of services, if appropriate;

15. personally manage financial affairs, unless legally determined otherwise;

16. give informed written consent prior to being involved in research projects;

17. refuse to participate in any research project without compromising access to services;

18. be free from mental, emotional and physical abuse, coercion and neglect;

19. be free from all restraints;

20. receive services that are delivered in a professional manner and are respectful of the client's wishes concerning their home environment;

21. receive services in the least intrusive manner appropriate to their needs;

22. contact any advocacy resources as needed, especially during grievance procedures;

23. discontinue services with one provider and freely choose the services of another provider;

24. freedom and support to control their own schedules and activities;

25. access to food at any time; and

26. have visitors of their choosing at any time.

B. An HCBS provider shall assist in obtaining an independent advocate:

1. if the client's rights or desires may be in jeopardy;

2. if the client is in conflict with the provider; or

3. upon any request of the client.

C. The client has the right to select an independent advocate, which may be:

1. a legal assistance corporation;

2. a state advocacy and protection agency;

3. a trusted church or family member; or

4. any other competent key person not affiliated in any way with the licensed provider.

D. The client, client's family and legal guardian, if one is known, shall be informed of their rights, both verbally and in writing in a language they are able to understand.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:78 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2512 (December 2017).

§5051. Grievances

A. The agency shall establish and follow a written grievance procedure to be used to formally resolve complaints by clients, their family member(s) or a legal representative regarding provision of services. The written grievance procedure shall be provided to the client.

1. The notice of grievance procedure shall include the names of organizations that provide free legal assistance.

B. The client, family member or legal representative shall be entitled to initiate a grievance at any time.

C. The agency shall annually explain the grievance procedure to the client, family member(s) or a legal representative, utilizing the most appropriate strategy for ensuring an understanding of what the grievance process entails.

1. The agency shall provide the grievance procedure in writing to the client at admission and grievance forms shall be made readily available as needed thereafter.

D. The administrator of the agency, or his/her designee, shall investigate all grievances and shall make all reasonable attempts to address the grievance.

E. The administrator of the agency, or his/her designee, shall issue a written report and/or decision within five business days of receipt of the grievance to the:

1. client;

2. client's advocate;

3. authorized representative; and

4. the person initiating the grievance.

F. The agency shall maintain documentation pursuant to §5051.A-E.4.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2513 (December 2017).

Subchapter F. Provider Responsibilities

§5053. General Provisions

A. HCBS providers shall have qualified staff sufficient in number to meet the needs of each client as specified in the ISP and to respond in emergency situations.

B. Additional staff shall be employed or contracted as necessary to ensure proper care of clients and adequate provision of services.

C. Staff shall have sufficient communication and language skills to enable them to perform their duties and interact effectively with clients and other staff persons.

D. All client calls to the provider's published telephone number shall be returned within one business day. Each client shall be informed of the provider's published telephone number, in writing, as well as through any other method of communication most readily understood by the client according to the following schedule:

1. upon admission to the HCBS provider agency;

2. at least once per year after admission; and

3. when the provider's published telephone number changes.

E. HCBS providers shall establish policies and procedures relative to the reporting of abuse, neglect, extortion, or exploitation of clients pursuant to the provisions of R.S. 15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws. Providers shall ensure that staff complies with these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2513 (December 2017).

§5055. Core Staffing Requirements

A. Administrative Staff. The following administrative staff is required for all HCBS providers:

1. a qualified administrator at each licensed geographic location who shall meet the qualifications as established in these provisions; and

2. other administrative staff as necessary to properly safeguard the health, safety and welfare of the clients receiving services.

B. Administrator Qualifications

1. The administrator shall be a resident of the state of Louisiana and shall have a high school diploma or equivalent, and shall meet the following requirements:

a. have a bachelor's degree, plus a minimum of four years of verifiable experience working in a field providing services to the elderly and/or persons with developmental disabilities; or

b. have a minimum of six years of verifiable experience working in a health or social service related business, plus a minimum of four additional years of verifiable experience working in a field providing services to the elderly and/or persons with developmental disabilities; or

c. is a registered nurse licensed and in good standing with the Louisiana State Board of Nursing and have at least two years' experience in providing care to the elderly or to adults with disabilities.

2. Any person convicted of a felony as defined in these provisions is prohibited from serving as the administrator of an HCBS provider agency.

C. Administrator Responsibilities. The administrator shall:

1. be a full time employee of the HCBS provider and shall not be a contract employee;

2. be available in person or by telecommunication at all times for all aspects of agency operation or designate in writing an individual to assume the authority and control of the agency if the administrator is temporarily unavailable;

3. direct the operations of the agency;

4. be responsible for compliance with all regulations, laws, policies and procedures applicable to home and community-based service providers;

5. employ, either by contract or staff, qualified individuals and ensure adequate staff education and evaluations;

6. ensure the accuracy of public information and materials;

7. act as liaison between staff, contract personnel and the governing body;

8. implement an ongoing, accurate and effective budgeting and accounting system;

9. ensure that all staff receive proper orientation and training on policies and procedures, client care and services and documentation, as required by law or as necessary to fulfill each staff person's responsibilities;

10. assure that services are delivered according to the client's individual service plan; and

11. not serve as administrator for more than one licensed HCBS provider.

D. Professional Services Staff

1. The provider shall employ, contract with or assure access to all necessary professional staff to meet the needs of each client as identified and addressed in the client's ISP. The professional staff may include, but not be limited to:

a. licensed practical nurses;

b. registered nurses;

c. speech therapists;

d. physical therapists;

e. occupational therapists;

f. social workers; and

g. psychologists.

2. Professional staff employed or contracted by the provider shall hold a current, valid professional license issued by the appropriate licensing board.

3. The provider shall maintain proof of annual verification of current professional licensure of all licensed professional staff.

4. All professional services furnished or provided shall be furnished or provided in accordance with professional standards of practice, according to the scope of practice requirements for each licensed discipline.

E. Direct Care Staff

1. The provider shall have sufficient numbers of trained direct care staff to safeguard the health, safety and welfare of clients.

2. The provider shall employ, either directly or through contract, direct care staff to ensure the provision of home and community-based services as required by the ISP.

3. The HCBS provider shall ensure that each client who receives HCBS services has a written individualized back-up staffing plan and agreement for use in the event that the assigned direct care staff is unable to provide support due to unplanned circumstances, including emergencies which arise during a shift. A copy of the individualized plan and agreement shall be provided to the client and/or the client's legally responsible party, and if applicable, to the support coordinator, within five working days of the provider accepting the client.

F. Direct Care Staff Qualifications

1. HCBS providers shall ensure that all non-licensed direct care staff, either contracted or employed, meet the minimum mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-40:2179.1 or a subsequently amended statute and any rules published pursuant to those statutes.

2. All direct care staff shall have the ability to read and write at a level that allows them to understand the client's services plan, document services provided, and carry out directions competently as assigned.

a. The training shall address needed areas of improvement, as determined by the worker's performance reviews, and may address the special needs of clients.

3. All direct care staff shall be trained in recognizing and responding to medical emergencies of clients.

G. Direct Care Staff Responsibilities. The direct care staff shall:

1. provide personal care services to the client, per the ISP;

2. provide the direct care services to the client at the time and place assigned;

3. report and communicate changes in a client's condition to a supervisor immediately upon discovery of the change;

4. report and communicate a client's request for services or change in services to a supervisor within 24 hours of the next business day of such request;

5. follow emergency medical training while attending the client;

6. subsequently report any medical or other types of emergencies to the supervisor, the provider or others, pursuant to the provider policies and procedures;

7. report any suspected abuse, neglect or exploitation of clients to a supervisor on the date of discovery, and as required by law;

8. be trained on daily documentation such as progress notes and progress reports; and

9. be responsible for accurate daily documentation of services provided and status of clients to be reported on progress notes and/or progress reports.

H. Direct Care Staff Training

1. The provider shall ensure that each direct care staff, either contracted or employed, satisfactorily completes a minimum of 16 hours of training upon hire and before providing direct care and services to clients. Such training shall include the following topics and shall be documented, maintained and readily available in the agency's records:

a. the provider's policies and procedures;

b. emergency and safety procedures;

c. recognizing and responding to medical emergencies including:

i. knowing when to make an immediate call to 911; and

ii. knowing how to support the client while waiting for the emergency personnel to arrive such as maintaining an open airway for breathing, checking for the presence of a pulse, or stopping bleeding, when needed;

d. client's rights;

e. detecting and reporting suspected abuse and neglect, utilizing the department's approved training curriculum;

f. reporting critical incidents;

g. universal precautions;

h. documentation;

i. implementing service plans;

j. confidentiality;

k. detecting signs of illness or impairment that warrant medical or nursing intervention;

l. basic skills required to meet the health needs and problems of the client;

m. the management of aggressive behavior, including acceptable and prohibited responses; and

n. scald prevention training.

2. The provider shall ensure that each direct care staff, either contracted or employed, satisfactorily completes a basic first aid course within 45 days of hire.

3. Training received by a direct care staff worker from previous employment with a HCBS agency is transferrable between HCBS agencies when the hiring HCBS agency:

a. obtains from the previous employer proof of the employee's successful documented completion of any required training; and

b. obtains documented evidence of the employee's continued competency of any required training received during employment with the previous HCBS provider.

I. Competency Evaluation

1. A competency evaluation shall be developed and conducted to ensure that, at a minimum, each direct care staff, either contracted or employed, is able to demonstrate competencies in the training areas in §5055.H.

2. Written or oral examinations shall be provided.

3. The examination shall reflect the content and emphasis of the training curriculum components in §5055.H and shall be developed in accordance with accepted educational principles.

4. The provider shall ensure that those direct care staff with limited literacy skills receive substitute examination sufficient to determine written reading comprehension and competency to perform duties assigned.

J. Continuing Education

1. Annually thereafter, the provider shall ensure that each direct care staff, either contracted or employed, satisfactorily completes a minimum of eight hours of training in order to ensure continuing competence. Orientation and normal supervision shall not be considered for meeting this requirement. This training shall address the special needs of clients and may address areas of employee weakness as determined by the direct care staff person's performance reviews.

K. Volunteers/Student Interns

1. A provider utilizing volunteers or student interns on any regular basis shall have a written plan for using such resources. This plan shall be given to all volunteers and interns. The plan shall indicate that all volunteers and interns shall:

a. be directly supervised by a paid staff member;

b. be oriented and trained in the philosophy, policy and procedures of the provider, confidentiality requirements and the needs of clients;

c. have documentation of reference checks in accordance with facility policy.

2. Volunteer/student interns shall be a supplement to staff employed by the provider but shall not provide direct care services to clients.

L. Direct Care Staff Supervisor. The HCBS provider shall designate and assign a direct care staff supervisor to monitor and supervise the direct care staff.

1. The supervisor shall be selected based upon the needs of the client outlined in the ISP.

2. A provider may have more than one direct care staff supervisor.

M. Direct Care Supervision

1. A direct care staff supervisor shall make an in-person supervisory visit of each direct care staff within 60 days of being hired or contracted and at least annually thereafter. Supervisory visits shall occur more frequently:

a. if dictated by the ISP;

b. as needed to address worker performance;

c. to address a client's change in status; or

d. to assure services are provided in accordance with the ISP.

2. The supervisory visit shall be unannounced and utilized to evaluate:

a. the direct care staff person's ability to perform assigned duties;

b. whether services are being provided in accordance with the ISP; and

c. if goals are being met.

3. Documentation of supervision shall include:

a. the worker/client relationship;

b. services provided;

c. observations of the worker performing assigned duties;

d. instructions and comments given to the worker during the onsite visit; and

e. client satisfaction with service delivery.

4. An annual performance evaluation for each direct care staff person shall be documented in his/her personnel record.

5. In addition to the in-person supervisory visits conducted with direct care staff, the provider shall visit the home of each client on a quarterly basis to determine whether the individual:

a. service plan is adequate;

b. continues to need the services; and

c. service plan needs revision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended LR 40:1007 (May 2014), LR 41:2639 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2513 (December 2017).

§5057. Client Records

A. Client records shall be accurately documented and maintained in the HCBS provider's office. Current progress notes shall be maintained at the home. The provider shall have a written record for each client which shall include:

1. other identifying data including:

a. name;

b. date of birth;

c. address;

d. telephone number;

e. social security number;

f. legal status; and

g. proof of interdiction or continuing tutorship, if applicable.

2. a copy of the client's ISP or Medicaid comprehensive plan of care, as well as any modifications or updates to the service plan;

3. the client's history including, where applicable:

a. family data;

b. next of kin;

c. educational background;

d. employment record;

e. prior medical history; and

f. prior service history;

4. the service agreement or comprehensive plan of care;

5. written authorization signed by the client or, where appropriate, the legally responsible person for emergency care;

6. written authorization signed by the client or, where appropriate, the legally responsible person for managing the client's money, if applicable;

7. an accurate financial record of each client's personal funds which includes a written record of all of the financial transactions involving the personal funds of the client deposited with the provider;

a. the client (or his legal representative) shall be afforded access to such record; and

b. the financial records shall be available through quarterly statements;

8. required assessment(s) and additional assessments that the provider may have received or is privy to;

9. the names, addresses and telephone numbers of the client's physician(s) and dentist;

10. written progress notes or equivalent documentation and reports of the services delivered for each client for each visit. The written progress notes shall include, at a minimum:

a. the date and time of the visit and services;

b. the services delivered;

c. who delivered or performed the services;

d. observed changes in the physical and mental condition(s) of the client, if applicable; and

e. doctor appointments scheduled or attended that day;

11. health and medical records of the client, including:

a. a medical history, including allergies;

b. a description of any serious or life threatening medical condition(s); and

c. a description of any medical treatment or medication necessary for the treatment of any medical condition;

12. a copy of any signed and dated advance directive that has been provided to the HCBS provider, or any

physician orders, signed and dated, relating to end of life care and services.

B. HCBS providers shall maintain client records for a period of no less than six years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:82 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2515 (December 2017).

§5059. Client Funds and Assets

A. The HCBS provider shall not require that the provider be the manager of the client's funds and shall develop and implement written policies and procedures to protect client funds. Clients shall have the right to control their personal resources.

B. In the case of a representative payee, all social security rules and regulations shall be adhered to. The provider shall obtain written authorization from the client and/or his/her legal or responsible representative if they will be designated as the representative payee of the client's social security payment.

C. If the provider manages a client's personal funds, the provider shall furnish a written statement which includes the client's rights regarding personal funds, a list of the services offered and charges, if any, to the client and/or his/her legal or responsible representative.

D. If a client chooses to entrust funds with the provider, the provider shall obtain written authorization from the client and/or his/her legal or responsible representative for the safekeeping and management of the funds.

E. The provider shall:

1. provide each client with an account statement on a quarterly basis with a receipt listing the amount of money the provider is holding in trust for the client;

2. maintain a current balance sheet containing all financial transactions;

3. provide a list or account statement regarding personal funds upon request of the client;

4. maintain a copy of each quarterly account statement in the client's record;

5. keep funds received from the client for management in a separate account and maintain receipts from all purchases with each receipt being signed by the client and the staff assisting the client with the purchase, or by the staff assisting the client with the purchase and an independent staff when the client is not capable of verifying the purchase; and

6. not commingle the clients' funds with the provider's operating account.

F. A client with a personal fund account managed by the HCBS provider may sign an account agreement acknowledging that any funds deposited into the personal account, by the client or on his/her behalf, are jointly owned by the client and his legal representative or next of kin. These funds do not include Social Security funds that are restricted by Social Security Administration (SSA) guidelines. The account agreement shall state that:

1. the funds in the account shall be jointly owned with the right of survivorship;

2. the funds in the account shall be used by the client or on behalf of the client;

3. the client or the joint owner may deposit funds into the account;

4. the client or joint owner may endorse any check, draft or other instrument to the order of any joint owner, for deposit into the account; and

5. the joint owner of a client's account shall not be an employee, either contracted or on staff, of the provider.

G. If the provider is managing funds for a client and he/she is discharged, any remaining funds shall be refunded to the client or his/her legal or responsible representative within five business days of notification of discharge.

H. Distribution of Funds upon the Death of a Client

1. Upon the death of a client, the provider shall act accordingly upon any burial policies of the client.

2. Unless otherwise provided by state law, upon the death of a client, the provider shall provide the executor or administrator of the client's estate or the client's responsible representative with a complete account statement of the client's funds and personal property being held by the provider.

3. If a valid account agreement has been executed by the client, the provider shall transfer the funds in the client's personal fund account to the joint owner within 30 days of the client's death.

4. If a valid account agreement has not been executed, the provider shall comply with the federal and state laws and regulations regarding the disbursement of funds in the account and the properties of the deceased. The provider shall comply with R.S. 9:151–181, the Louisiana Uniform Unclaimed Property Act, and the procedures of the Louisiana Department of the Treasury regarding the handling of a deceased client's funds that remain unclaimed.

I. A termination date of the account and the reason for termination shall be recorded on the client'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.

J. Burial Policies. Upon discharge of a client, the provider shall release any and all burial policies to the client or his/her legal or responsible representative.

K. Life Insurance Policies. An HCBS provider and/or its employee(s), either contracted or staff, shall not purchase a life insurance policy on an HCBS client and designate the

provider and/or its employee(s) as the beneficiary of the policy.

L. The provisions of this section shall have no effect on federal or state tax obligations or liabilities of the deceased client's estate. If there are other laws or regulations which conflict with these provisions, those laws or regulations will govern over and supersede the conflicting provisions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:82 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2515 (December 2017).

§5061. Quality Enhancement Plan

A. An HCBS provider shall develop, implement and maintain a quality enhancement (QE) plan that:

1. ensures that the provider is in compliance with federal, state, and local laws;

2. meets the needs of the provider's clients;

3. is attaining the goals and objectives established by the provider;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual client outcomes and individual client satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan;

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QE plan shall include:

1. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients of the HCBS provider receiving services, that includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

2. a process to review and resolve individual client issues that are identified;

3. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above;

4. a process to correct problems that are identified through the program that actually or potentially affect the health and safety of the clients; and

5. a process of evaluation to identify or trigger further opportunities for improvement in identification of individual client care and service components.

C. The QE program shall hold bi-annual committee meetings to:

1. assess and choose which QE plan activities are necessary and set goals for the quarter;

2. evaluate the activities of the previous quarter; and

3. implement any changes that protect the clients from potential harm or injury.

D. The QE plan committee shall:

1. develop and implement the QE plan; and

2. report to the administrator any identified systemic problems.

E. The HCBS provider shall maintain documentation of the most recent 12 months of the QE plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:83 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2515 (December 2017).

§5063. Emergency Preparedness

A. A disaster or emergency may be a local, community-wide, regional or statewide event. Disasters or emergencies may include, but are not limited to:

1. tornados;

2. fires;

3. floods;

4. hurricanes;

5. power outages;

6. chemical spills;

7. biohazards;

8. train wrecks; or

9. declared health crisis.

B. Providers shall ensure that each client has a documented individual plan in preparation for, and response to, emergencies and disasters and shall assist clients in identifying the specific resources available through family, friends, the neighborhood and the community.

C. Continuity of Operations. The provider shall have written disaster and emergency preparedness plans which are based on a risk assessment using an all hazards approach for both internal and external occurrences, developed and approved by the governing body and updated annually:

1. to maintain continuity of the provider's operations in preparation for, during and after an emergency or disaster;

2. to manage the consequences of all disasters or emergencies that disrupt the provider's ability to render care and treatment, or threaten the lives or safety of the clients; and

3. that are prepared in coordination with the provider's local and/or parish Office of Homeland Security and Emergency Preparedness (OHSEP) and include provisions for persons with disabilities.

D. The HCBS provider shall develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which shall be reviewed and updated at least annually to maintain continuity of the agency's operations in preparation for, during and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that disrupt the provider's ability to render care and treatment, or threatens the lives or safety of the clients.

1. At any time that the HCBS provider has an interruption in services or a change in the licensed location due to an emergency situation, the provider shall notify HSS no later than the next business day.

E. The provider shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency. The plan shall include, at a minimum:

1. provisions for the delivery of essential services to each client as identified in the individualized emergency plan for each client, whether the client is in a shelter or other location;

2. provisions for the management of staff, including provisions for adequate, qualified staff as well as for distribution and assignment of responsibilities and functions;

3. provisions for back-up staff;

4. the method that the provider will utilize in notifying the client's family or caregiver if the client is evacuated to another location either by the provider or with the assistance or knowledge of the provider. This notification shall include:

a. the date and approximate time that the provider or client is evacuating;

b. the place or location to which the client(s) is evacuating which includes the name, address and telephone numbers; and

c. a telephone number that the family or responsible representative may call for information regarding the provider's evacuation;

5. provisions for ensuring that sufficient supplies, medications, clothing and a copy of the individual service plan are sent with the client, if the client is evacuated; and

6. the procedure or methods that will be used to ensure that identification accompanies the individual. The identification shall include the following information:

a. current and active diagnoses;

b. medication(s), including dosages and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin, including contact information.

F. Emergency Plan Review and Summary. The provider shall review and update its emergency preparedness plan, as well as each client's emergency plan at least annually.

G. The provider shall cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and shall provide information as requested.

H. The provider shall monitor weather warnings and watches as well as evacuation order from local and state emergency preparedness officials.

I. All agency employees, either contracted or staff, shall be trained in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for all personnel.

J. Upon request by the department, the HCBSP shall submit a copy of its emergency preparedness plan and a written summary attesting how the plan was followed and executed. The summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:83 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2516 (December 2017).

Subchapter G. Adult Day Care Module

§5071. General Provisions

A. Providers applying for the Adult Day Care module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section.

B. An ADC program shall provide services for 10 or more functionally impaired adults who are not related to the owner or operator of the HCBS provider.

1. For the purposes of this Section, "*functionally impaired adult*" shall be defined as individuals 17 years of age or older who are physically, mentally or socially impaired to a degree that requires supervision.

C. The following two programs shall be provided under the ADC module.

1. Day Habilitation Services

a. Day habilitation services include assistance with acquisition, retention or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting separate from the recipient's private residence or other residential living arrangement. Day habilitation services provide activities and environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

i. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the recipient's residence and are not limited to a fixed-site facility.

b. Services are furnished to a client who is 17 years of age or older and has a developmental disability, or who is a functionally impaired adult, on a regularly scheduled basis during normal daytime working hours for one or more days per week, or as specified in the recipient's service plan.

c. Day habilitation services focus on enabling the recipient to attain or maintain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies in the service plan. These services may also serve to reinforce skills or lessons taught in other settings.

2. Prevocational Services

a. Prevocational services prepare a recipient for paid employment or volunteer opportunities. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but are aimed at a generalized result. These services are reflected in the recipient's service plan and are directed to habilitative (e.g. attention span, motor skills) rather than explicit employment objectives.

b. Individuals receiving prevocational services shall have an employment related goal as part of their individual service plan.

c. This service is not available to clients eligible to receive services under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA).

D. When applying for the ADC module under the HCBS provider license, the provider shall indicate whether it is providing day habilitation, prevocational/employment-related services or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:85 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2517 (December 2017).

§5073. Operational Requirements for ADC Facilities

A. The client/staff ratio in an ADC facility shall be a minimum of one staff person per eight clients, unless additional staff coverage is needed to meet the needs of the client, as specified in the service plan.

B. Staff Training

1. ADC Staff in supervisory positions shall have annual training in supervisory and management techniques.

2. Each ADC facility shall have a training supervisor who shall receive at least 15 hours of annual vocational and/or community-based employment training.

3. Once the training supervisor receives all of the required training, he/she shall be responsible for ensuring that direct care staff receives training on vocational and/or community-based employment training.

C. Food and Nutrition

1. If meals are prepared by the facility or contracted from an outside source, the following conditions shall be met:

a. menus shall be written in advance and shall provide for a variety of nutritional foods from which a client may choose;

b. records of menus, as served, shall be filed and maintained for at least 30 days;

c. modified diets shall be prescribed by a physician;

d. only food and drink of safe quality shall be purchased;

e. storage, preparation, and serving techniques shall be provided to ensure nutrients are retained and spoilage is prevented;

f. food preparation areas and utensils shall be kept clean and sanitary;

g. there shall be an adequate area for eating; and

h. the facility shall designate one staff member who shall be responsible for meal preparation/serving if meals are prepared in the facility.

2. When meals are not prepared by the facility, the following conditions shall be met:

a. provisions shall be made for obtaining food for clients who do not bring their lunch; and

b. there shall be an adequate area for eating.

3. Drinking water shall be readily available. If a water fountain is not available, single-use disposable cups shall be used.

4. Dining areas shall be adequately equipped with tables, chairs, eating utensils and dishes designed to meet the functional needs of clients. Clients shall have choice of where and with whom to eat within the ADC facility.

5. Adequate refrigeration of food shall be maintained.

D. General Safety Practices

1. A facility shall not maintain any firearms or chemical weapons at any time.

2. A facility shall ensure that all poisonous, toxic and flammable materials are safely secured and stored in appropriate containers and labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of clients, staff and visitors.

3. Sufficient supervision/training shall be provided where potentially harmful materials such as cleaning solvents and/or detergents are used.

4. A facility shall ensure that a first aid kit is available in the facility and in all vehicles used to transport clients.

5. Medication shall be locked in a secure storage area or cabinet.

6. Fire drills shall be performed at least once a quarter. Documentation of performance shall be maintained.

E. Physical Environment

1. The ADC building shall be constructed, equipped and maintained to ensure the safety of all individuals. The building shall be maintained in good repair and kept free from hazards such as those created by any damage or defective parts of the building.

2. The provider shall maintain all areas of the facility that are accessible to individuals, and ensure that all structures on the ground of the facility are in good repair and kept free from any reasonable foreseeable hazards to health or safety.

3. The facility shall be accessible to and functional for those cared for, the staff and the public. All necessary accommodations shall be made to meet the needs of clients. Training or supports shall be provided to help clients effectively negotiate their environments.

4. There shall be a minimum of 35 square feet of space per client. Kitchens, bathrooms and halls used as passageways, and other spaces not directly associated with program activities, shall not be considered as floor space available to clients.

5. There shall be storage space, as needed by the program, for training and vocational materials, office supplies, and client's personal belongings.

6. Rooms used for recipient activities shall be well ventilated and lighted.

7. Chairs and tables shall be adequate in number to serve the clients.

8. Bathrooms and lavatories shall be accessible, operable and equipped with toilet paper, soap and paper towels or hand drying machines.

a. The ratio of bathrooms to number of clients shall meet the requirements in accordance with applicable state and/or federal laws, rules and regulations.

b. Individuals shall be ensured privacy when using bathroom facilities.

c. Every bathroom door shall be designed to permit opening of the locked door from the outside, in an emergency, and the opening device shall be readily accessible to the staff.

9. Stairways shall be kept free of obstruction and fire exit doors shall be maintained in working order. All stairways shall be equipped with handrails.

10. There shall be a telephone available and accessible to all clients.

11. The ADC shall be equipped with a functional air conditioning and heating unit(s) which maintains an ambient temperature between 65 and 80 degrees Fahrenheit throughout the ADC or in accordance with industry standards, if applicable.

12. The building in which the ADC is located shall meet the requirements of the OSFM in accordance with applicable state and federal laws, rules and regulations.

F. Employment of Clients

1. The provider shall meet all of the state and federal wage and hour regulations regarding employment of clients who are admitted to the agency.

a. The provider shall maintain full financial records of clients' earnings if the facility pays the client.

b. The provider shall have written assurance that the conditions and compensation of work are in compliance with applicable state and federal employment regulations.

c. The provider shall have a current U.S. Department of Labor sub-minimum wage certificate if the provider pays sub-minimum wage.

2. Clients shall not be required to perform any kind of work involving the operation or maintenance of the facility without compensation in accordance with the U.S. Department of Labor sub-minimum standard.

3. Clients shall be directly supervised when operating any type of power driven equipment such as lawn mowers or electrical saws, unless:

a. the ID team has determined that direct supervision is not necessary;

b. equipment has safety guards or devices; and

c. sufficient training is given to the recipient and the training is documented.

4. Clients shall be provided with the necessary safety apparel and safety devices to perform the job.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:85 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2517 (December 2017).

Subchapter H. Family Support Module

§5075. General Provisions

A. Providers applying for the Family Support module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section.

B. Services covered by the family support module may include:

1. special equipment;
2. limited adaptive housing;
3. medical expenses and medications;
4. nutritional consultation and regime;
5. related transportation;
6. special clothing;
7. special therapies;
8. respite care;
9. dental care; and
10. family training and therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:86 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2518 (December 2017).

§5077. Operational Requirements for Family Support Providers

A. Providers shall ensure that each family receiving services is assigned a service coordinator.

B. The service coordinator shall perform the following tasks:

1. prepare a family study, based on a home visit interview with the client, in order to ascertain what appropriate family support services may be provided;

2. visit each client at least quarterly;

3. maintain documentation of all significant contacts; and

4. review and evaluate, at least every six months, the care, support and treatment each client is receiving.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012).

Subchapter I. Personal Care Attendant Module

§5079. General Provisions

A. Providers applying for the Personal Care Attendant module under the HCBS license shall meet the core licensing requirement as well as the module specific requirements of this Section.

B. Personal care attendant services may include:

1. assistance and prompting with:

a. personal hygiene;

b. dressing;

c. bathing;

d. grooming;

e. eating;

f. toileting;

g. ambulation or transfers;

h. behavioral support;

i. other personal care needs; and

j. any non-complex medical task which can be delegated;

2. assistance and/or training in the performance of tasks in accordance with the plan of care and related to:

a. maintaining a safe and clean home environment such as housekeeping, bed making, dusting, vacuuming and laundry;

b. cooking;

c. shopping;

d. budget management;

e. bill paying; and

f. evacuating the home in emergency situations;

3. personal support and assistance in participating in community, health and leisure activities which may include transporting and/or accompanying the participant to these activities;

4. support and assistance in developing relationships with neighbors and others in the community; and

5. enabling and promoting individualized community supports targeted toward inclusion into meaningful, integrated experiences (e.g. volunteer work and community awareness) activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2518 (December 2017).

§5081. Operational Requirements for PCA Providers

A. PCA providers shall schedule personal care attendant staff in the manner and location as required by each client's ISP.

B. PCA providers shall have a plan that identifies at least one trained and qualified back-up worker for each client served.

1. It is the responsibility of the provider to ensure that a trained and qualified back-up worker is available as needed to meet the requirements of the ISP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012).

Subchapter J. Respite Care

§5083. General Provisions

A. Providers applying for the Respite Care module under the HCBS license shall meet the core licensing requirement as well as the applicable module specific requirements of this Section.

B. Respite care may be provided as an in-home or center-based service. The services may be provided in the client's home or in a licensed respite center.

C. Providers of in-home respite care services must comply with:

1. all HCBS providers core licensing requirements;

2. PCA module specific requirements; and

3. the respite care services module in-home requirements.

D. Providers of center-based respite care services shall comply with:

1. all HCBS providers core licensing requirements;

2. respite care services module in-home requirements; and

3. the respite care services module center-based requirements.

E. When applying for the respite care service module under the HCBS provider license, the provider shall indicate whether it is providing in-home respite care, center-based respite care or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:87 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2518 (December 2017).

§5085. Operational Requirements for In-Home Respite Care

A. All in-home respite care service providers shall:

1. make available to clients, the public and HSS the day and hours that respite is to be provided;

2. make available to clients, the public and HSS a detailed description of populations served as well as services and programming; and

B. In-home respite care service providers shall have sufficient administrative, support, professional and direct care staff to meet the needs of clients at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:88 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2518 (December 2017).

§5087. Operational Requirements for Center-Based Respite Care

A. All center-based respite care service providers shall meet the following daily aspects of care.

1. The daily schedule shall be developed in relation to the needs of the clients.

2. Clients shall be assisted in ADL's as needed.

a. The provider shall ensure that the client has an adequate supply of clothing, needed personal care supplies, and medications, if needed.

3. The provider shall make available to each client an adequate number of supervised recreational activities.

B. All center-based respite care service providers shall meet the following health aspects of care.

1. Responsibility for the health supervision of the client shall be placed with the client's personal physician.

a. The provider shall have written agreements for obtaining diagnosis and treatment of medical and dental problems for clients who do not have a personal physician. This agreement can be with a local hospital, clinic or physician.

2. Arrangements for medical isolation shall be available. The provider shall inform the family to move the client to isolation when medically determined as necessary.

3. Medication shall be prescribed only by a licensed health care practitioner in accordance with the individual's professional licensing laws.

C. Food and Nutrition

1. Planning, preparation and serving of foods shall be in accordance with the nutritional, social, emotional and medical needs of the clients. The menu shall include a

minimum of three varied, nutritious and palatable meals a day plus nourishing snacks.

2. All milk and milk products used for drinking shall be Grade A and pasteurized.

3. There shall be no more than 14 hours between the last meal or snack offered on one day and the first meal offered of the following day.

D. The provider shall request from the family that all clients over five years of age have money for personal use. Money received by a client shall be his own personal property and shall be accounted for separately from the provider's funds.

E. Privacy

1. The HCBS provider staff shall function in a manner that allows appropriate privacy for each client.

2. The space and furnishings shall be designed and planned to enable the staff to respect the clients' right to privacy and at the same time provide adequate supervision according to the ages and developmental needs of the client.

3. The provider shall not use reports or pictures, nor release (or cause to be released) research data, from which clients can be identified without written consent from the client, parents or legal guardians.

F. Contact with Family, Friends and Representatives

1. Clients in care shall be allowed to send and receive uncensored mail and conduct private telephone conversations with family members.

2. If it has been determined either medically or legally that the best interests of the client necessitate restrictions on communications or visits, these restrictions shall be documented in the service plan.

3. If limits on communication or visits are indicated for practical reasons, such as expense of travel or telephone calls, such limitations shall be determined with the participation of the client and family.

G. Furnishings and Equipment

1. Furnishings and equipment shall be adequate, sufficient and substantial for the needs of the age groups in care.

2. All bedrooms shall be on or above street grade level and be outside rooms. Bedrooms shall accommodate no more than four residents. Bedrooms shall provide at least 60 square feet per person in multiple sleeping rooms and not less than 80 square feet in single rooms.

3. Each resident shall be provided a separate bed of proper size and height, a clean, comfortable mattress and bedding appropriate for weather and climate.

4. There shall be separate and gender segregated sleeping rooms for adults and for adolescents. When possible, there should be individual sleeping rooms for clients whose behavior would be disruptive to other clients.

5. Appropriate furniture shall be provided including but not limited to, a chest of drawers, a table or desk, an individual closet with clothes racks and shelves accessible to the residents.

6. Individual storage space reserved for the client's exclusive use shall be provided for personal possessions such as clothing and other items so that they are easily accessible to the resident during his/her stay.

H. Bath and Toilet Facilities

1. There shall be a separate toilet/bathing area for males and females beyond pre-school age. The provider shall have one toilet/bathing area for each eight clients admitted, but in no case shall have less than two toilet/bathing areas.

2. Toilets should be convenient to sleeping rooms and play rooms.

3. Toilets, bathtubs and showers shall provide for individual privacy unless specifically contraindicated for the individual, as stated in the service plan.

4. Bath/toilet area shall be accessible, operable and equipped with toilet paper, soap and paper towels or hand drying machines.

5. Every bath/toilet shall be wheelchair accessible.

6. Individuals shall be provided privacy when using a bath/toilet area.

7. Every bath/toilet area door shall be designed to permit opening of the locked door from the outside, in an emergency. The opening device shall be readily accessible to the staff.

I. There shall be a designated space for dining. Dining room tables and chairs shall be adjusted in height to suit the ages and physical needs of the clients.

J. Heat and Ventilation

1. The temperature shall be maintained within a reasonable comfort range (65 to 80 degrees Fahrenheit).

2. Each habitable room shall have access to direct outside ventilation by means of windows, louvers, air conditioner, or mechanical ventilation horizontally and vertically.

K. Health and Safety

1. The facility shall comply with all applicable federal, state and local building codes, fire and safety laws, ordinances and regulations.

2. Secure railings shall be provided for flights of more than four steps and for all porches more than four feet from the ground.

3. Where clients under age two are in care, secure safety gates shall be provided at the head and foot of each flight of stairs accessible to these clients.

4. Before swimming pools are made available for client use, written documentation shall be received by LDH-

OPH confirming that the pool meets the requirements of the Virginia Graeme Baker Pool and Spa Safety Act of 2007 or, in lieu of, written documentation confirming that the pool meets the requirements of ANSI/APSP-7 (2006 Edition) which is entitled the "American National Standard for Suction Entrapment Avoidance in Swimming Pools, Wading pools, Spas, Hot Tubs and Catch Basins."

a. An outdoor swimming pool shall be enclosed by a six foot high fence. All entrances and exits to pools shall be closed and locked when not in use. Machinery rooms shall be locked to prevent clients from entering.

b. An individual, 18 years of age or older, shall be on duty when clients are swimming in ponds, lakes or pools where a lifeguard is not on duty. The facility shall have staff sufficient in number certified in water safety by the American Red Cross or other qualified certifying agency to meet the needs of the clients served.

c. The provider shall have written plans and procedures for water safety.

d. The provider shall have available water safety devices sufficient in number for clients served and staff trained in the proper usage of such devices.

5. Storage closets or chests containing medicine or poisons shall be kept securely locked.

6. Garden tools, knives and other potentially dangerous instruments shall be inaccessible to clients without supervision.

7. Electrical devices shall have appropriate safety controls.

L. Maintenance

1. Buildings and grounds shall be kept clean and in good repair.

2. Outdoor areas shall be well drained.

3. Equipment and furniture shall be safely and sturdily constructed and free of hazards to clients and staff.

4. The arrangement of furniture in living areas shall not block exit ways.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:88 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2518 (December 2017).

Subchapter K. Substitute Family Care Module

§5089. General Provisions

A. Providers applying for the Substitute Family Care module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section. In addition to complying with the appropriate licensing regulations, SFC providers shall also establish:

1. an advisory committee comprised of persons with developmental disabilities and their families to provide guidance on the aspirations of persons with developmental disabilities who live in home and community settings;

2. a medical decision-making committee for each SFC client who is unable to give informed consent for surgical or medical treatment which shall fulfill the requirements for executing medical decision-making for those clients as required by R.S. 40.1299.53 or its successor statute.

B. Substitute family care services are delivered by a principal caregiver, in the caregiver's home, under the oversight and management of a licensed SFC provider.

1. The SFC caregiver is responsible for providing the client with a supportive family atmosphere in which the availability, quality and continuity of services are appropriate to the age, capabilities, health conditions and special needs of the individual.

2. The licensed SFC provider shall not be allowed to serve as the SFC caregiver.

C. Potential clients of the SFC program shall meet the following criteria:

1. have a developmental disability as defined in R.S. 28:451.1-455.2 of the Louisiana Developmental Disability Law or its successor statute;

2. be at least 18 years of age;

3. have an assessment and service plan pursuant to the requirements of the HCBS provider licensing rule.

a. The assessment and service plan shall assure that the individual's health, safety and welfare needs can be met in the SFC setting.

D. SFC Caregiver Qualifications

1. An SFC caregiver shall be certified by the SFC provider before any clients are served. In order to be certified, the SFC caregiver applicant shall:

a. undergo a professional home study conducted by the provider;

b. participate in all required orientations, trainings, monitoring and corrective actions required by the SFC provider; and

c. meet all of the caregiver specific requirements of this Section.

2. The personal qualifications required for certification include:

a. residency. The caregiver shall reside in the state of Louisiana and shall provide SFC services in the caregiver's home. The caregiver's home shall be located in the state of Louisiana and in the region in which the SFC provider is licensed;

b. criminal record and background clearance. Members of the SFC caregiver's household shall not have any felony convictions. Other persons approved to provide care or supervision of the SFC client for the SFC caregiver shall not have any felony convictions:

i. prior to certification, the SFC caregiver, all members of the SFC caregiver applicant's household and persons approved to provide care or supervision of the SFC client on a regular or intermittent basis, shall undergo a statewide criminal record background check conducted by the Louisiana State Police, or its authorized agent;

ii. annually thereafter, the SFC caregiver, all members of the SFC caregiver applicant's household and persons approved to provide care or supervision of the SFC client on a regular or intermittent basis, shall have criminal record background checks;

c. age. The SFC principal caregiver shall be at least 21 years of age. Maximum age of the SFC principal caregiver shall be relevant only as it affects his/her ability to provide for the SFC client as determined by the SFC provider through the home assessment. The record shall contain proof of age.

3. The SFC caregiver may be either single or married. Evidence of marital status shall be filed in the SFC provider's records and shall include a copy of legal documents adequate to verify marital status.

4. The SFC caregiver is not prohibited from employment outside the home or from conducting a business in the home provided that:

a. the SFC home shall not be licensed as another healthcare provider;

b. such employment or business activities do not interfere with the care of the client;

c. such employment or business activities do not interfere with the responsibilities of the SFC caregiver to the client;

d. a pre-approved, written plan for supervision of the participant which identifies adequate supervision for the participant is in place; and

e. the plan for supervision is signed by both the SFC caregiver and the administrator or designee of the SFC provider.

E. The SFC caregiver shall not be certified as a foster care parent(s) for the Department of Child and Family Services (DCFS) while serving as a caregiver for a licensed SFC provider.

1. The SFC provider, administrator or designee shall request confirmation from DCFS that the SFC caregiver applicant is not presently participating as a foster care parent and document this communication in the SFC provider's case record.

F. In addition to the discharge criteria in the core requirements, the client shall be discharged from the SFC program upon the client meeting any of the following criteria:

1. incarceration or placement under the jurisdiction of penal authorities or courts for more than 30 days;

2. lives in or changes his/her residence to another region in Louisiana or another state;

3. admission to an acute care hospital, rehabilitation hospital, intermediate care facility for persons with intellectual disabilities (ICF/ID) or nursing facility with the intent to stay longer than 90 consecutive days;

4. the client and/or his legally responsible party(s) fails to cooperate in the development or continuation of the service planning process or service delivery;

5. a determination is made that the client's health and safety cannot be assured in the SFC setting; or

6. failure to participate in SFC services for 30 consecutive days for any reason other than admission to an acute care hospital, rehabilitation hospital, ICF/ID facility or nursing facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:89 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2519 (December 2017).

§5090. Operational Requirements for Substitute Family Care Providers

A. Training

1. Prior to the introduction of an SFC client into a SFC home, the SFC provider shall ensure that the caregiver receives a minimum of six hours of training designed to assure the health and safety of the client, including any areas relevant to the SFC client's support needs.

a. The provider shall also conduct a formal review of the SFC client's support needs, particularly regarding medical and behavioral concerns as well as any other pertinent areas.

2. Within the first 90 days following the client's move into the home, the SFC provider shall provide and document training to the SFC caregiver(s) inclusive of the following:

a. the client's support plan and the provider's responsibilities to assure successful implementation of the plan;

b. emergency plans and evacuation procedures;

c. client rights and responsibilities; and

d. any other training deemed necessary to support the person's individual needs.

3. Annually, the SFC provider shall provide the following training to the SFC caregiver:

a. six hours of training related to the client's needs and interests including the client's specific priorities and preferences; and

b. six hours of training on issues of health and safety such as the identification and reporting of allegations of abuse, neglect or exploitation and misappropriation of client's funds.

4. On an as needed basis the SFC provider shall provide the SFC caregiver with additional training as may be deemed necessary by the provider.

B. Supervision and Monitoring. The SFC provider shall provide ongoing supervision of the SFC caregiver to ensure quality of services and compliance with licensing standards. Ongoing supervision and monitoring shall consist of the following.

1. The SFC provider shall conduct no less than monthly face to face reviews of each SFC caregiver and/or household in order to:

a. monitor the health and safety status of the client through visits;

i. more frequent visits shall be made when concerns are identified;

b. monitor the implementation of the client's service plan to ensure that it is effective in promoting accomplishment of the client's goals;

c. assure that all services included in the service plan are readily available and utilized as planned;

d. assure that the objectives of the medical, behavioral or other plans are being accomplished as demonstrated by the client's progress; and

e. resolve discrepancies or deficiencies in service provision.

2. The SFC provider shall conduct annual reviews of each SFC caregiver and/or household in order to assure the annual certification relating to health, safety and welfare issues and the client's adjustment to the SFC setting. The annual review shall include:

a. written summaries of the SFC caregiver's performance of responsibilities and care for the client(s) placed in the home;

b. written evaluation of the strengths and needs of the SFC home and the client's relationship with the SFC caregiver, including the goals and future performance;

c. review of all of the licensing standards to ensure compliance with established standards;

d. review of any concerns or the need for corrective action, if indicated; and

e. complete annual inventory of the client's possessions.

C. The SFC provider shall assure the following minimum services are provided by the SFC caregiver:

1. 24-hour care and supervision, including provisions for:

a. a flexible routine that includes client's choices or preferences;

b. household tasks;

c. food and nutrition;

d. clothing;

e. care of personal belongings;

f. hygiene; and

g. routine medical and dental care;

2. room and board;

3. routine and reasonable transportation;

4. assurance of minimum health, safety and welfare needs;

5. participation in school, work or recreational/leisure activities, as appropriate;

6. access to a 24-hour emergency response through written emergency response procedures for handling emergencies and contact numbers for appropriate staff for after hours; and

a. For purposes of these provisions, after hours shall include holidays, weekends, and hours between 4:31 p.m. and 7:59 a.m. on Monday through Friday;

7. general supervision of personal needs funds retained for the client's use if specified in the service plan.

D. Client Records

1. SFC providers shall ensure that the SFC caregiver complies with the following standards for client records that are maintained in the SFC's home.

a. Information about clients and services of the contract agency shall be kept confidential and shared with third parties only upon the written authorization of the client or his/her authorized representative, except as otherwise specified in law.

b. The SFC caregiver shall make all client records available to the department or its designee and any other state or federal agency having authority to review such records.

c. The SFC caregiver shall ensure the privacy of the client's protected health information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:90 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2520 (December 2017).

§5091. Operational Requirements for Substitute Family Care Caregivers

A. The SFC caregiver(s) shall provide environments that meet the needs of the clients.

B. The SFC caregiver's home shall be located within a 25 mile radius of community facilities, resources and services such as medical care, schools, recreation facilities, churches and other community facilities.

C. The home of the SFC family shall not be used as lodging for any person(s) who is not subject to the prior approval certification process of the SFC family. The SFC family shall notify the administrator, or designee of the SFC provider, of any person(s) allowed to reside in the home following the initial certification.

1. In a non-emergent situation, prior notification is required. In an emergent situation, notification shall be made within 48 hours of the additional person's move into the substitute's family home.

2. All persons residing with the SFC family, including temporary or on a non-permanent basis, shall undergo statewide criminal record background checks conducted by the Louisiana State Police, or its authorized agent.

3. The SFC family shall accept persons requiring care or supervision only through the SFC provider with whom they have a current contract.

D. The SFC caregiver shall care for no more than two SFC clients in the caregiver's home. The SFC caregiver shall allow no more than three persons unrelated to the principal caregiver to live in the home. These three persons include the SFC clients.

E. The SFC caregiver shall have a stable income sufficient to meet routine expenses, independent of the payments for their substitute family care services, as demonstrated by a reasonable comparison between income and expenses conducted by the administrator or designee of the SFC provider upon initiation of services and as necessary thereafter.

F. The SFC caregiver shall have a plan that outlines in detail the supports to be provided. This plan shall be approved and updated as required and as necessary by the SFC provider. The SFC caregiver shall allow only SFC approved persons to provide care or supervision to the SFC client.

1. An adequate support system for the supervision and care of the participant in both on-going and emergent situations shall include:

a. identification of any person(s) who will supervise the participant on a routine basis which shall be prior approved by the administrator or designee of the SFC agency provider;

b. identification of any person(s) who will supervise for non-planned (emergency) assumption of supervisory duties who has not been previously identified and who shall be reported to the agency provider administrator or designee within 12 hours; and

c. established eligibility for available and appropriate community resources.

G. The SFC caregiver and/or household shall receive referrals only from the licensed SFC provider with whom it has a contract.

H. SFC Caregiver's Home Environment

1. The home of the SFC caregiver shall be safe and in good repair, comparable to other family homes in the neighborhood. The home and its exterior shall be free from materials and objects which constitute a potential for danger to the individual(s) who reside in the home.

2. SFC homes featuring either a swimming or wading pool shall ensure that safety precautions prevent unsupervised accessibility to clients.

3. The home of the SFC caregiver shall have:

a. functional air conditioning and heating units which maintain an ambient temperature between 65 and 80 degrees Fahrenheit;

b. a working telephone;

c. secure storage of drugs and poisons;

d. secure storage of alcoholic beverages;

e. pest control;

f. secure storage of fire arms and ammunition;

g. household first aid supplies to treat minor injuries;

h. plumbing in functional working order and availability of a method to maintain safe water temperatures for bathing; and

i. a clean and sanitary home, free from any health and/or safety hazards.

4. The SFC home shall be free from fire hazards such as faulty electrical cords, faulty appliances and non-maintained fireplaces and chimneys, and shall have the following:

a. operating smoke alarms within 10 feet of each bedroom;

b. portable chemical fire extinguishers located in the kitchen area of the home;

c. posted emergency evacuation plans which shall be practiced at least quarterly; and

d. two unrestricted doors which can be used as exits.

5. The SFC home shall maintain environments that meet the following standards.

a. There shall be a bedroom for each client with at least 80 square feet exclusive of closets, vestibules and

bathrooms and equipped with a door, that locks from the inside for privacy unless contraindicated by any condition of the client. Clients shall be afforded privacy within their sleeping units.

i. The department may grant a waiver from individual bedroom and square feet requirements upon good cause shown, as long as the health, safety and welfare of the client are not at risk.

b. Each client shall have his own bed unit, including frame, which is appropriate to his/her size and is fitted with a non-toxic mattress with a water proof cover.

c. Each client shall have a private dresser or similar storage area for personal belongings that is readily accessible to the client.

d. There shall be a closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the client.

e. The client shall have access to a working telephone.

f. The home shall have one bathroom for every two members of the SFC household, unless waived by the department.

g. The home shall have cooking and refrigeration equipment and kitchen and or dining areas with appropriate furniture that allows the client to participate in food preparation and family meals.

h. The home shall have sufficient living or family room space, furnished comfortably and accessible to all members of the household.

i. The home shall have adequate light in each room, hallway and entry to meet the requirements of the activities that occur in those areas.

j. The home shall have window coverings to ensure privacy.

I. Automobile Insurance and Safety Requirements

1. Each SFC caregiver shall have a safe and dependable means of transportation available as needed for the client.

2. The SFC caregiver shall provide the following information to the SFC provider who is responsible for maintaining copies in its records:

a. current and valid driver's licenses of persons routinely transporting the client;

b. current auto insurance verifications demonstrating at least minimal liability insurance coverage;

c. documentation of visual reviews of current inspection stickers; and

d. documentation of a driver's license status inquiry report on each family member who will be transporting the client.

3. If the client(s) are authorized to operate the family vehicle, liability insurance coverage specific to the client(s) use shall be maintained at all times in accordance with state law.

J. Client Records

1. The SFC caregiver shall forward all client records, including progress notes and client service notes to the SFC provider on a monthly basis. The following information shall be maintained in the client records in the SFC caregiver's home:

a. client's name, sex, race and date of birth;

b. client's address and the telephone number of the client's current place of employment, school or day provider;

c. clients' Medicaid/Medicare and other insurance cards and numbers;

d. client's social security number and legal status;

e. name and telephone number of the client's preferred hospital, physician and dentist ;

f. name and telephone number of the closest living relative or emergency contact person for the client;

g. preferred religion (optional) of the client;

h. Medicaid eligibility information;

i. medical information, including, but not limited to:

i. current medications, including dosages, frequency and means of delivery;

ii. the condition for which each medication is prescribed; and

iii. allergies;

j. identification and emergency contact information on persons identified as having authority to make emergency medical decisions in the case of the individual's inability to do so independently;

k. progress notes written on at least a monthly basis summarizing services and interventions provided and progress toward service objectives; and

l. a copy of the client's ISP and any vocational and behavioral plans.

2. Each SFC family shall have documentation attesting to the receipt of an adequate explanation of:

a. the client's rights and responsibilities;

b. grievance procedures;

c. critical incident reports; and

d. formal grievances filed by the client.

3. All records maintained by the SFC caregiver shall clearly identify the:

a. date the information was entered or updated in the record;

b. signature or initials of the person entering the information; and

c. documentation of the need for ongoing services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:91 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2520 (December 2017).

Subchapter L. Supervised Independent Living Module

§5093. General Provisions

A. Providers applying for the Supervised Independent Living Module under the HCBS license shall meet the core licensing requirements as well as the module specific requirements of this Section.

B. When applying for the SIL module under the HCBS provider license, the provider shall indicate whether the provider is initially applying as an SIL or as an SIL via shared living conversion process, or both.

C. Clients receiving SIL services shall be at least 18 years of age. An SIL living situation is created when an SIL client utilizes an apartment, house or other single living unit as his place of residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:93 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2521 (December 2017).

§5094. Operational Requirements for the Supervised Independent Living Module

A. A provider shall ensure that the living situation is freely selected by the client from among non-disability specific settings. An SIL residence may be owned or leased by either the provider or the client. At the expense of the owner or lessee, a provider shall ensure that the living situation shall be:

1. accessible and functional, considering any physical limitations or other disability of the client;

2. free from any hazard to the health or safety of the client;

3. properly equipped with accommodations for activities of daily living;

4. in compliance with applicable health, safety, sanitation and zoning codes;

5. a living situation that affords the client's individual privacy, including the ability to lock entrance doors;

6. arranged such that if there is more than one client in the living situation, the living environment does not conflict with the individual ISP of either client;

7. equipped with a functional kitchen area including space for food storage and a preparation area;

8. equipped with a functional private full bathroom. There shall be at least one full or half bathroom for every two clients residing at the SIL;

9. equipped with a living area;

10. equipped with an efficiency bedroom space or a separate private bedroom with a door that locks from the inside for privacy, if not contraindicated by a condition of the client residing in the room:

a. There shall be at least one bedroom for each two unrelated clients living in the SIL;

b. Each client shall have the right to choose whether or not to share a bedroom and a bed with another client;

11. equipped with hot and cold water faucets that are easily identifiable. If an assessment has been made that the client is at risk of scalding, the hot water heater shall be adjusted accordingly;

12. equipped with functional utilities, including:

a. water;

b. sewer; and

c. electricity;

13. equipped with functional air conditioning and heating units which is capable of maintaining an ambient temperature between 65 and 80 degrees Fahrenheit throughout the SIL;

14. kept in a clean, comfortable home-like environment;

15. equipped with the following furnishings if owned or leased by a provider:

a. a bed unit per client which includes a frame, clean mattress and clean pillow;

b. a private dresser or similar storage area for personal belongings that is readily accessible to the resident. There shall be one dresser per client;

c. one closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the resident. There shall be one closet per bedroom;

d. a minimum of two chairs per client;

e. a table for dining;

f. window treatments to ensure privacy; and

g. adequate light in each room, hallway and entry to meet the requirements of the activities that occur in those areas; and

16. equipped with functional smoke detectors and a fire extinguisher.

B. A provider shall ensure that any client placed in the living situation has:

1. 24-hour access to a working telephone in the SIL;

2. access to transportation;

3. access to any services in the client's approved ISP; and

4. privacy within their living and sleeping units.

C. The department shall have the right to inspect the SIL and client's living situation as deemed necessary.

D. An SIL provider shall ensure that no more than four unrelated clients are placed in an apartment, house or other single living unit utilized as a supervised independent living situation.

1. A SIL living situation shall make allowances for the needs of each client to ensure reasonable privacy which shall not conflict with the program plan of any resident of the living situation.

2. No clients shall be placed together in a living situation against their choice. The consent of each client shall be documented in the clients' record.

E. Supervision

1. For purposes of this Section, a supervisor is defined as a person, so designated by the provider agency, due to experience and expertise relating to needs of clients with developmental disabilities.

2. A supervisor shall have a minimum of two documented contacts per week with the client. The weekly contacts may be made by telephone, adaptive communication technology or other alternative means of communication. There shall be documentation of what was discussed with the client and any outcomes.

a. The supervisor shall have a minimum of one face-to-face contact per month with the client in the client's home. The frequency of the face-to-face contacts shall be based on the client's needs. There shall be documentation of what was discussed with the client and any outcomes.

b. In the event that the client has been admitted to a hospital or other inpatient facility, a face-to-face contact in the facility may substitute for a face-to-face contact in the client's home.

c. Providers may make as many contacts in a day as are necessary to meet the needs of the client. However, only one of those contacts will be accepted as having met one of the two documented weekly contacts or the one monthly face-to-face contact.

3. Attempted contacts are unacceptable and will not count towards meeting the requirements.

F. In addition to the core licensing requirements, the SIL provider shall:

1. provide assistance to the client in obtaining and maintaining housing;

2. allow participation in the development, administration and oversight of the client's service plan to assure its effectiveness in meeting the client's needs;

3. assure that bill payment is completed timely in accordance with the individual service plan, if applicable; and

4. assure that staff receive training in identifying health and safety issues including, but not limited to, scald prevention.

G. An SIL provider shall assess the following in conjunction with the client or client's legal representative when selecting the location of the SIL situation for the client:

1. risks associated with the location;

2. client cost;

3. proximity to the client's family and friends;

4. access to transportation;

5. proximity to health care and related services;

6. client choice;

7. proximity to the client's place of employment; and

8. access to community services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:93 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2521 (December 2017).

§5095. Supervised Independent Living Shared Living Conversion Process

A. The SIL Shared Living Conversion process is a situation in which a home and community-based shared living model, for up to six persons, may be chosen as a living option for participants in the Residential Options Waiver or any successor waiver.

B. Only an existing ICF/ID group or community home with up to eight beds may voluntarily and permanently close its home and its related licensed, Medicaid certified and enrolled ICF/ID beds to convert to new community-based waiver opportunities (slots) for up to six persons in shared living model or in combination with other ROW residential options. These shared living models will be located in the community.

1. Notwithstanding any other provision to the contrary, an SIL Shared Living Conversion model shall ensure that no more than six ROW waiver clients live in an apartment, house or other single living situation upon conversion.

C. The LDH Office for Citizens with Developmental Disabilities (OCDD) shall approve all individuals who may be admitted to live in and to receive services in an SIL shared living conversion model.

D. The ICF/ID provider who wishes to convert an ICF/ID to an SIL via the shared living conversion model shall be approved by OCDD and shall be licensed by HSS prior to providing services in this setting, and prior to accepting any ROW participant or applicant for residential or any other developmental disability service(s).

E. An ICF/ID provider who elects to convert to an SIL via the shared living conversion model may convert to one or more conversion models, provided that the total number of SIL shared living conversion slots; beds shall not exceed the number of Medicaid facility need review bed approvals of the ICFs/ID so converted.

1. The conversion of an ICFs/ID to an SIL via the shared living conversion process may be granted only for the number of beds specified in the applicant's SIL shared living conversion model application to OCDD.

2. At no point in the future may the provider of a converted SIL, which converted via the shared living conversion process, be allowed to increase the number of SIL slots approved at the time of conversion.

3. Any remaining Medicaid facility need review bed approvals associated with an ICF/ID that is being converted cannot be sold or transferred and are automatically considered terminated.

F. An ICF/ID provider who elects to convert to an SIL via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/ID prior to beginning the process of conversion.

G. Application Process

1. The ICF/ID owner or governing board must sign a conversion agreement with OCDD regarding the specific beds to be converted and submit a plan for the conversion of these beds into ROW shared living or other ROW residential waiver opportunities, along with a copy of the corresponding and current ICF/ID license(s) issued by HSS.

a. This conversion plan shall be approved and signed by OCDD and the owner or signatory of the governing board prior to the submittal of a HCBS provider, SIL module licensing application to LDH-HSS.

2. A licensed and certified ICF/ID provider who elects to convert an ICF/ID to an SIL via the shared living conversion process shall submit a licensing application for a HCBS provider license, SIL module. The ICF/ID applicant seeking to convert shall submit the following information with his licensing application:

a. a letter from OCDD stating that the owner or governing board has completed the assessment and planning requirements for conversion and that the owner or governing board may begin the licensing process for an HCBS provider, SIL Module;

b. a letter of intent from the owner or authorized representative of the governing board stating:

i. that the license to operate an ICF/ID will be voluntarily surrendered upon successfully completing an initial licensing survey and becoming licensed as an SIL via the shared living conversion process; and

ii. that the ICF/ID Medicaid facility need review bed approvals will be terminated upon the satisfactory review of the conversion as determined by OCDD, pursuant to its 90 day post conversion site visit; and

3. an executed copy of the conversion agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:94 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2522 (December 2017).

Subchapter M. Supported Employment Module

§5099. General Provisions

A. The provider applying to be licensed as a supported employment provider agency shall meet all of the HCBS provider core licensing requirements with the exception of the following requirements. The supported employment provider agency is not required to:

1. return all telephone calls from clients within one business day, other than during working hours;

2. have written policies and procedures approved by the owner or governing body that addresses client funds and emergency preparedness;

3. have written policies and procedures for behavior management, provided that the provider has no client with behavior management issues;

4. have licensed nursing services staff and direct care staff;

5. have a client's assessment of needs conducted by a registered nurse; and

6. maintain progress notes at the client's home.

B. The administrator of the supported employment provider agency shall be exempt from the education qualifications listing in the core licensing requirements of this Chapter.

C. The assessment of needs shall be done prior to placement of the client on a job site. A Medicaid HCBS comprehensive assessment approved by an LDH program office for a Medicaid recipient shall not substitute for the assessment of needs. A comprehensive plan of care approved by the department for Medicaid or waiver reimbursement shall not substitute for the ISP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORY NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:95 (January 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2522 (December 2017).

Chapter 51. Home and Community-Based Services Providers

Subchapter A. Monitored In-Home Caregiving Module

§5101. General Provisions

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a client who lives in a private unlicensed residence.

1. The principal caregiver shall:

a. be contracted by the licensed HCBS provider having a MIHC service module; and

b. reside with the client.

2. Professional staff employed by the HCBS provider shall provide oversight, support, and monitoring of the principal caregiver, service delivery, and client outcomes through on-site visits, training, and daily web-based electronic information exchange.

B. Providers applying for the monitored in-home caregiving module under the HCBS license shall meet the core licensing requirements (except those set forth in §5005.B.4, §5005.C.ii and §5007.F.1.c) and the module-specific requirements of this Section.

C. During any survey or investigation of the HCBS provider with the MIHC module conducted by the LDH-HSS, the survey process begins once the surveyor enters either the client's place of residence or the provider's licensed place of business. When the survey begins at the client's residence, the provider shall transmit any records requested by the HSS surveyor within two hours of such request to the location as designated by the HSS surveyor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2639 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2522 (December 2017).

§5103. Staffing Requirements, Qualifications, and Duties

A. The MIHC provider shall employ a registered nurse (RN) and a care manager who will monitor all clients served. The RN or the care manager may also serve as the administrator if he/she meets the requirements as set forth in §5055.A.1.

B. The HCBS provider with a MIHC module shall contract with at least one principal caregiver for each client served.

1. The principal caregiver shall:

a. serve only one client at any time; and

b. be able to provide sufficient time to the client as required to provide the care in accordance with the ISP.

2. Prior to MIHC services being provided to the client, the HCBS provider shall perform an assessment of the client's ability to be temporarily unattended by the principal caregiver and determine how the client will manage safely in the qualified setting without the continuous presence of a principal caregiver.

C. The MIHC registered nurse shall:

1. be licensed and in good standing with the Louisiana State Board of Nursing; and

2. have at least two years' experience in providing care to the elderly or to adults with disabilities.

D. The responsibilities of the registered nurse include:

1. participating in the determination of the qualified setting for MIHC services, based on on-site assessment of the premises;

2. ensuring that the client's applicable health care records are available and updated as deemed necessary;

3. developing, in collaboration with the care manager, client and principal caregiver, the client's person-centered ISP, based upon assessment of the client and medical information gathered or provided;

4. periodically reviewing and updating, at least annually, each client's ISP;

5. certifying, training, and evaluating principal caregivers in conjunction with the care manager;

6. monitoring, through daily review of electronic client progress notes, observation of at-home visits, and by documented consultations with other involved professionals, the status of all clients to ensure that MIHC services are delivered in accordance with the ISP;

7. conducting on-site visits with each client at the qualified setting at least every other month or more often as deemed necessary by the client's health status;

8. completing a nursing progress note corresponding with each on-site visit or more often as deemed necessary by the client's health status; and

9. planning for, and implementing, discharges of clients from MIHC services relative to if the health care needs of the client can be met in the qualified setting.

E. MIHC Care Manager Qualifications

1. The MIHC care manager shall meet one of the following requirements:

a. possess a bachelor's or master's degree in social work from a program accredited by the Council on Social Work Education;

b. possess a bachelor's or master's degree in nursing (RN) currently licensed in Louisiana (one year of experience as a licensed RN will substitute for the degree);

c. possess a bachelor's or master's degree in a human service related field which includes:

i. psychology;

ii. education;

iii. counseling;

iv. social services;

v. sociology;

vi. philosophy;

vii. family and participant sciences;

viii. criminal justice;

ix. rehabilitation services;

x. substance abuse treatment;

xi. gerontology; or

xii. vocational rehabilitation; or

d. possess a bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields in §5103.E.1.c.i-xii.

2. The MIHC care manager shall have at least two years' experience in providing care to the elderly or to adults with disabilities.

3. The MIHC care manager may serve as the administrator of the HCBS provider; however, any such individual that serves as both administrator and care manager shall meet both sets of minimum qualifications and have the ability to service both sets of specified functions.

F. Care Manager Responsibilities. The following responsibilities of the care manager for the MIHC module shall substitute for the requirements in §5055.L and §5055.M. The responsibilities of the MIHC care manager shall include:

1. conducting the initial and ongoing assessment and determination of the qualified setting;

2. certifying, training, and evaluating principal caregivers in conjunction with the registered nurse;

3. developing, in collaboration with the registered nurse, an ISP for delivery of MIHC services for each client, based upon assessment and medical information gathered or provided;

4. monitoring, in collaboration with the registered nurse, through daily review of electronic client progress notes, and observation of at-home visits, the status of all clients to ensure that all MIHC services are delivered;

5. conducting on-site visits with each client at the qualified setting every other month or more often as deemed necessary by the client's health status;

6. completing a care management client progress note corresponding with each on-site visit every other month or more often as the client's condition warrants;

7. assisting with obtaining information and accessing other health-care and community services in accordance with the ISP;

8. reviewing and documenting the fire and safety procedures for the qualified setting;

9. providing training related to MIHC services for each principal caregiver before the principal caregiver begins to provide care;

10. participating in discharge planning of clients from monitored in-home care services by determining if the needs of the client can be met safely in the qualified setting;

11. reviewing and documenting that the qualified setting continues to meet the needs of the client, in accordance with the ISP, at every on-site visit and as situations change; and

l2. being readily accessible and available to the principal caregivers either by telephone or other means of prompt communication.

a. The care manager shall maintain a file on each principal caregiver which shall include documentation of each principal caregiver's performance during the care manager's bimonthly on-site visit and more often as caregiver's performance warrants.

G. MIHC Principal Caregiver Qualifications. The following principal caregiver qualifications under the MIHC module shall substitute for the requirements in §5055.F.

1. The principal caregiver shall be certified by the HCBS provider before serving a client.

2. In order to be certified, the principal caregiver applicant shall:

a. participate in all required orientations, trainings, monitoring, and corrective actions required by the HCBS provider;

b. have a statewide criminal background check conducted by the Louisiana State Police, or its authorized agent, in accordance with the applicable state laws;

c. comply with the provisions of R.S. 40:2179-2179.2 and the rules regarding the direct service worker registry;

d. be at least 18 years of age;

e. have the ability to read, write, and carry out directions competently as assigned; and

f. be trained in recognizing and responding to medical emergencies of clients.

3. To maintain certification, the principal caregiver shall reside in the state of Louisiana and shall provide MIHC services in a qualified setting located in Louisiana.

H. MIHC Principal Caregiver Responsibilities. The following principal caregiver responsibilities under the MIHC module shall substitute for the responsibilities in §5055.G. The responsibilities of the principal caregiver shall include:

1. supervision and assistance with personal care services for the client that is necessary for his/her health, safety and well-being in accordance with the ISP;

2. monitoring and reporting any non-urgent or nonemergency changes in the client's medical condition to the HCBS care manager;

3. promptly reporting and communicating a client's request for services or change in services to the care manager;

4. maintaining the qualified setting consistent with the criteria noted herein;

5. completing and submitting to the HCBS agency an electronic client progress note daily;

6. providing ongoing supervision of health-related activities, including, but not limited to:

a. reminding the client to take prescribed medications;

b. ensuring that the client's prescriptions are refilled timely;

c. transporting or arranging for client transportation to medical and other appointments;

d. assisting the client to comply with health care instructions from health care providers, including but not limited to, dietary restrictions;

e. recognizing and promptly arranging for needed urgent medical care by activating the 911 call system;

f. notifying the care manager of the need for alternative care of the client;

g. immediately reporting any suspected abuse, neglect, or exploitation of a client to the HCBS care manager, as well as timely reporting any suspected abuse, neglect, or exploitation of a client to any other persons required by law to receive such notice;

h. immediately notifying the care manager when any of the following events occur:

i. death of a client;

ii. a medical emergency or any significant change in a client's health or functioning;

iii. a fire, accident, and/or injury that requires medical treatment or the medical diagnosis of a reportable communicable disease of the client and/or principal caregiver;

iv. any planned or unexpected departure from the residence by a client or principal caregiver; and

v. all other client or principal caregiver major incidents or accidents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2639 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2523 (December 2017).

§5105. Operational Requirements for Monitored In-Home Caregiving

A. Training. The following requirements for training and competency for the MIHC module shall substitute for the training and competency requirements in §5055.H, §5055.I, and §5055.J.

1. Prior to the principal caregiver providing MIHC services to a client, the HCBS provider shall ensure that the principal caregiver satisfactorily completes documented training in the following areas:

a. the client's support needs in accordance with the ISP, including the following:

i. medical and behavioral diagnoses;

ii. medical and behavioral health history;

iii. required ADLs and IADLs;

iv. management of aggressive behaviors, including acceptable and prohibited responses; and

v. any other pertinent information;

b. completion and transmission of the daily electronic client progress note;

c. emergency and safety procedures, including the HCBS provider's fire, safety, and disaster plans;

i. this training shall include recognizing and responding to medical emergencies or other emergencies that require an immediate call to 911;

d. detection and reporting suspected abuse, neglect and exploitation, including training on the written policies and procedures of the HCBS provider regarding these areas;

e. written policies and procedures of the HCBS provider including, but not limited to:

i. documentation and provider's reporting requirements;

ii. infection control;

iii. safety and maintenance of the qualified setting;

iv. assistance with medication(s);

v. assistance with ADLs and IADLs;

vi. transportation of clients; and

vii. client rights and privacy;

f. confidentiality;

g. detecting signs of illness or dysfunction that warrant medical or nursing intervention; and

h. the roles and responsibilities of the HCBS staff and the principal caregiver.

2. The HCBS provider shall ensure that each principal caregiver satisfactorily completes a basic first aid course within 45 days of hire.

B. Transmission of Information

1. The HCBS provider shall use secure, web-based information collection from principal caregivers for the purposes of monitoring client health and principal caregiver performance.

2. All protected health information shall be transferred, stored, and utilized in compliance with applicable federal and state privacy laws.

3. HCBS providers shall sign, maintain on file, and comply with the most current DHH HIPAA business associate addendum.

C. Monitoring. The HCBS provider shall provide ongoing monitoring of the client and the performance of the principal caregiver in accordance with the ISP. Ongoing monitoring shall consist of the following:

1. conducting on-site visits with each client at the qualified setting monthly by either the RN or the care manager in order to monitor the health and safety status of the client and to ensure that all MIHC services are delivered by the principal caregiver in accordance with the ISP;

2. reviewing and documenting at least every other month that the qualified setting meets the needs of the MIHC services to be provided to the client in accordance with the ISP;

3. receiving and reviewing the daily electronic client progress notes to monitor the client's health status and principal caregiver's performance to ensure appropriate and timely follow up;

4. ensuring the competency of the principal caregiver by written or oral exam before providing services and annually; and

5. ensuring that each principal caregiver receives annual training to address the needs of the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2641 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2523 (December 2017).

§5107. Qualified Setting Provisions

A. The residence where MIHC services are provided to a client shall be a qualified setting as stipulated herein. The qualified setting determination shall be completed by the HCBS provider as part of the admission process and on an on-going basis as stipulated herein.

B. In order for a setting to be determined qualified for MIHC services, the setting shall meet the following criteria:

1. is a private residence located in Louisiana, occupied by the client and a principal caregiver and shall not be subject to state licensure or certification as a hospital, nursing facility, group home, intermediate care facility for individuals with intellectual disabilities or as an adult residential care provider;

2. is accessible to meet the specific functional, health and mobility needs of the client residing in the qualified setting;

3. is in compliance with local health, fire, safety, occupancy, and state building codes for dwelling units;

4. is equipped with appropriate safety equipment, including, at a minimum, an easily accessible class ABC fire extinguisher, smoke and carbon monoxide detectors (which shall be audible in the client's and principal caregiver's sleeping areas when activated);

5. is equipped with heating and refrigeration equipment for client's meals and/or food preparation, e.g. warming or cooling prepared foods;

6. has a bedroom for the client which shall contain a bed unit appropriate to his/her size and specific needs that includes a frame, a mattress, and pillow(s). The bedroom shall have a closeable door and window coverings to ensure privacy of the client with adequate lighting to provide care in accordance with the ISP;

7. has a closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the client or the principal caregiver;

8. has a bathroom with functioning indoor plumbing for bathing and toileting with availability of a method to maintain safe water temperatures for bathing;

9. is equipped with functional air temperature controls which maintain an ambient seasonal temperature between 65 and 80 degrees Fahrenheit;

10. is maintained with pest control;

11. is equipped with a 24 hour accessible working telephone and/or other means of communication with health care providers;

12. is equipped with household first aid supplies to treat minor cuts or burns; and

13. as deemed necessary, has secured storage for potentially hazardous items, such as fire arms and ammunition, drugs or poisons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2641 (December 2015).

§5109. Waiver of Module Provisions

A. In its application for a license, or upon renewal of its license, a provider may request a waiver of specific MIHC module licensing provisions.

1. The waiver request shall be submitted to HSS, and shall provide a detailed description as to why the provider is requesting that a certain licensing provision be waived.

2. HSS shall review such waiver request. Upon a good cause showing, HSS, at its discretion, may grant such waiver, provided that the health, safety, and welfare of the client is not deemed to be at risk by such waiver of the provision(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2642 (December 2015).

Chapter 52. Pediatric Day Health Care Facilities

Subchapter A. General Provisions

§5201. Introduction

A. A pediatric day health care (PDHC) facility serves medically fragile individuals under the age of 21, including technology dependent children who require close supervision. These facilities offer an alternative health care choice to receiving in-home nursing care. A PDHC facility may operate seven days per week and may provide up to 12 hours of services per day per individual served.

B. The care and services to be provided by the PDHC facility shall include, but is not limited to:

1. nursing care, including but not limited to tracheotomy and suctioning care, medication management, IV therapy, and gastrostomy care;

2. respiratory care;

3. physical, speech, and occupational therapies;

4. assistance with activities of daily living;

5. transportation services;

6. socialization; and

7. education and training.

C. In addition to the provision of care and services, the PDHC facility shall also function as an emergency shelter as provided in these licensing regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2760 (December 2009).

§5203. Definitions

Administrator—the person who is in charge of the daily operation of the PDHC facility.

Department or DHH—the Louisiana Department of Health and Hospitals.

Child—a medically fragile individual under the age of 21 who receives services from a PDHC facility, including a technology dependent child who requires close supervision.

Licensee—the person, partnership, company, corporation, association, organization, professional entity, or other entity to whom a license is granted by the licensing agency and upon whom rests the ultimate responsibility and authority for the conduct of and services provided by the PDHC facility.

Medically Fragile—an individual who has a medically complex condition characterized by multiple, significant medical problems that require extended care.

Parent—parent(s) or guardian with legal custody of the child.

Pediatric Day Health Care (PDHC) Facility—a facility that serves medically fragile individuals under the age of 21, including technology dependent children who require close supervision.

Pediatric Nursing Experience—being responsible for the care of acutely ill or chronically ill children.

Plan of Care—the comprehensive plan developed by the PDHC facility for each child receiving services for implementation of medical, nursing, psychosocial, developmental, and educational therapies.

Prescribing Physician—a physician, currently licensed to practice medicine in Louisiana, who:

1. signs the order admitting the child to the PDHC facility;

2. maintains overall responsibility for the child's medical management; and

3. is available for consultation and collaboration with the pediatric day health care staff.

Secretary—the secretary of the Louisiana Department of Health and Hospitals, or his designee.

Technology Dependent Child—a child who has a chronic disability that requires specific nursing interventions to compensate for the deficit of a life sustaining body function. The child requires daily, ongoing, intermittent care or monitoring by health care professionals or other trained personnel as prescribed by a physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2760 (December 2009).

Subchapter B. Licensing Procedures

§5205. General Provisions

A. All pediatric day health care facilities must be licensed by the department. A PDHC facility shall not be established, opened, operated, managed, maintained, or conducted in this state without a current valid license issued by the Department of Health and Hospitals (DHH). DHH is the only licensing authority for PDHC Facilities in the state of Louisiana. It shall be unlawful to operate a PDHC facility without possessing a current, valid license by DHH. Each PDHC facility shall be separately licensed.

B. A parent or legal guardian or legally responsible person providing care to a medically fragile child in his/her home or any other extended care or long term care facility is not considered to be a PDHC facility and shall not be licensed as a PDHC facility.

C. A PDHC license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the facility to which it is issued and only for the specific geographic address of that facility;

3. be valid for one year from the date of issuance, unless revoked, suspended, modified, or terminated prior to that date, or unless a provisional license is issued;

4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the PDHC facility;

5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

D. In order for the PDHC facility to be considered operational and retain licensed status, the facility shall meet the following conditions.

1. The PDHC facility shall always have at least two employees, one of whom is an RN, on duty at the facility location during operational hours.

2. There shall be staff employed and available to be assigned to provide care and services to each child during all operational hours. Services rendered shall be consistent with the medical needs of each child.

3. The PDHC facility shall have provided services to at least two children in the preceding 12 month period in order to be eligible to renew its license.

E. The licensed PDHC facility shall abide by and adhere to any state law, rules, policy, procedure, manual, or memorandums pertaining to such facilities.

F. A separately licensed PDHC facility shall not use a name which is substantially the same as the name of another such facility licensed by the department, unless such PDHC facility is under common ownership with other PDHC facilities.

G. No branches, satellite locations or offsite campuses shall be authorized for a PDHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2761 (December 2009).

§5207. Initial Licensing Application Process

A. An initial application for licensing as a PDHC facility shall be obtained from the department. A completed initial license application packet for a PDHC facility must be submitted to and approved by the department prior to an applicant providing PDHC facility services. An applicant must submit a completed initial licensing packet to the department, which shall include:

1. a completed PDHC facility licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural facility plans from the DHH Department of Engineering and Architectural Services and the Office of the State Fire Marshal (OSFM);

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health (OPH);

5. a copy of statewide criminal background checks on all individual owners with a 5 percent or more ownership interest in the PDHC facility entity, and on all members of the PDHC facility's board of directors, if applicable, and administrators;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

7. if applicable, Clinical Laboratory Improvement Amendments (CLIA) certificate or CLIA certificate of waiver;

8. a completed disclosure of ownership and control information form;

9. a floor sketch or drawing of the premises to be licensed;

10. the days and hours of operation; and

11. any other documentation or information required by the Department for licensure.

B. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a PDHC facility must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application packet has been approved by the department, notification of the approval shall be forwarded to the applicant. Within 90 days of receipt of the approval notification, the applicant must notify the department that the PDHC facility is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application has been closed, an applicant who is still interested in becoming a PDHC facility must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2761 (December 2009).

§5209. Types of Licenses

A. The Department shall have the authority to issue the following types of licenses:

1. Full Initial License. The department shall issue a full license to the facility when the initial licensing survey finds that the PDHC facility is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. The department may issue a provisional initial license to the facility when the initial licensing survey finds that the PDHC facility is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the children or participants. The provisional license shall be valid for a period not to exceed six months.

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

b. The facility must submit a plan of correction to the department for approval and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional initial license.

c. A follow-up survey shall be conducted prior to the expiration of the provisional initial license.

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

ii. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional initial license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed PDHC facility which is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional Renewal License. The department, in its sole discretion, may issue a provisional license to an existing licensed PDHC facility for a period not to exceed six months.

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

b. A provisional renewal license may be issued for the following reasons:

i. the existing PDHC facility has more than five deficient practices or deficiencies cited during any one survey;

ii. the existing licensed PDHC facility has more than three validated complaints in a one year period;

iii. the existing PDHC facility has been issued a deficiency that involved placing a child or participant at risk for serious harm or death;

iv. the existing PDHC facility has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

v. the existing pediatric day health care provider is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

c. When the department issues a provisional renewal license to an existing licensed pediatric day health care provider, the department shall conduct an on-site follow-up survey at the pediatric day health care facility prior to the expiration of the provisional license.

i. If the on-site follow-up survey determines that the PDHC facility has corrected the deficient practices and has maintained compliance during the period of the

provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the PDHC facility license.

ii. If the on-site follow-up survey determines that the PDHC facility has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional renewal license shall expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee, if no timely informal reconsideration or administrative appeal is filed pursuant to this Chapter.

B. If an existing licensed PDHC facility has been issued a notice of license revocation, suspension, or termination, and the facility's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

1. If a timely administrative appeal has been filed by the provider regarding the license revocation, suspension, or termination, the administrative appeal shall be suspensive and the facility shall be allowed to continue to operate and provide services until such time as the department's Bureau of Appeals issues a decision on the license revocation, suspension, or termination.

2. If the secretary of the department determines that the violations of the PDHC facility pose an imminent or immediate threat to the health, welfare, or safety of a child, the imposition of such action may be immediate and may be enforced during the pendency of the administrative appeal. The PDHC facility shall be notified of this determination in writing.

3. The denial of the license renewal application shall not affect in any manner the license revocation, suspension, or termination.

C. The renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the facility.

D. The license for a PDHC facility shall be valid for one year from the date of issuance, unless revoked, suspended, modified, or terminated prior to that time.

E. The initial pediatric day health care license shall specify the capacity of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2762 (December 2009).

§5211. Licensing Surveys

A. Prior to the initial license being issued to the PDHC facility, an initial licensing survey shall be conducted on-site at the facility to assure compliance with licensing standards. The facility shall not provide services to any child until the initial licensing survey has been performed and the facility found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. Once an initial license has been issued, the department shall conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

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

1. A new provider that is issued a provisional initial license or an existing provider that is issued a provisional renewal license shall be required to correct all noncompliance or deficiencies at the time the follow-up survey is conducted.

2. The department shall issue written notice to the provider of the results of the follow-up survey.

D. An acceptable plan of correction may be required for any survey where deficiencies have been cited.

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. civil monetary penalties;

2. directed plans of correction; and

3. license revocations.

F. DHH surveyors and staff shall be:

1. given access to all areas of the facility and all relevant files during any licensing survey or other survey; and

2. allowed to interview any provider staff, child or participant as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2763 (December 2009).

§5213. Changes in Licensee Information or Personnel

A. A PDHC facility license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any change regarding the PDHC facility name, "doing business as" name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the occurrence. Any change regarding the PDHC facility name or "doing business as" name requires a change to the facility license and shall require a $25 fee for the reissuance of an amended license.

C. Any change regarding the facility's key administrative personnel shall be reported in writing to the department within five days of the change.

1. Key administrative personnel include the:

a. administrator;

b. medical director; and

c. director of nursing.

2. The facility's notice to the department shall include the individual's:

a. name;

b. address;

c. hire date; and

d. qualifications.

D. A change of ownership (CHOW) of the PDHC facility shall be reported in writing to the department within five days of the change of ownership.

1. The license of a PDHC facility is not transferable or assignable. The license of a PDHC facility cannot be sold.

2. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

3. A PDHC facility that is under license suspension, revocation, or termination may not undergo a CHOW.

E. Any request for a duplicate license must be accompanied by a $25 fee.

F. A PDHC facility that intends to change the physical address of its geographic location is required to have plan review approval, Office of State Fire Marshall approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the relocation the facility.

1. Written notice of intent to relocate must be submitted to the licensing section of the department when plan review request is submitted to the department for approval.

2. Relocation of the facility's physical address results in a new anniversary date and the full licensing fee must be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2763 (December 2009).

§5215. Cessation of Business

A. A facility that intends to close or cease operations shall comply with the following procedures:

1. give 30 days advance written notice to:

a. the department;

b. the prescribing physician; and

c. the parent(s) or legal guardian or legal representative;

2. notify the department of the location where the records will be stored and the contact person for the records; and

3. provide for an orderly discharge and transition of all children admitted to the facility.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2764 (December 2009).

§5217. Renewal of License

A. License Renewal Application. A PDHC facility must submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. the days and hours of operation;

3. a copy of the current on-site inspection report with approval for occupancy from the:

a. Office of the State Fire Marshal; and

b. Office of Public Health;

4. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

5. the license renewal fee; and

6. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the pediatric day health care license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2764 (December 2009).

§5219. Denial of License, Revocation of License, Denial of License Renewal

A. In accordance with the provisions of the Administrative Procedure Act, the department may:

1. deny an application for a license;

2. deny a license renewal; or

3. revoke a license.

B. Denial of an Initial License

1. The department shall deny an initial license when the initial licensing survey finds that the PDHC facility is noncompliant with any licensing laws or regulations or with any other required statutes, laws, ordinances, rules or regulations and such noncompliance presents a potential threat to the health, safety, or welfare of the children who will be served by the facility.

2. The department may deny an initial license for any of the reasons in this Chapter that a license may be revoked or non-renewed.

C. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

2. If a provider fails to timely renew its license, the facility shall immediately cease providing services, unless the provider is actively treating children, in which case the provider shall:

a. immediately provide written notice to the department of the number of children receiving treatment at this PDHC facility;

b. immediately provide written notice to the prescribing physician and to the child, parent, legal guardian, or legal representative of the following:

i. voluntary non-renewal of license;

ii. date of closure; and

iii. plans for orderly transition of the child;

c. discharge and transition of each child within 15 days of voluntary non-renewal; and

d. notify the department of the location where records will be stored and the contact person for the records.

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

D. Revocation of License or Denial of License Renewal. A PDHC facility license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the PDHC facility licensing laws, rules and regulations, or with other required statutes, laws, ordinances, rules, or regulations;

2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the department, the Attorney General's Office, any regulatory agency, or any law enforcement agency;

3. failure to uphold child rights whereby deficient practices result in harm, injury, or death of a child;

4. negligence or failure to protect a child from a harmful act of an employee or other child including, but not limited to:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a child's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

5. failure to notify the proper authorities, as required by federal or state law, rules, or regulations, of all suspected cases of:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a child's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

6. knowingly making a false statement, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. records, including:

i. clinical;

ii. child; or

iii. facility;

d. matters under investigation by the department or the Office of the Attorney General; or

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to department employees or to law enforcement agencies;

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

9. fraudulent operation of a PDHC facility by the owner, administrator, manager, member, officer, or director;

10. an owner, officer, member, manager, administrator, director, or person designated to manage or supervise child care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court.

a. For purposes of these provisions, conviction of a felony means a felony relating to any of the following;

i. violence, abuse, or negligence of another person;

ii. misappropriation of property belonging to another person;

iii. cruelty, exploitation, or sexual battery of a person with disabilities;

iv. a drug offense;

v. crimes of a sexual nature;

vi. a firearm or deadly weapon; or

vii. fraud or misappropriation of federal or state funds, including Medicare or Medicaid funds;

11. failure to comply with all reporting requirements in a timely manner as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview provider staff or children;

13. failure to allow or refusal to allow access to facility or child records by authorized departmental personnel;

14. bribery, harassment, or intimidation of any child or family member designed to cause that child or family member to use or retain the services of any particular PDHC facility; or

15. cessation of business or non-operational status.

E. If a PDHC facility license is revoked or renewal is denied, (other than for cessation of business or non-operational status) any owner, officer, member, director, manager, or administrator of such PDHC facility may be prohibited from opening, managing, directing, operating, or owning another PDHC facility for a period of two years from the date of the final disposition of the revocation or denial action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2765 (December 2009).

§5221. Notice and Appeal of License Denial, License Revocation and License Non-Renewal and Appeal of Provisional License

A. Notice of a license denial, license revocation or license non-renewal shall be given to the provider in writing.

B. The PDHC facility has a right to an informal reconsideration of the license denial, license revocation, or license non-renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The PDHC facility must request the informal reconsideration within 10 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration must be in writing and shall be forwarded to the DHH Health Standards Section.

2. The request for informal reconsideration must include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the facility shall receive written notification of the date of the informal reconsideration.

4. The facility shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or non-renewal, shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The facility shall be notified in writing of the results of the informal reconsideration.

C. The PDHC facility has a right to an administrative appeal of the license denial, license revocation, or license non-renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The PDHC facility must request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or license non-renewal. The facility may forego its rights to an informal reconsideration, and if so, the facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for administrative appeal must be in writing and shall be submitted to the DHH Bureau of Appeals.

2. The request for administrative appeal must include any documentation that demonstrates that the determination was made in error and must include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the Bureau of Appeals, the administrative appeal of the license revocation or license non-renewal shall be suspensive, and the facility shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the facility pose an imminent or immediate threat to the health, welfare, or safety of a child, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. The facility shall be notified of this determination in writing.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation, or non-renewal shall not be a basis for the administrative appeal.

D. If an existing PDHC facility has been issued a notice of license revocation and the facility's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect in any manner the license revocation.

E. If a timely administrative appeal has been filed by the facility on a license denial, license non-renewal, or license revocation, the Bureau of Appeals shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Bureau of Appeals if good cause is shown.

1. If the final agency decision is to reverse the license denial, the license non-renewal, or the license revocation, the facility's license will be re-instated or granted upon the payment of any licensing fees or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final agency decision is to affirm the license non-renewal or the license revocation, the facility shall discharge any and all children receiving services. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where the child's records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new PDHC facility. The issuance of a provisional license to an existing PDHC facility is not considered to be a denial of license, a denial of license renewal, or a license revocation.

G. A facility with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal regarding the deficiencies cited at the follow-up survey.

1. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The facility shall submit a written request for informal reconsideration within five calendar days of receipt of the department's notice of the results of the follow-up survey.

a. The facility may forego its right to an informal reconsideration.

4. The facility shall submit a written request to the DHH Bureau of Appeals for an administrative appeal within five calendar days of receipt of the department's notice of the results of the informal reconsideration.

a. If the facility has opted to forego the informal reconsideration process, a written request for an administrative appeal shall be made within five calendar days of receipt of the department's notice of the results of the follow-up survey.

H. A facility with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge children unless the Bureau of Appeals issues a stay of the expiration.

1. A stay may be granted upon application by the provider at the time the administrative appeal is filed and only:

a. after a contradictory hearing; and

b. upon a showing that there is no potential harm to the children being served by the facility.

I. If a timely administrative appeal has been filed by a facility with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Bureau of Appeals shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Bureau of Appeals if good cause is shown.

1. If the final agency decision is to remove all deficiencies, the facility's license will be reinstated upon the payment of any licensing fees or other fees due to the department, and the payment of any outstanding sanctions due to the department.

2. If the final agency decision is to uphold the deficiencies and affirm the expiration of the provisional license, the facility shall discharge all children receiving services. Within 10 calendar days of the final agency decision, the facility shall provide written notification to the department's licensing section of the secure and confidential location of where the child's records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2765 (December 2009).

§5223. Complaint Surveys

A. The department shall conduct complaint surveys in accordance with La. R.S. 40:2009.13, et seq.

B. Complaint surveys shall be unannounced surveys.

C. An acceptable plan of correction may be required by the department for any complaint survey where deficiencies have been cited. If the department determines other action, such as license revocation is appropriate, a plan of correction may not be required and the facility will be notified of such action.

D. A follow-up survey may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices. If the department determines that other action, such as license revocation, is appropriate, a follow-up survey may not be required. The facility will be notified of any action.

E. The department may issue appropriate sanctions, including but not limited to, civil monetary penalties, directed plans of correction, and license revocations, for deficiencies and non-compliance with any complaint survey.

F. DHH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. DHH surveyors and staff shall be allowed to interview any provider staff, child, or participant, as necessary or required to conduct the survey.

G. A PDHC facility which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 10 calendar days of the facility's receipt of the notice of the violations or deficiencies.

H. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation. The written request for an informal reconsideration shall be submitted to the Health Standards Section. The department must receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

I. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as an administrative review. The facility or complainant shall submit all documentation or information for review for the informal reconsideration and the department shall consider all documentation or information submitted. There is no right to appear in person at the informal reconsideration of a complaint survey or investigation. Correction of the violation or deficiency shall not be the basis for the reconsideration. The provider and the complainant shall be notified in writing of the results of the informal reconsideration.

J. Except as provided in §5223.K, the informal reconsideration shall constitute final action by the department regarding the complaint survey or investigation, and there shall be no right to an administrative appeal.

K. In those complaints in which the department's Health Standards Section determines that the complaint involves issues that have resulted in, or are likely to result in, serious harm or death to the consumer, the complainant or the provider may appeal the informal reconsideration findings to the Bureau of Appeals.

1. The written request for an administrative appeal shall be submitted to the Bureau of Appeals and must be received within 30 calendar days of the receipt of the results of the informal reconsideration.

2. The hearing before the Bureau of Appeals is limited to the evidence presented at the informal reconsideration, unless the complainant or the facility has obtained additional evidence vital to the issues which could not have been obtained with due diligence before or during the informal reconsideration.

3. The administrative law judge shall only make a determination on the administrative appeal, based on the evidence presented, as to whether or not the complaint investigation or survey was conducted properly or improperly. The administrative law judge shall not have the authority to overturn or delete deficiencies or violations and shall not have the authority to add deficiencies or violations.

4. If the administrative law judge determines that the complaint investigation or survey was not conducted properly, he/she shall designate in writing and with specificity the methods by which a re-investigation shall be conducted.

5. No appeal shall lie from a re-investigation upon a prima facie showing that the re-investigation was conducted in accordance with the designations of the administrative law judge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2767 (December 2009).

§5225. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to the PDHC facility shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to a PDHC facility shall be available for disclosure to the public 30 calendar days after the provider submits an acceptable plan of correction of the deficiencies

or 90 calendar days after the statement of deficiencies is issued to the provider, whichever occurs first.

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

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

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

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2767 (December 2009).

Subchapter C. Administration and Organization

§5231. Facility Administration and Management

A. The licensee of each PDHC facility shall have full legal authority and responsibility for the operation of the facility.

B. Each PDHC facility shall be organized in accordance with a written table of organization which describes the lines of authority and communication from the administrative level to the child care level. The organizational structure shall be designed to ensure an integrated continuum of services to the children.

C. The licensee of each facility shall designate one person as administrator who is responsible and accountable for the overall management and supervision of the PDHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2768 (December 2009).

§5233. Policy and Procedures

A. The PDHC facility through collaboration by the medical director, administrator, and director of nursing shall develop, implement and maintain written policies and procedures governing all child care and related medical or other services provided. to participants. The child care policies and procedures shall ensure compliance with these licensing standards.

B. All child care policies and procedures shall be reviewed at least annually and revised as needed.

C. Child care policies and procedures shall address the prevention, reporting, and investigation of abuse and neglect. All facility staff shall immediately report any suspected abuse and/or neglect of a child in accordance with state law.

D. The facility's written policy on prevention, reporting, and investigation of abuse and neglect, as well as the local child protection agency's telephone number, shall be posted in the facility in a conspicuous location.

E. The PDHC facility shall develop and implement a grievance policy and procedures. The grievance policy shall be used to process complaints by the child or parent.

1. The child or parent shall be entitled to initiate a grievance at any time.

2. The child and/or parent shall be informed of and provided a written copy of the grievance policy of the PDHC facility upon acceptance to the facility.

3. The administrator of the facility or his designee shall investigate all grievances and shall make reasonable attempts to address the grievance(s).

4. The administrator or his designee shall issue a written report or decision to the child and/or parent within five business days of receipt of the grievance. The written report shall contain:

a. the findings of the investigation;

b. resolution of the investigation; and

c. the address and contact number of the licensing section of the department to which a complaint may be filed.

5. The facility shall prominently post the grievance procedure in an area accessible to the child and family.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2768 (December 2009).

Subchapter D. Participation Requirements

§5237. Acceptance Criteria

A. Each PDHC facility shall have written policies and procedures governing the acceptance and participation of children in their pediatric day health care program.

B. Infants or children shall be considered for acceptance to the facility if they have been diagnosed with a medically complex condition(s) which is characterized by multiple

significant medical problems that require extended care (i.e., medically fragile).

1. For purposes of these provisions, medically fragile conditions include, but are not limited to:

a. severe lung disease requiring oxygen;

b. severe lung disease requiring ventilator or tracheotomy care;

c. complicated spina bifida;

d. heart disease;

e. malignancy;

f. asthmatic exacerbations;

g. cystic fibrosis exacerbations;

h. neuromuscular disease;

i. encephalopathy; and

j. seizure disorders.

C. The child shall be stable for outpatient medical services and require ongoing nursing care and other interventions. Children with risk of infectious disease or acute infection shall be accepted only as authorized by the prescribing physician in collaboration with the PDHC facility medical director.

D. The prescribing physician, in consultation with the parent(s), shall recommend participation in a pediatric day health care program, taking into consideration the medical, emotional, psychosocial and environmental factors.

1. No child shall be accepted to participate in PDHC facility services without a prescription from the child's prescribing physician.

2. The medical director of the PDHC facility may provide the referral to the facility only if he/she is the child's prescribing physician, and only if the medical director has no ownership interest in the PDHC facility.

3. No member of the board of directors of the PDHC facility may provide a referral to the PDHC. No member of the board of directors of the PDHC facility may sign a prescription as the prescribing physician for a child to participate in the PDHC facility services.

4. No physician with ownership interest in the PDHC may provide a referral to the PDHC. No physician with ownership interest in the PDHC may sign a prescription as the prescribing physician for a child to participate in the PDHC facility services.

5. Notwithstanding anything to the contrary, providers are expected to comply with all applicable federal and state rules and regulations including those regarding anti-referral and the Stark Law.

E. A consent form, outlining the purpose of the facility, parent's responsibilities, authorized treatment and emergency disposition plans shall be signed by the parent(s) and witnessed prior to acceptance into the facility's PDHC program. The parent(s) shall be provided a copy of the consent form and the facility shall retain a copy in their records.

F. Before care is initiated, the PDHC facility shall inform the parent orally and in writing of:

a. those charges for services that will not be covered by the child's payor source; and

b. the charges that the parent may be responsible for paying.

G. Conference Prior to Attendance. If the child meets the criteria for acceptance into a PDHC facility program, the prescribing physician or his/her designee shall contact the medical or nursing director of the PDHC facility to schedule a conference prior to the child attending the facility.

1. If the child is hospitalized at the time of referral, planning for PDHC participation shall include the parent(s), relevant hospital medical, nursing, social services and developmental staff to begin development of the plan of care that will be implemented following acceptance to the PDHC facility.

2. If the child is not hospitalized at the time of referral, planning for PDHC participation shall be conducted with the prescribing physician, parent(s), PDHC facility representative(s), and representative(s) of other relevant agencies to begin development of the plan of care that will be implemented following acceptance to the PDHC facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2768 (December 2009), amended LR 41:134 (January 2015).

§5239. Plan of Care

A. Each child that has been accepted to a facility and participates in a PDHC program shall have a plan of care developed to assure that the child receives appropriate services. Development of the plan of care shall begin within 72 hours of receipt of the referral to allow sufficient time for implementation of the plan upon placement in the facility.

B. The plan of care shall be developed under the direction of the facility's nursing director and shall:

1. be individualized to address the child's problems, goals, and required services including, but not limited to medical, nursing, psychosocial, therapy, dietary, and educational services;

2. ensure that the child's developmental needs are addressed;

a. the PDHC facility shall consider developmentally appropriate learning and play experiences as well as social interaction with other children;

3. identify specific goals for care;

a. plans for achieving the goals shall be determined and a schedule for evaluation of progress shall be established; and

4. contain specific criteria for transitioning from or discontinuing participation in pediatric day health care with the facility.

C. The plan of care shall be signed by the prescribing physician, the authorized representative of the facility, and the parent(s). Copies of the plan of care shall be given to the prescribing physician and other agencies as appropriate. The facility shall retain a copy in their records and a copy shall be given to the parent(s) if requested.

D. The plan of care for continuation of services shall be:

1. reviewed and updated at least quarterly or as indicated by the needs of the child;

2. completed by a registered nurse;

3. reviewed and ordered by the prescribing physician; and

4. incorporated into the patient's clinical record within seven calendar days of receipt of the prescribing physician's order.

E. The medical director shall review the plans of care in consultation with PDHC staff and the prescribing physician every 90 days or more frequently as the child's condition dictates. Prescribed services and therapies included in the plan of care shall be adjusted in consultation with the prescribing physician to accommodate the child's condition.

F. Facility staff shall administer services and treatments in accordance with the plan of care as ordered by the physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2769 (December 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017).

§5241. Participant Rights

A. The parent(s) of a child who participates in PDHC services shall, prior to or upon acceptance, receive a written statement of the services provided by the facility.

B. Before care is initiated, the child and or the parent have the right to be advised in writing of his/her liability for payment for services rendered by the PDHC facility.

C. Each child that participates in PDHC facility services shall:

1. be treated with consideration, respect, and full recognition of his or her dignity and individuality;

2. receive care, treatment, and services in accordance with their plan of care;

3. have the right to privacy regarding medical treatment and medical records; and

a. personal and medical records shall be treated confidentially in compliance with federal and state laws, rules and regulations;

4. be free from mental and physical abuse.

D. The PDHC facility shall refrain from using chemical and physical restraints unless authorized by a physician according to clear and indicated medical requirements.

E. Each child or parent shall have the right, personally or through others, to present grievances without reprisal, interference, coercion, or discrimination against the child as a result of such grievance.

F. The facility shall prominently post the child's rights and the abuse and neglect procedures in an area accessible to the child and family.

G. Each parent shall be notified of any accidents or incidents involving their child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2769 (December 2009).

Subchapter E. Pediatric Day Health Care Services

§5245. General Provisions

A. During the delivery of services, child care goals and interventions shall be coordinated in conjunction with providers and caregivers to ensure appropriate continuity of care from acceptance to the PDHC facility until the child's participation ends.

B. The facility shall maintain a system of communication and integration of services, whether provided directly or under arrangement, that ensures:

1. identification of the child's needs and barriers to care;

2. ongoing coordination of all disciplines providing care; and

3. contact with the physician regarding any relevant medical issues.

C. The child's prescribing physician shall maintain responsibility for the overall medical therapeutic plan and shall be available for consultation and collaboration with the facility's medical and nursing personnel as needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2769 (December 2009).

§5247. Developmental and Educational Services

A. If the PDHC facility provides services for which a school district is responsible, the PDHC facility may enter into a Memorandum of Understanding (MOU) with the school district.

B. For any child enrolled in the early intervention program (EarlySteps) or the local school district's program

under the Individuals with Disabilities Act, the PDHC facility shall adhere to the following.

1. In the development of the plan of care, the PDHC facility shall consider the components of the individualized family services plan for children under 3 years old or the individualized education program for children from 3 years old through 21 years old.

2. The PDHC facility shall not duplicate services already provided through the early intervention program or the local school district. EarlySteps services cannot be provided in the PDHC unless specifically approved in writing by the DHH EarlySteps Program. Medicaid waiver services cannot be provided in the PDHC unless specifically approved in writing by the Medicaid waiver program. The PDHC shall maintain a copy of such written approval in the child's medical record.

3. Upon request by the early intervention program or the local school district, the PDHC facility shall make available any records necessary to develop, review or revise an individualized family service plan or individualized education plan.

C. If a child has not been previously enrolled in a Local Education Agency (LEA), the PDHC facility shall make a referral to the LEA in the area where the PDHC facility is located. If a child has not been previously enrolled in the early intervention system, the PDHC facility shall refer the child to the regional single point of entry (SPOE).

D. The PDHC facility shall secure a signed release from the child's parent or guardian in order to receive copies of records for a:

1. school aged child from any school system that the child may have been enrolled in; or

2. child, from birth to three years old, for early intervention services from the regional SPOE.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2770 (December 2009), amended LR 41:134 (January 2015).

§5249. Medication Administration

A. All medications administered to children in the PDHC facility shall be ordered in writing by the child's prescribing physician or by a specialty physician after consultation and coordination with the PDHC facility. This includes, but is not limited to:

1. over the counter medications;

2. oral electrolyte solutions (Pedialyte, Pedia Vance or similar products); and

3. oxygen.

B. The PDHC facility shall coordinate with the child/parent(s) to ensure that the child's medications are brought to the facility each day the child receives services at the facility.

C. The facility shall adhere to the following medication handling and administration standards.

1. Medications shall be kept in their original packaging and contain the original labeling from the pharmacy.

2. Each child's medications shall be individually stored in a secured location.

3. The PDHC facility shall demonstrate coordination between family and staff regarding medication administration (i.e. last dose given by family or staff).

4. Schedule II substances shall be kept in a separately locked, securely fixed box or drawer(s) in a locked medication cabinet, hence under two separate locks.

a. The facility shall have established policies and procedures for the handling and administration of controlled substances.

5. Medications requiring refrigeration shall be kept in a refrigerator separate from foods.

D. The PDHC facility shall maintain a record of medication administration. The record shall contain:

1. each medication ordered;

2. each medication administered;

3. the date, time and dosage of each medication administered; and

4. the initials of the person administering the medication.

D. The PDHC facility shall have policies and procedures that address notification of the appropriate authorities of any theft or unexplained loss of any controlled substances, syringes, needles or prescription pads within 48 hours of discovery of such loss or theft.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2770 (December 2009).

§5251. Nutritional Services

A. The facility shall ensure that if dietary services are ordered in the child's plan of care, the services shall be provided by a Louisiana licensed registered dietician. The registered dietician shall be available regarding the nutritional needs, the special diets of individual children, and to assist in the development of policies and procedures for the handling, serving, and storage of food.

B. Meals shall be provided on an as needed or prescribed basis. The facility shall incorporate appropriate nutritional services into the child's plan of care as prescribed by the physician and in collaboration with the child and parents to ensure appropriate formula, foods, utensils, equipment, and supplies are readily available. Therapeutic diet orders shall be maintained in the child's file.

C. A minimum of one meal and appropriate snacks and beverages shall be provided as prescribed in the plan of care. The meals and snacks shall be age appropriate.

1. If the plan of care requires more frequent meals or nutrition, the PDHC facility shall provide these services while the child is at the PDHC facility. The PDHC facility shall coordinate with the child and family to ensure that nutritional supplies and formula used by the child are available at the PDHC facility without duplication.

D. All food in the facility shall be safe for human consumption.

1. Grade "A" pasteurized fluid milk and fluid milk products shall be used or served.

E. All food preparation areas shall be maintained in accordance with state and local sanitation and safe food handling standards. Pets are not allowed in food preparation and serving areas.

F. If food is prepared in a central kitchen and delivered to separate facilities, provisions shall be made and approved by the Department of Health and Hospitals, Office of Public Health for proper maintenance of food temperatures and a sanitary mode of transportation.

G. The facility's refrigerator(s) shall be maintained at a temperature of 45 degrees Fahrenheit or below. Thermometers shall be provided for all refrigerators. A daily temperature log of the refrigerator shall be maintained by the PDHC facility. Food stored in the refrigerator shall be dated, labeled and appropriately packaged.

H. The water supply shall be adequate, of a safe sanitary quality and from an approved source. Clean sanitary drinking water shall be available and accessible in adequate amounts at all times.

1. Disposable cups, if used, shall be stored in such a way as to prevent contamination.

I. The ice scoop for ice machines shall be maintained in a sanitary manner with the handle at no time coming in contact with the ice.

J. Staff shall be available in the dining area to serve the food and to give individual attention as needed.

K. Specific times for serving meals shall be established and posted.

L. Written reports of inspections by the Office of Public Health shall be kept on file in the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2770 (December 2009).

§5253. Social Services

A. The facility shall provide directly or through contract or arrangement the social services as ordered by the prescribing physician or medical director. Social services shall be provided in accordance with the Louisiana State Board of Social Work Examiners requirements.

B. The facility shall ensure that if social services are ordered in the child's plan of care, the care or services shall be rendered by a social worker.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2771 (December 2009).

§5255. Therapy Services

A. The facility shall provide directly or through contract or arrangement the therapies as ordered by the prescribing physician or medical director. Therapies and services shall be provided in accordance with applicable State Boards' requirements and the child's plan of care if so ordered.

B. Occupational Therapy. The facility shall ensure that occupational therapy services are provided by:

1. an individual authorized by the Louisiana State Board of Medical Examiners (LSBME); or

2. a certified occupational therapy assistant in accordance with the LSBME's requirements.

C. Physical Therapy. The facility shall ensure that physical therapy services are provided by:

1. an individual licensed by the Louisiana State Board of Physical Therapy Examiners (LSBPTE); or

2. a physical therapy assistant in accordance with the LSBPTE reqirements.

D. Respiratory Care. The facility shall ensure that respiratory care shall be provided by:

1. an individual licensed as a respiratory therapist by the LSBME;

2. a registered nurse with documented experience in providing respiratory care in accordance with the Louisiana State Board of Nursing; or

3. a licensed practical nurse with documented experience in providing respiratory care in accordance with the Louisiana State Board of Practical Nurse Examiners.

E. Speech-Language Pathology. The facility shall ensure that speech-language pathology services are provided by an individual authorized by the Louisiana Board of Examiners for Speech-Language Pathology and Audiology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2771 (December 2009).

§5257. Transportation

A. The PDHC facility shall provide or arrange transportation of children to and from the facility; however, no child, regardless of his/her region of origin, may be in transport for more than one hour on any single trip. The

PDHC facility is responsible for the safety of the children during transport. The family may choose to provide their own transportation.

B. Whether transportation is provided by the facility on a daily basis or as needed, the general regulations under this Section shall apply.

C. If the PDHC facility provides transportation for children, the PDHC facility shall maintain in force at all times current commercial liability insurance for the operation of PDHC facility vehicles, including medical coverage for children in the event of accident or injury.

1. This policy shall extend coverage to any staff member who provides transportation for any child in the course and scope of his/her employment.

2. The PDHC facility shall maintain documentation that consists of the insurance policy or current binder that includes the name of the PDHC facility, the name of the insurance company, policy number, and period of coverage and explanation of coverage.

3. DHH Health Standards shall specifically be identified as the certificate holder on the policy and any certificate of insurance issued as proof of insurance by the insurer or producer (agent). The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

D. If the PDHC facility arranges transportation for children through a transportation agency, the facility shall maintain a written contract which is signed by a facility representation and a representative of the transportation agency. The contract shall outline the circumstances under which transportation will be provided.

1. The written contract shall be dated and time limited and shall conform to these licensing regulations.

2. The transportation agency shall maintain in force at all times current commercial liability insurance for the operation of transportation vehicles, including medical coverage for children in the event of accident or injury. Documentation of the insurance shall consist of the:

a. insurance policy or current binder that includes the name of the transportation agency;

b. name of the insurance agency;

c. policy number;

d. period of coverage; and

e. explanation of coverage.

3. DHH Health Standards shall specifically be identified as the certificate holder on the policy and any certificate of insurance issued as proof of insurance by the insurer or producer (agent). The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

E. Transportation arrangements, whether provided by the PDHC facility directly or arranged by the PDHC facility through a written contract with a transportation agency shall meet the following requirements.

1. Transportation agreements shall conform to state laws, including laws governing the use of seat belts and child restraints. Vehicles shall be accessible for people with disabilities or so equipped to meet the needs of the children served by the PDHC facility.

2. The driver or attendant shall not leave the child unattended in the vehicle at any time.

F. Vehicle and Driver Requirements

1. The requirements of Subsection F of this Section shall apply to all transportation arrangements, whether provided by the PDHC facility directly or arranged by the PDHC facility through a written contract with a transportation agency.

2. The vehicle shall be maintained in good repair with evidence of an annual safety inspection.

3. The following actions shall be prohibited in any vehicle while transporting children:

a. the use of tobacco in any form;

b. the use of alcohol;

c. the possession of illegal substances; and

d. the possession of firearms, pellet guns, or BB guns (whether loaded or unloaded).

4. The number of persons in a vehicle used to transport children shall not exceed the manufacturer's recommended capacity.

5. The facility shall maintain a copy of a valid appropriate Louisiana driver's license for all individuals who drive vehicles used to transport children on behalf of the PDHC facility. At a minimum, a class "D" chauffeur's license is required for all drivers who transport children on behalf of the PDHC facility.

6. Each transportation vehicle shall have evidence of a current safety inspection.

7. There shall be first aid supplies in each facility or contracted vehicle. This shall include oxygen, pulse oximeter, and suction equipment. Additionally, this shall include airway management equipment and supplies required to meet the needs of the children being transported.

8. Each driver or attendant shall be provided with a current master transportation list including:

a. each child's name;

b. pick up and drop off locations; and

c. authorized persons to whom the child may be released.

i. Documentation shall be maintained on file at the PDHC facility whether transportation is provided by the facility or contracted.

9. The driver or attendant shall maintain an attendance record for each trip. The record shall include:

a. the driver's name;

b. the date of the trip;

c. names of all passengers (children and adults) in the vehicle; and

d. the name of the person to whom the child was released and the time of release.

10. There shall be information in each vehicle identifying the name of the administrator and the name, telephone number, and address of the facility for emergency situations.

G. Child Safety Provisions

1. The requirements of Subsection G of this Section shall apply to all transportation arrangements, whether provided by the PDHC facility directly or arranged by the PDHC facility through a written contract with a transportation agency.

2. The driver and one appropriately trained staff member shall be required at all times in each vehicle when transporting any child. Staff shall be appropriately trained on the needs of each child, and shall be capable and responsible for administering interventions when appropriate.

3. Each child shall be safely and properly:

a. assisted into the vehicle;

b. restrained in the vehicle;

c. transported in the vehicle; and

d. assisted out of the vehicle.

4. Only one child shall be restrained in a single safety belt or secured in any American Academy of Pediatrics recommended age appropriate safety seat.

5. The driver or appropriate staff person shall check the vehicle at the completion of each trip to ensure that no child is left in the vehicle.

a. The PDHC facility shall maintain documentation that includes the signature of the person conducting the check and the time the vehicle is checked. Documentation shall be maintained on file at the PDHC facility whether transportation is provided by the facility or contracted.

6. During field trips, the driver or staff member shall check the vehicle and account for each child upon arrival at, and departure from, each destination to ensure that no child is left in the vehicle or at any destination.

a. The PDHC facility shall maintain documentation that includes the signature of the person conducting the check and the time the vehicle was checked for each loading and unloading of children during the field trip. Documentation shall be maintained on file at the PDHC facility whether transportation is provided by the facility or contracted.

7. Appropriate staff person(s) shall be present when each child is delivered to the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2771 (December 2009), amended LR 41:134 (January 2015).

Subchapter F. Facility Responsibilities

§5263. General Provisions

A. A PDHC facility shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the facility's responsibilities are carried out and that the following functions are adequately performed:

1. administrative functions;

2. fiscal functions;

3. clerical functions;

4. housekeeping, maintenance and food service functions;

5. direct service functions;

6. supervisory functions;

7. record-keeping and reporting functions;

8. social services functions; and

9. ancillary service functions.

B. The facility shall ensure that all staff members are properly certified and/or licensed as legally required.

C. The facility shall establish procedures to assure adequate communication among staff in order to provide continuity of services to the participant. This system of communication shall include:

1. a regular review of individual and aggregate problems of participants, including actions taken to resolve these problems;

2. sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and

3. the maintenance of all accidents, personal injuries and pertinent incidents records related to implementation of the child's plan of care.

D. The facility shall not provide service to more participants than the number specified on its license on any given day or at any given time.

E. The facility shall make available to the department any information, which the facility is required to have under these licensing provisions and is reasonably related to the assessment of compliance with these provisions. The

participant's rights shall not be considered abridged by this requirement.

F. The PDHC facility shall request a criminal history check on non-licensed persons prior to employment, upon rehire at the PDHC facility, and at least once every three years.

1. A PDHC facility may make an offer of temporary employment to a non-licensed person pending receipt of the results of the criminal history check provided that the check has been requested of the appropriate agency. Any non-licensed individual offered temporary employment prior to the receipt of the results of the criminal history check shall be under the direct supervision of a permanent employee or shall be in the presence of an adult member of the immediate family of the patient.

G. The PDHC facility shall not hire any non-licensed individual who has been convicted of a crime listed in R.S. 40:1300.53(A)(1).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2772 (December 2009).

§5265. Staffing Requirements

A. Administrator. The facility administrator shall be a full time employee of the PDHC facility and shall designate in writing a person to be responsible for the facility when he/she is absent from the facility for more than 24 hours. This person is known as the administrator's designee.

1. Qualifications. The administrator and administator's designee shall have three years of experience in the delivery of health care services and meet one of the following criteria:

a. be a physician currently licensed in Lousiana;

b. be a registered nurse currently licensed in Louisiana;

c. be a college graduate with a bachelors degree; or

d. have an associate's degree, with one additional year of documented management experience.

2. Any licensed person functioning in the role of administrator or adminstrator's designee shall have an unrestricted, current license issued by the appropriate Louisiana licensing board.

3. The administrator and the administrator's designee shall be at least 21 years of age.

4. The administrator or the administrator's designee shall have the following responsibilities:

a. ensuring that the PDHC facility complies with federal, state and local laws, rules and regulations;

b. maintaining the following written records and any other records required by local, state or federal laws and these licensing provisions:

i. daily census record, which shall indicate the name of each child currently receiving services in the facility; and

ii. a record of all accidents, unusual incidents, and incidents involving alleged abuse or neglect involving any child or staff member that caused, or had the potential to cause, injury or harm to any person or property within the facility;

(a). Such records shall contain a clear description of each accident or incident, the names of the persons involved, a description of all medical or other services provided to these , specifying who provided such services, and the steps taken to prevent recurrence of such accident or incidents in the future.

c. ensuring that the facility immediately notifies the parent/guardian of any and all accidents or incidents involving their child;

d. ensuring that the facility provides written notification within 24 hours to the parent/guardian of any and all accidents or incidents; and

e. making all reports and referrals to law enforcement or other authorities as required by Federal or State law, rule or regulation.

5. The administrator shall maintain a copy of current agreements with consultants and contracted individuals utilized by the PDHC facility in the facility's records. The record shall include verification of credentials and relevant experience of each person providing service.

6. The administrator shall maintain a personnel record for each employee which shall contain:

a. a current copy of a Louisiana certificate and/or license as applicable;

b. the original employment application, references, employment history for the preceding five years if applicable; and

c. a copy of all job performance evaluations.

7. The administrator shall ensure that the facility develops and maintains a current job description for each employee.

8. The administrator shall provide each employee access to written personnel policies governing conditions of employment. The PDHC facility shall develop and implement an employee grievance procedure.

9. The administrator shall ensure that the facility conducts annual written job performance evaluations or contract monitoring for each employee and contracted individual. The performance evaluation shall note strengths and weaknesses and shall include plans to correct any job performance weakness. Performance evaluations or contract monitioring shall be reviewed with each employee and each contracted individual.

10. The administrator shall ensure that the facility assigns duties to employees that are consistent with their job

descriptions and with their levels of education, preparation and experience.

11. The administrator shall ensure that the facility provides necessary qualified personnel and ancillary services to ensure the health, safety, and proper care of each child.

12. The administrator shall ensure that the facility develops and implements policies and procedures which shall be included in the facility's policy manual.

13. The Administrator shall ensure that the facility has documentation of a satisfactory criminal record check of each non-licensed employee, and shall comply with the provisions of R.S. 40:1300.51-56.

B. Medical Director. The medical director of the PDHC shall be a physician currently licensed in Louisiana without restrictions.

1. The medical director shall be:

a. a board certified pediatrician;

b. a pediatric specialist with knowledge of medically fragile children; or

c. another medical specialist or subspecialist with knowledge of medically fragile children.

2. Responsibilities of the medical director include, but are not limited to:

a. periodic review of the services provided by the PDHC facility to assure acceptable levels of quality of care and services;

b. participation in development and implementation of appropriate performance improvement and safety initiatives;

c. participation in the development of new programs and modifications of existing programs;

d. assurance that medical consultation will be available in the event of the medical director's absence;

e. serving on committees as defined and required by these rules and by the facility's policies;

f. consulting with the facility's administrator on the health status of the facility's personnel as it relates to infection control and or the child's health and safety;

g. reviewing reports of all accidents or unusual incidents occurring on the premises and identifying to the facility's administrator hazards to health and safety; and

h. development and implementation of a policy and procedure for the delivery of emergency services and the delivery of regular physician's services when the child's attending physician or designated alternative is not available.

3. The medical director shall be available for consultation or collaboration with the prescribing physician and/or facility staff.

4. The medical director shall participate in reviews of the plan of care for each child receiving services.

5. The Medical Director may serve as the administrator of the PDHC facility.

C. Director of Nursing (DON). Each PDHC shall have a full time director of nursing.

1. The director of nursing shall be a registered nurse (RN) currently licensed in the state of Louisiana without restrictions, and shall:

a. hold a current certification in Cardio Pulmonary Resuscitation (CPR);

b. hold current certification in Basic Cardiac Life Support (BCLS) and Pediatric Advanced Life Support (PALS); and

c. have a minimum of two years general pediatric nursing experience of which at least six months shall have been spent caring for medically fragile or technology dependent infants or children in one of the following settings:

i. pediatric intensive care;

ii. neonatal intensive care;

iii. pediatric emergency care;

iv. PDHC facility;

v. prescribed pediatric extended care center; or

vi. similar care setting during the previous five years.

2. The DON's responsibilities shall include, but are not limited to:

a. the supervision of all aspects of patient care to ensure compliance with the plan of care;

b. all activities of professional nursing staff and direct care staff to ensure compliance with current standards of accepted nursing and medical practice;

c. compliance with all federal and state laws, rules and regulation related to the delivery of nursing care and services;

d. daily clinical operations of the PDHC facility;

e. implementation of personnel and employment policies to assure that only qualified personnel are hired, including verification of licensure and/or certification prior to employment and anually thereafter;

f. maintaining records to support competency of all nursing and direct care staff;

g. implementation of PDHC facility policy and procedures that establish and support quality patient care;

h. development, implementation and supervision of an employee health program in accordance with state laws, rules or regulations;

i. providing for orientation and in-service training to employees to promote effective PDHC services and safety

to the patient and to familiarize staff with regulatory issues, as well as agency policy and procedures;

j. performing timely annual nursing and direct care personnel perforamance evaluations;

k. ensuring the PDHC facility has mechanisms for disciplinary action for nursing and direct care personnel;

l. assuring participation in regularly scheduled appropriate continuing education for all nursing and direct care personnel;

m. assuring that the care provided by the nursing and direct care personnel promotes effective PDHC services and the safety of the child; and

n. being on-site during normal operating hours.

3. The agency shall designate in writing a registered nurse who will assume the responsibilities of the DON during his/her absence.

4. The DON may serve as the administrator or administrator's designee if qualified. If the DON is functioning as the administrator or administrator's designee, the DON shall not be included in the total staffing ratio for nursing or direct care services.

D. Registered Nurse (RN). Each PDHC shall have sufficient RN staffing to ensure that the care and services provided to each child is in accordance with the child's plan of care.

1. Each RN employed by the facility shall have at least the following qualifications and experience:

a. be currently licensed in the state of Louisiana without restrictions as a registered nurse;

b. hold a current certification in CPR; and

c. have either:

i. one or more years of pediatric experience as an RN, with at least six months experience caring for medically fragile or technologically dependent children; or

ii. two or more years of documented prior pediatric nursing experience as a licensed practical nurse (LPN)and with at least six months experience caring for medically fragile or technologically dependent children.

E. Licensed Practical Nurse(LPN). Each PDHC facility shall have sufficient LPN staffing to ensure that the care and services provided to each child is in accordance with the child's plan of care.

1. Each LPN employed by the facility shall have at least the following qualifications and experience:

a. be currently licensed in the state of Louisiana without restrictions as a licensed practical nurse; and

b. hold a current certification in CPR; and

c. have either:

i. one year or more years experience in pediatrics as an LPN; or

ii. two years of documented prior pediatric experience working as a direct care worker caring for medically fragile child(ren).

F. Direct Care Staff. Direct care staff shall work under the supervision of the registered nurse and shall be responsible for providing direct care to children at the PDHC facility.

1. For the purposes of this Section, other direct care staff shall include:

a. nursing assistants;

b. certified nursing assistants;

c. patient care technicians;

c. medical assistants;

e. emergency medical technicians (EMT);

f. on-site therapists; and

g. individuals with training and experience in education, social services or child care related fields.

2. Each direct care staff person employed by the facility shall have at least the following qualifications and experience:

a. one year documented employment experience in the care of infants or children or one year experience in caring for a medically fragile child;

b. be able to demonstrate the necessary skills and competency to meet the direct care needs of the child(ren) to which they are assigned;

c. be currently registered with the Certified Nurse Aide (CAN) Registry or Direct Service Worker (DSW) Registry as a CNA or DSW in good standing and without restrictions;

d. hold a current certification in Cardio Pulmonary Resuscitation (CPR); and

e. be 18 years of age or older.

G. Nursing and Direct Care Staffing Levels

1. PDHC facilities shall have sufficient nursing and direct care staff to meet the needs of each infant and child receiving services in the PDHC in accordance with the plan of care.

2. Total staffing for nursing services and direct care shall, at a minimum, meet the following ratios according to the daily census.

Children	Total Nursing or Direct Care Staff	RN	RN or LPN	RN, LPN, or Direct Care staff
1	1	1		
2-6	2	1		1
7-9	3	1	1	1
10-12	4	1	1	2
13-15	5	2	1	2
16-18	6	2	1	3
19-21	7	2	2	3
22-24	8	2	2	4
25-27	9	3	2	4
28-30	10	3	2	5
31-33	11	3	3	5
34-36	12	3	3	6
37-39	13	4	3	6
40-42	14	4	3	7
43-45	15	4	4	7

3. If the PDHC facility has a census of more than 45 children, the staffing shall increase by one staff for every three children alternating between a direct care staff, an RN, and an LPN in such order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2773 (December 2009).

§5267. Orientation, Staff Development and Training

A. Each PDHC facility shall develop staff and parent orientation and training programs.

B. The PDHC facility shall maintain documentation of orientation and training of each new employee. The orientation shall include, but is not limited to the PDHC facility's:

1. philosophy;

2. organization;

3. practices, policies and procedures;

4. ethics and confidentiality;

5. record keeping;

6. information related to child development; and

7. goals.

C. Orientation shall be given to parents with children who are accepted at the PDHC facility to acquaint the parent(s) with the philosophy and services that will be provided.

D. The PDHC facility shall maintain documentation of an assessment of the skills, knowledge and competencies of the staff.

E. The PDHC facility shall develop training to include:

1. quarterly staff development programs appropriate to the category of personnel;

2. documentation of all staff development programs, and required participation; and

3. Current Basic Life Support certification for all staff.

E. On-going training shall be provided to the parent(s) as necessary and based on the individual needs of the child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2775 (December 2009).

§5269. Record Keeping

A. Medical Records. A medical record shall be developed at the time the child is accepted at the PDHC facility and maintained throughout the facility's care of the child.

1. The record shall be signed by authorized personnel and shall contain at least the following documents:

a. a medical plan of treatment and a nursing plan of care;

b. the referral and admission documents concerning the child;

c. physician orders;

d. medical history, including allergies and special precautions;

e. documentation of immunizations;

f. medication/treatment administration record;

g. concise, accurate information and initialed case notes reflecting progress toward achievement of care goals or reasons for lack of progress;

h. documentation of nutritional management and therapeutic diets, as appropriate;

i. documentation of physical, occupational, speech and other special therapies;

j. correspondence and other documents concerning the child;

k. an order written by the prescribing physician if the child terminates services with the facility, if applicable; and

l. a summary, including the reason why the child is terminating services with the facility, if applicable.

2. The medical records shall contain the individualized nursing care plan that shall be developed within 10 working days of the child's acceptance to the PDHC facility.

a. The nursing care plan shall be reviewed and revised quarterly, or more frequently as necessary. The nursing care plan shall include any recommendations and revisions to the care plan based on consultation with other professionals involved in the child's care.

3. The plan of care, telephone and/or verbal orders shall be signed by the physician within a timely manner, not to exceed 30 days.

a. The physician's verbal orders may be accepted by a registered nurse, a qualified therapist or a licensed practical nurse as authorized by state and federal laws and regulations.

b. Verbal orders taken by an LPN shall be cosigned by an RN or appropriate therapist.

c. Electronic physician signatures may be accepted per PDHC facility policies.

d. Stamped physician signatures shall not be accepted.

4. All medical and patient records shall be maintained by the PDHC facility in accordance with federal and state law,rule, and regulation regarding confidentiality, privacy and retention.

B. Personnel Records. Personnel records shall be kept in a place, form and system in accordance with appropriate medical and business practices. All personnel records shall be available in the facility for inspection by the department during normal business hours. These records shall be maintainted in accordance with federal and state laws, rules, and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2775 (December 2009).

§5271. Infection Control

A. The PDHC facility, at the minimum, shall meet the following infection control requirements.

1. The PDHC facility shall have an isolation room with a glass area for observation of the child.

2. Isolation procedures shall be used to prevent cross-infections.

3. All cribs and beds shall be labeled with the child's name. Linens shall be removed from the crib for laundering purposes only.

4. Bed linens shall be changed when soiled and as necessary, but not less than twice weekly.

5. Antimicrobial soap and disposable paper towels shall be at each sink.

6. To prevent the spread of infection from one child to another, staff shall wash their hands using appropriate hand washing techniques or use antibacterial agents after direct contact with each child,.

7. Children suspected of having a communicable disease, which may be transmitted through casual contact, as determined by the facility's medical director in consultation with the prescribing physician or other specialist, shall be isolated. The following actions must be taken:

a. the parents shall be notified of the condition immediately;

b. the child shall be removed from the PDHC facility as soon as possible; and

c. when the communicable disease is no longer present, as evidenced by a written physician's statement, the child may return to the PDHC facility.

B. The facility shall have policies and procedures that address staff members who are suspected of having a communicable disease.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2776 (December 2009).

§5273. Quality Assurance

A. All PDHC facilities shall have a quality assurance program and shall conduct quarterly reviews of the facility's medical records for at least a fourth of the children served by the PDHC facility at the time of the quality assurance review. The quarterly review sample shall be randomly selected so each child served at the center has an equal opportunity to be included in the review.

B. Each facility shall establish a quality assurance committee comprised of the following members:

1. the medical director;

2. the administrator;

3. the director of nursing; and

4. three other committee members as determined by each PDHC facility.

C. The quality assurance review shall be conducted by at least two members of the quality assurance committee. Within 15 calendar days of its review, the quality assurance committee shall furnish copies of its report to the PDHC facility medical and nursing directors.

D. Each quarterly quality assurance review shall include:

1. a review of the goals in each child's nursing plan of care;

2. a review of the steps, process, and success in achieving the goals;

3. identification of goals not achieved as expected;

4. reasons for lack of goal achievement;

5. plans to promote goal achievement;

6. recommendations to be implemented; and

7. a review of previous recommendations or revisions to determine if such were implemented and effective.

E. The quality assurance review will also ascertain and assure the presence of the following documents in each child's medical record:

1. a properly executed consent form;

2. a medical history for the child including notations from visits to health care providers; and

3. documentation of immunizations, allergies and special precautions.

F. The PDHC facility medical and nursing directors shall review the quality assurance committee report within 10 days. The medical director in consultation with the prescribing physician shall approve and order implementation of revisions to the plan of care as appropriate.

G. The PDHC facility shall ensure the plan of care has been revised to implement the approved recommendations of the quality assurrance report.

1. Evidence that the plan of care has been revised shall be forwarded to the quality assurance committee within 10 calendar days of receipt of the quality assurance committee report.

2. Implementation of revisions to the plan of care shall be documented in the child's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2776 (December 2009).

Subchapter G. Safety and Emergency Preparedness

§5279. Safety and Emergency Services

A. All PDHC facilities shall conform to state standards prepared by the Office of State Fire Marshal (OFSM), and shall be inspected annually by OFSM. A copy of the current annual fire inspection report shall be on file at the facility. Documentation of a satisfactory fire safety inspection shall be provided at the time of the licensee's annual licenese renewal.

B. A working telephone capable of incoming and outgoing calls shall be available at all times in the PDHC facility. Coin operated telephones or cellular telephones are not acceptable for this purpose. If the PDHC has multiple buildings, such a working telephone shall be located in each of the buildings.

C. Emergency telephone numbers shall be posted on or in the immediate vicinity of all telephones. Fire, police, medical facility and poison control shall be posted on or near each telephone.

D. The PDHC facility's address shall be posted with the emergency numbers.

E. Emergency transportation shall be provided by a licensed emergency medical services provider. If emergency transportation is necessary, the PDHC facility shall immediately notify the parents. If the parents are not able to be contacted, the PDHC facility shall send a staff member to meet the child at the hospital.

1. The PDHC facility shall provide a transfer form to the emergency transportation provider.

2. The transfer form shall include:

a. the child's name and age;

b. contact information for the family;

c. the prescribing physician's name and contact information;

d. the PDHC facility's name and contact information; and

e. the child's diagnoses, allergies, and medications.

F. Construction, remodeling or alteration of structures shall be done in such a manner to prevent hazards or unsafe conditions (fumes, dust, safety hazards).

G. Unused electrical outlets shall be protected by a safety plug cover.

H. Strings and cords such as those used on window coverings shall not be within the reach of children.

I. First aid supplies shall be kept on site and easily accessible to employees, but not within the reach of children.

J. Fire drills shall be conducted at least once per quarter. These shall be conducted at various times of the day and night (if night time care is provided) and shall be documented. Documentation shall include:

1. the date and time of the drill;

2. the number of children present;

3. the amount of time to evacuate the PDHC facility;

4. any problems noted during the drill and corrective action taken; and

5. the signatures (not initials) of staff present.

K. The entire PDHC facility shall be checked after the last child departs to ensure that no child is left unattended at the facility. Documentation of the visual check shall include the date, time and signature of the staff member(s) conducting the visual check.

L. Sharp wastes, including needles, scalpels, razors or other sharp instruments used for patient care procedures shall be segregated from other wastes and aggregated in puncture resistant containers immediately after use.

1. Needles and syringes shall not be recapped, cut, dismantled, or destroyed after use, but shall be placed intact directly into a puncture resistant container.

2. The containers of sharp wastes shall either be incinerated, on site or off site, or rendered nonhazardous by a technology of equal or superior efficacy, which is approved by both the Cabinet for Human Resources and the Natural Resources and Environmental Protection Cabinet.

M. The PDHC facility shall establish a written policy that is compliant with Occupational Safety and Health

Administration standards for the handling and disposal of all infectious, pathological, and contaminated waste.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2777 (December 2009).

§5281. Emergency Preparedness

A. A disaster or emergency is a man-made or natural event or occurrence which causes harm or damage, or has the potential to cause harm or damage. A disaster or emergency may be local, community-wide, regional or statewide. Disasters or emergencies include, but are not limited to:

1. tornados;
2. fires;
3. floods;
4. hurricanes;
5. power outages;
6. chemical spills;
7. biohazards;
8. train wrecks; or
9. health crisis.

B. The PDHC facility shall provide education and resources to assist the parents in developing an emergency preparedness plan for their family. The PDHC facility shall ensure that each child has a plan in the event of an emergency or disaster.

C. The PDHC facility's emergency preparedness plan shall include provisions for providing shelter and services during a diaster or emergency situation to each technology dependent child admitted to or receiving services at the PDHC facility. The PDHC facility's emergency preparedness plan shall also contain provisions for assisting the state, parish, and Office of Homeland Security and Emergency Preparedness (OHSEP) with the provision of shelter and services during a disaster or emergency situation to other technology dependent children on a case-by-case basis considering the PDHC's capacity and safety to all children receiving services.

D. Continuity of Operations. The PDHC facility shall have an emergency preparedness plan to maintain continuity of the facility's operations in preparation for, during and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the children. The facility shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency. The plan shall address at a minimum:

1. provisions for the delivery of essential care and services to children;

2. provisions for the management of staff, including provisions for adequate, qualified staff as well as for distribution and assignment of responsibilities and functions;

3. provisions for back up staff;

4. the method that the PDHC facility will utilize in notifying the child's family if the child is evacuated to another location while in the direct care of the PDHC facility. This notification shall include:

a. the date and approximate time that the facility is evacuating;

b. the place or location to which the child is evacuating, including the:

i. name;

ii. address; and

iii. telephone number; and

c. a telephone number that the family may call for information regarding the facility's evacuation;

5. provisions for ensuring that supplies, medications, and a copy of the plan of care are sent with the child if the child is evacuated; and

6. the procedure or methods that will be used to attach identification to the child. The facility shall designate a staff person to be responsible for this identification procedure. This identification shall remain attached to the child during all phases of an evacuation and shall include the following minimum information:

a. current and active diagnosis;

b. medications, including dosage and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin, including contact information.

E. The PDHC facility shall have an emergency generator with sufficient generating power to continue the functions of medical equipment and the HVAC system in the event of a power failure. The emergency generator shall be tested every 30 days and satisfactory mechanical operation shall be documented on a log designed for that purpose and signed by the person conducting the test.

F. If the state, parish or local office of OHSEP orders a mandatory evacuation of the parish in which the PDHC facility is located, the PDHC facility shall ensure that any child at the PDHC facility at that time shall be evacuated in accordance with the child's emergency plan and the PDHC facility's emergency preparedness plan.

G. Emergency Plan, Review and Summary

1. The PDHC facility shall review and update each child's emergency plan in coordination with the parent(s) at least annually.

2. The PDHC facility shall review and update its emergency preparedness plan at least annually.

3. The facility's emergency plan shall be activiated, either in response to an actual emergency or in a drill at least annually.

H. Facility Requirements

1. The PDHC facility shall cooperate with the department and with the state, parish and local OHSEP in the event of an emergency or disaster and shall provide information as requested.

2. The PDHC facility shall monitor weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials.

I. All PDHC facility employees shall be trained in emergency or disaster preparedness. Training shall include orientation, ongoing training, and participation in planned drills for all personnel. The purpose shall be that each employee promptly and correctly performs his/her specific role in the event of a disaster or emergency.

J. Upon request by the department, the PDHC facility shall submit a copy of its emergency preparedness plan and a written summary attesting how the plan was followed and executed. The summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of children that occurred during execution of the plan, evacuation or temporary relocation, including the date, time, causes and circumstances of the injuries and deaths.

K. Inactivation of License due to Declared Disaster or Emergency

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

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

i. the PDHC facility has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster;

ii. the licensed PDHC facility intends to resume operation as a PDHC facility in the same service area;

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

iv. includes an attestation that all children have been properly released or transferred to another provider; and

v. provides a list of each child's name and the location where that child has been released or transferred to;

b. the licensed PDHC facility resumes operating as a PDHC facility in the same service area within one year of the issuance of such an executive order or proclamation of emergency or disaster;

c. the licensed PDHC facility continues to pay all fees and costs due and owed to the department including, but not limited to:

i. annual licensing fees; and

ii. outstanding civil monetary penalties; and

d. the licensed PDHC facility continues to submit required documentation and information to the Department, including but not limited to cost reports.

2. Upon receiving a completed written request to inactivate a PDHC facility license, the department shall issue a notice of inactivation of license to the PDHC facility.

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

a. the PDHC facility shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening;

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

c. the license reinstatement request shall include a completed licensing application with appropriate licensing fees, approval from the Office of Public Health and the Office of State Fire Marshall; and

d. the provider resumes operating as a PDHC facility in the same service area within one year.

4. Upon receiving a completed written request to reinstate a PDHC facility license, the department shall schedule a licensing survey. If the PDHC facility meets the requirements for licensure and the requirements under this Subsection, the department shall issue a notice of reinstatement of the PDHC facility license.

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

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

7. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the PDHC facility license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2777 (December 2009).

Subchapter H. Physical Environment

§5285. General Requirements

A. The standards in this Subchapter I shall apply to newly constructed PDHC facilities and alterations, additions, or renovations to an existing PDHC facility and to an existing building to create a PDHC facility.

B. Plan Review

1. A PDHC facility must submit architectural plans and specifications to the department's Division of Engineering and Architectural Services and any other documents as the division so requires.

2. A PDHC facility must also submit plans and specifications to the Office of the State Fire Marshal, and any other documents as the OSFM requires.

3. Plans and specifications must be prepared by or under the direction of a licensed architect or qualified engineer and shall include scaled architectural plans stamped by an architect.

4. Approval of such plans by the DHH Division of Engineering and Architectural Services and the OSFM shall be submitted to the Health Standards Section with all new applications for a PDHC facility or with any alterations, additions, or renovations to an existing PDHC facility or to an existing building that will be used to create a new PDHC facility.

5. All PDHC facilities shall comply with the rules, sanitary code and enforcement policies as promulgated by the Office of Public Health. It shall be the primary responsibility of the OPH to determine if applicants are complying with those requirements.

6. The PDHC facility shall have approval for occupancy from the OPH and the OSFM which shall be submitted to the Health Standards Section as part of the application packet. It shall be the responsibility of the PDHC facility to contact the OPH and the OSFM to schedule an onsite visit for each of these offices to verify and grant approval of occupancy.

C. Design Criteria. The project shall be designed in accordance with:

1. the current edition of NFPA 101 Life Safety Code;

2. Part XIV (Plumbing) of the Louisiana State Sanitary Code;

3. the American's with Disabilities Act/Accessibility Guidelines for Buildings and Facilities; and

4. the department's licensing regulations for PDHC facilities.

D. Interior Spaces

1. The PDHC facility shall consist of a building(s) suitable for the purpose intended, and shall have a minimum of 50 square feet of space per child exclusive of kitchen, toilet facilities, storage areas, hallways, stairways, basements and attics.

2. If rooms are used exclusively for dining or sleeping the space shall not be included in the licensed capacity.

3. The PDHC facility shall have sufficient rooms to accommodate and segregate the different age groups being served by the facility.

4. As the child ages, the PDHC facility shall make privacy accommodations for the PDHC facility staff to attend to the personal care needs of the child.

5. The PDHC facility shall have a kitchen or food preparation area designated for the preparation of meals, snacks or prescribed nourishments which shall be maintained in accordance with state and local sanitation and safe food handling standards.

6. Toileting facilities shall be appropriately accessible to persons with disabilities and age appropriate in design and shall contain hand-washing stations.

7. The PDHC facility shall have separate toilet facilities for PDHC staff.

8. There shall be a hand-washing station in each play area, classroom and therapy room or area.

9. The PDHC facility shall have individual labeled space available for each child's personal belongings.

10. There shall be a designated secure area for the storage and preparation of medications.

11. The PDHC facility shall have secure clean storage areas for supplies and equipment.

12. The PDHC facility shall have separate storage areas for clean and soiled linen.

13. The PDHC facility shall have a secure room for the safe storage of janitorial supplies and equipment, poisonous materials, and toxic materials.

a. Poisonous and toxic materials shall be so labeled and identified and placed in cabinets which are used for no other purpose.

14. Areas determined to be unsafe for the child or family shall be secured and locked. These areas would include high voltage areas, equipment rooms, etc.

15. The PDHC facility shall have an area for the safe and secure maintenance and storage of medical records and other facility files, records, and manuals.

16. Garbage, rubbish and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises regularly. Containers shall be cleaned regularly.

E. Exterior Spaces

1. The PDHC facility shall have a covered entry. Such roof overhang or canopy shall extend as far as practicable to the face of the driveway or curb of the passenger access door of the passenger vehicle.

2. The PDHC facility shall provide for an outdoor play space with a direct exit from the center into the outdoor play yard.

3. A PDHC facility shall ensure that the structures and the grounds of the facility that are accessible to children are maintained in good repair and are free from hazards to health and safety.

4. Areas determined to be unsafe, including but not limited to steep grades, cliffs, open pits, swimming pools, high voltage boosters, high voltage equipment or high speed roads shall be fenced off or have natural barriers to protect children.

5. Fences shall be in good repair.

6. Garbage, rubbish and trash that is stored outside shall be stored securely in covered containers. Trash collection receptacles and incinerators shall be separate from outdoor recreational space and located as to avoid being a nuisance.

F. Housekeeping, laundry and maintenance services

1. Housekeeping. The center shall maintain a clean and safe facility. The facility shall be free of unpleasant odors. Odors shall be eliminated at their source by prompt and thorough cleaning of commodes, urinals, bedpans and other sources.

2. Laundry. The PDHC facility shall have a supply of clean linen sufficient to meet the needs of the children. Clean laundry shall be provided by a laundry service either in-house, contracted with another health care facility or in accordance with an outside commercial laundry service. Laundry services shall be provided in compliance with OPH requirements. Linens shall be handled, stored, processed and transported in such a manner as to prevent the spread of infection.

3. Maintenance. The premises shall be well kept and in good repair.

a. The center shall insure that the grounds are well kept and the exterior of the building, including the sidewalks, steps, porches, ramps, and fences are in good repair.

b. The interior of the building including walls, ceilings, floors, windows, window coverings, doors, plumbing and electrical fixtures shall be in good repair.

G. A pest control program shall be in operation and the center's pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. If pest control chemicals are stored in the facility, they shall be kept in a locked location.

H. Heating, Ventilation and Air Conditioning (HVAC)/Ventilation.

1. The facility shall provide safe HVAC systems sufficient to maintain comfortable temperatures with a minimum of 65 degrees and a maximum of 80 degrees Fahrenheit in all public and private areas in all seasons of the year. During warm weather conditions the temperature within the facility shall not exceed 80 degrees Fahrenheit. The HVAC system(s) shall be maintained in good repair.

2. All gas heating units shall bear the stamp of approval of the American Gas Association Testing Laboratories, Inc. or other nationally recognized testing agency for enclosed, vented heaters for the type of fuel used.

3. All gas heating units and water heaters shall be vented adequately to carry the products of combustion to the outside atmosphere. Vents shall be constructed and maintained to provide a continuous draft to the outside atmosphere in accordance with the American Gas Association recommended procedures.

4. All heating units shall be provided with a sufficient supply of outside air so as to support combustion without depletion of the air in the occupied room.

5. The use of portable heaters by the PDHC facility is strictly prohibited.

6. Filters for heaters and air conditioners shall be provided as needed and maintained in accordance with the manufacturer's specifications.

I. Water Supply.

1. An adequate supply of water, under pressure, shall be provided at all times.

2. When a public water system is available, a connection shall be made thereto. If water from a source other than a public water supply is used, the supply shall meet the requirements set forth under these regulations and OPH.

3. A PDHC facility shall have a plan and policy for an alternative water supply in the event of interruption of water supply and for the prolonged loss of water to the facility.

J. Sewage

1. All sewage shall be disposed of by means of either:

a. a public system where one is accessible within 300 feet; or

b. an approved sewage disposal system that is constructed and operated in conformance with the standards established for such systems by OPH.

K. Signage. The facility's address and name shall be displayed so as to be easily visible from the street.

L. Distinct Part Facilities

1. Physical and Programmatic Separation. A PDHC facility shall be both physically and programmatically distinct from any business to which it is attached or of which it is a part.

2. Physical Separation. If more than one business occupies the same building, premises, or physical location, the PDHC facility shall have its own entrance. This separate entrance shall not be accessed solely through another business or health care provider. This separate entrance shall have appropriate signage and shall be clearly identifiable as belonging to the PDHC facility.

3. All spaces licensed as the PDHC facility shall be contiguous. If a PDHC facility has more than one building, protection from the elements shall be provided.

M. Furnishings and Equipment

1. Each PDHC facility shall maintain an age appropriate and developmentally appropriate environment in each of the areas where services are provided to a child.

2. At a minimum each PDHC facility shall provide or arrange to provide the following:

a. suctioning supplies and equipment to meet the routine or emergency needs of the children;

b. oxygen supplies and equipment to meet the routine or emergency needs of the children;

c. pulse oximeter and supplies; and

d. any supplies or equipment necessary to meet the emergency needs of the children.

3. The PDHC facility shall coordinate with the child and family to ensure that equipment and supplies used by the child are available to the child at the PDHC facility without duplication.

N. Waivers. The secretary of the department may, within his sole discretion, grant waivers to building and construction guidelines.

1. The facility shall submit a waiver request in writing to the Division of Engineering and Architectural Services.

2. The facility shall demonstrate how patient safety and the quality of care offered are not compromised by the waiver.

3. The secretary shall make a written determination of the waiver request.

4. Waivers are not transferrable in an ownership change and are subject to review or revocation upon any change in circumstances to the waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193–40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2779 (December 2009).

Chapter 53. Level III Crisis Receiving Centers

Subchapter A. General Provisions

§5301. Introduction

A. The purpose of this Chapter is to:

1. provide for the development, establishment, and enforcement of statewide licensing standards for the care of patients and clients in level III crisis receiving centers (CRCs);

2. ensure the maintenance of these standards; and

3. regulate conditions in these facilities through a program of licensure which shall promote safe and adequate treatment of clients of behavioral health facilities.

B. The purpose of a CRC is to provide intervention and stabilization services in order for the client to achieve stabilization and be discharged and referred to the lowest appropriate level of care that meets the client's needs. The estimated length of short term stay in a CRC is 3-7 days.

C. In addition to the requirements stated herein, all licensed CRCs shall comply with applicable local, state, and federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:101 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:472 (April 2021).

§5303. Definitions

Active Client—a client of the CRC who is currently receiving services from the CRC.

Administrative Procedure Act—R.S. 49:950 et seq.

Administrative Review—Health Standards Section's review of documentation submitted by the center in lieu of an on-site survey.

Adult—a person that is at least 18 years of age.

Authorized Licensed Prescriber—a physician or nurse practitioner licensed in the state of Louisiana and with full prescriptive authority authorized by the CRC to prescribe treatment to clients of the specific CRC at which he/she practices.

Building and Construction Guidelines—structural and design requirements applicable to a CRC; does not include occupancy requirements.

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

Change of Ownership (CHOW)—the addition, substitution, or removal, whether by sale, transfer, lease, gift or otherwise, of a licensed health care provider subject to this rule by a person, corporation, or other entity, which results in a change of ownership (CHOW) or change of controlling interest of assets or other equity interests of the licensed entity may constitute a CHOW of the licensed entity. An example of an action that constitutes a CHOW includes, but is not limited to, the leasing of the licensed entity.

CLIA—clinical laboratory improvement amendment.

Client Record—a single complete record kept by the CRC which documents all treatment provided to the client. The record may be electronic, paper, magnetic material, film or other media.

Construction Documents—building plans and specifications.

Contraband—any object or property that is against the CRC's policies and procedures to possess.

Coroner's Emergency Certificate (CEC)—a certificate issued by the coroner pursuant to R.S. 28:53.3.

Crisis Receiving Services—services related to the treatment of people in behavioral crisis, including crisis identification, intervention and stabilization.

Department—the Louisiana Department of Health

Direct Care Staff—any member of the staff, including an employee or contractor, that provides the services delineated in the comprehensive treatment plan. Food services, maintenance and clerical staff and volunteers are not considered as direct care staff.

Disaster or *Emergency*—a local, community-wide, regional or statewide event that may include, but is not limited to:

1. tornados;
2. fires;
3. floods;
4. hurricanes;
5. power outages;
6. chemical spills;
7. biohazards;
8. train wrecks; or
9. declared public health crisis.

Division of Administrative Law (DAL)—the Division of Administrative Law or its successor entity.

Grievance—a formal or informal written or verbal complaint that is made to the CRC by a client or the client's family or representative regarding the client's care, abuse or neglect when the complaint is not resolved at the time of the complaint by staff present.

HSS—the Health Standards Section of the Department of Health, Office of the Secretary, Office of Management and Finance.

Human Services Field—an academic program with a curriculum content in which at least 70 percent of the required courses for the major field of study are based upon the core mental health disciplines.

Level III Crisis Receiving Center (or Center or CRC)—an agency, business, institution, society, corporation, person or persons, or any other group, licensed by the Department of Health to provide crisis identification, intervention and stabilization services for people in behavioral crisis. CRCs receive, examine, triage, refer, or treat people in behavioral health crisis. A CRC shall have no more than:

a. 36 chairs for crisis stabilization/observation; and

b. 24 beds for short term stay (three to seven days).

NOTE: Refer to physical environment Section of this Chapter for physical space requirements.

Licensed Mental Health Professional (LMHP)—an individual who is licensed in the state of Louisiana to diagnose and treat mental illness or substance abuse, acting within the scope of all applicable state laws and their professional license. A LMHP must be one of the following individuals licensed to practice independently:

1. a physician/psychiatrist;
2. a medical psychologist;
3. a licensed psychologist;
4. a licensed clinical social worker (LCSW);
5. a licensed professional counselor (LPC);
6. a licensed marriage and family therapist (LMFT);
7. a licensed addiction counselor (LAC);
8. an advanced practice registered nurse or APRN (must be a nurse practitioner specialist in adult psychiatric and mental health or family psychiatric and mental health);
9. a certified nurse specialist in one of the following:

a. psychosocial, gerontological psychiatric mental health;

b. adult psychiatric and mental health; or

c. child-adolescent mental health.

LSBME—Louisiana State Board of Medical Examiners.

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

MHERE—mental health emergency room extension operating as a unit of a currently-licensed hospital.

Minor—a person under the age of 18.

Minor Alteration—repair or replacement of building materials and equipment with materials and equipment of a

similar type that does not diminish the level of construction below that which existed prior to the alteration. This does not include any alteration to the function or original design of the construction.

OBH—the Department of Health, Office of Behavioral Health.

OHSEP—Office of Homeland Security and Emergency Preparedness.

On Call—immediately available for telephone consultation and less than one hour from ability to be on duty.

On Duty—scheduled, present, and awake at the site to perform job duties.

OPC—order for protective custody issued pursuant to R.S. 28:53.2.

OSFM—the Louisiana Department of Public Safety and Corrections, Office of State Fire Marshal.

PEC—an emergency certificate executed by a physician, psychiatric mental health nurse practitioner, or psychologist pursuant to R.S. 28:53.

Physician—an individual who holds a medical doctorate or a doctor of osteopathy from a medical college in good standing with the LSBME and a license, permit, certification, or registration issued by the LSBME to engage in the practice of medicine in the state of Louisiana.

Qualifying Experience—experience used to qualify for any position that is counted by using one year equals 12 months of full-time work.

Seclusion Room—a room that may be secured in which one client may be placed for a short period of time due to the client's increased need for security and protection.

Shelter in Place—when a center elects to stay in place rather than evacuate when located in the projected path of an approaching storm equal to or greater than tropical storm strength.

Sleeping Area—a single constructed room or area that contains a minimum of three individual beds.

Tropical Storm Strength—a tropical cyclone in which the maximum sustained surface wind speed (using the U.S. 1 minute average standard) ranges from 34 kt (39 mph 17.5 m/s) to 63 kt (73 mph 32.5 mps).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:102 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:472 (April 2021).

Subchapter B. Licensing

§5309. General Licensing Provisions

A. All entities providing crisis receiving services shall be licensed by the Department of Health and Hospitals (DHH). It shall be unlawful to operate as a CRC without a license issued by the department. DHH is the only licensing authority for CRCs in Louisiana.

B. A CRC license authorizes the center to provide crisis receiving services.

C. The following entities are exempt from licensure under this Chapter:

1. community mental health centers;

2. hospitals;

3. nursing homes;

4. psychiatric rehabilitative treatment facilities;

5. school-based health centers;

6. therapeutic group homes;

7. HCBS agencies;

8. substance abuse/addictive disorder facilities;

9. mental health clinics;

10. center-based respites;

11. MHEREs;

12. individuals certified by OBH to provide crisis intervention services; and

13. federally-owned facilities.

D. A CRC license is not required for individual or group practice of LMHPs providing services under the auspices of their individual professional license(s).

E. A CRC license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the CRC to which it is issued and only for the geographic address of that CRC approved by DHH;

3. be valid for up to one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;

4. expire on the expiration date listed on the license, unless timely renewed by the CRC;

5. be invalid if sold, assigned, donated or transferred, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

F. In order for the CRC to be considered operational and retain licensed status, the following applicable operational requirements shall be met. The CRC shall:

1. be open and operating 24 hours per day, 7 days per week;

2. have the required staff on duty at all times to meet the needs of the clients; and

3. be able to screen and either admit or refer all potential clients at all times.

G. The licensed CRC shall abide by any state and federal law, rule, policy, procedure, manual or memorandum pertaining to crisis receiving centers.

H. The CRC shall permit designated representatives of the department, in the performance of their duties, to:

1. inspect all areas of the center's operations; and

2. conduct interviews with any staff member, client, or other person as necessary.

I. CRC Names

1. A CRC is prohibited from using:

a. the same name as another CRC;

b. a name that resembles the name of another center;

c. a name that may mislead the client or public into believing it is owned, endorsed, or operated by the state of Louisiana when it is not owned, endorsed, or operated by the state of Louisiana.

J. Plan Review

1. Any entity that intends to operate as a CRC, except one that is converting from a MHERE or an existing CRC, shall complete the plan review process and obtain approval for its construction documents for the following types of projects:

a. new construction;

b. any entity that intends to operate and be licensed as a CRC in a physical environment that is not currently licensed as a CRC; or

c. major alterations.

2. The CRC shall submit one complete set of construction documents with an application and review fee to the OSFM for review. Plan review submittal to the OSFM shall be in accordance with R.S. 40:1574, and the current *Louisiana Administrative Code* (LAC) provisions governing fire protection for buildings (LAC 55:V.Chapter 3 as of this promulgation), and the following criteria:

a. any change in the type of license shall require review for requirements applicable at the time of licensing change;

b. requirements applicable to occupancies, as defined by the most recently state-adopted edition of *National Fire Protection Association (NFPA) 101*, where services or treatment for four or more patients are provided;

c. requirements applicable to construction of business occupancies, as defined by the most recently state-adopted edition of NFPA 101; and

d. the specific requirements outlined in the Physical Environment requirements of this Chapter.

3. Construction Document Preparation

a. The CRC's construction documents shall be prepared by a Louisiana licensed architect or licensed engineer as governed by the licensing laws of the state for the type of work to be performed.

b. The CRC's construction documents shall be of an architectural or engineering nature and thoroughly illustrate an accurately drawn and dimensioned project that contains noted plans, details, schedules and specifications.

c. The CRC shall submit at least the following in the plan review process:

i. site plans;

ii. floor plan(s). These shall include architectural, mechanical, plumbing, electrical, fire protection, and if required by code, sprinkler and fire alarm plans;

iii. building elevations;

iv. room finish, door, and window schedules;

v. details pertaining to Americans with Disabilities Act (ADA) requirements; and

vi. specifications for materials.

4. Upon OSFM approval, the CRC shall submit the following to DHH:

a. the final construction documents approved by OSFM; and

b. OSFM's approval letter.

K. Waivers

1. The secretary of DHH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of or otherwise required under the provisions of the state *Sanitary Code*.

2. In order to request a waiver, the CRC shall submit a written request to HSS that demonstrates:

a. how patient safety and quality of care offered is not comprised by the waiver;

b. the undue hardship imposed on the center if the waiver is not granted; and

c. the center's ability to completely fulfill all other requirements of service.

3. DHH will make a written determination of each waiver request.

4. Waivers are not transferable in an ownership change or geographic change of location, and are subject to review or revocation upon any change in circumstances related to the waiver.

5. DHH prohibits waivers for new construction.

L. A person or entity convicted of a felony or that has entered a guilty plea or a plea of nolo contendere to a felony

is prohibited from being the CRC or owner, clinical supervisor or any managing employee of a CRC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:103 (January 2015).

§5311. Initial Licensure Application Process

A. Any entity, organization or person interested in operating a crisis receiving center must submit a completed initial license application packet to the department for approval. Initial CRC licensure application packets are available from HSS.

B. A person/entity/organization applying for an initial license must submit a completed initial licensing application packet which shall include:

1. a completed CRC licensure application;

2. the non-refundable licensing fee as established by statute;

3. the approval letter of the architectural center plans for the CRC from OSFM, if the center must go through plan review;

4. the on-site inspection report with approval for occupancy by the OSFM, if applicable;

5. the health inspection report from the Office of Public Health (OPH);

6. a statewide criminal background check, including sex offender registry status, on all owners and managing employees;

7. except for governmental entities or organizations, proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

b. general liability insurance of at least $500,000 per occurrence;

c. worker's compensation insurance in the amount as required by state law;

d. professional liability insurance of at least $100,000 per occurrence/$500,000 per annual aggregate, or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient’s Compensation Fund (PCF):

i. if the CRC is not enrolled in the PCF, professional liability limits shall be $1,000,000 per occurrence/$3,000,000 per annual aggregate; and

e. the LDH-HSS shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent);

8. an organizational chart and names, including position titles, of key administrative personnel and the governing body;

9. a legible floor sketch or drawing of the premises to be licensed;

10. a letter of intent indicating whether the center will serve minors or adults and the center's maximum number of beds;

11. if operated by a corporate entity, such as a corporation or an limited liability corporation (LLC), current proof of registration and status with the Louisiana Secretary of State's office;

12. a letter of recommendation from the OBH regional office or its designee; and

13. any other documentation or information required by the department for licensure.

C. If the initial licensing packet is incomplete, the applicant shall:

1. be notified of the missing information; and

2. be given 90 days from receipt of the notification to submit the additional requested information or the application will be closed.

D. Once the initial licensing application is approved by LDH, notification of such approval shall be forwarded to the applicant.

E. The applicant shall notify LDH of initial licensing survey readiness within the required 90 days of receipt of application approval. If an applicant fails to notify LDH of initial licensing survey readiness within 90 days, the application will be closed.

F. If an initial licensing application is closed, an applicant who is still interested in operating a CRC must submit a:

1. new initial licensing packet; and

2. non-refundable licensing fee.

G. Applicants must be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the CRC will be issued an initial license to operate.

H. An entity that intends to become a CRC is prohibited from providing crisis receiving services to clients during the initial application process and prior to obtaining a license, unless it qualifies as one of the following facilities:

1. a hospital-based CRC;

2. an MHERE;

3. an MHERE that has communicated its intent to become licensed as a CRC in collaboration with the department prior to February 28, 2013; or

4. a center-based respite.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:104 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:473 (April 2021).

§5313. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial licensing survey shall be conducted on-site to ensure compliance with the licensing laws and standards.

B. If the initial licensing survey finds that the center is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the center.

C. In the event that the initial licensing survey finds that the center is noncompliant with any licensing laws or regulations, or any other required rules or regulations, that present a potential threat to the health, safety, or welfare of the clients, the department shall deny the initial license.

D. In the event that the initial licensing survey finds that the center is noncompliant with any licensing laws or regulations, or any other required rules or regulations, and the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients, the department:

1. may issue a provisional initial license for a period not to exceed six months; and

2. shall require the center to submit an acceptable plan of correction.

a. The department may conduct a follow-up survey following the initial licensing survey after receipt of an acceptable plan of correction to ensure correction of the deficiencies. If all deficiencies are corrected on the follow-up survey, a full license will be issued.

b. If the center fails to correct the deficiencies, the initial license may be denied.

E. The initial licensing survey of a CRC shall be an announced survey. Follow-up surveys to the initial licensing surveys are unannounced surveys.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:105 (January 2015).

§5315. Types of Licenses

A. The department has the authority to issue the following types of licenses.

1. Initial License

a. The department shall issue a full license to the CRC when the initial licensing survey indicates the center is compliant with:

i. all licensing laws and regulations;

ii. all other required statutes, laws, ordinances, rules, regulations; and

iii. fees.

b. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, or suspended.

2. Provisional Initial License

a. The department may issue a provisional initial license to the CRC when the initial licensing survey finds that the CRC is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients.

i. The center shall submit a plan of correction to the department for approval, and the center shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

ii. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license will be issued.

iii. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a client are cited, the provisional license will expire and the center shall be required to begin the initial licensing process again by submitting a new initial license application packet and the appropriate licensing fee.

3. Renewal License. The department may issue a renewal license to a licensed CRC that is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional License. The department may issue a provisional license to a licensed CRC for a period not to exceed six months.

a. A provisional license may be issued for the following reasons:

i. more than five deficiencies cited during any one survey;

ii. four or more validated complaints in a consecutive 12-month period;

iii. a deficiency resulting from placing a client at risk for serious harm or death;

iv. failure to correct deficiencies within 60 days of notification of such deficiencies, or at the time of a follow-up survey; or

v. failure to be in substantial compliance with all applicable federal, state, departmental and local statutes,

laws, ordinances, rules regulations and fees at the time of renewal of the license.

b. The department may extend the provisional license for an additional period not to exceed 90 days in order for the center to correct the deficiencies.

c. The center shall submit an acceptable plan of correction to DHH and correct all noncompliance or deficiencies prior to the expiration of the provisional license.

d. The department shall conduct a follow-up survey of the CRC, either on-site or by administrative review, prior to the expiration of the provisional license.

e. If the follow-up survey determines that the CRC has corrected the deficiencies and has maintained compliance during the period of the provisional license, the department may issue a license that will expire on the expiration date of the most recent renewal or initial license.

f. The provisional license shall expire if:

i. the center fails to correct the deficiencies by the follow-up survey; or

ii. the center is cited with new deficiencies at the follow-up survey indicating a risk to the health, safety, or welfare of a client.

g. If the provisional license expires, the center shall be required to begin the initial licensing process by submitting a:

i. new initial license application packet; and

ii. non-refundable fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:105 (January 2015).

§5317. Changes in Licensee Information or Personnel

A. Within five days of the occurrence, the CRC shall report in writing to HSS the following changes to the:

1. CRC's entity name;

2. business name;

3. mailing address; or

4. telephone number.

B. Any change to the CRC's name or "doing business as" name requires the applicable nonrefundable fee for the issuance of an amended license with the new name.

C. A CRC shall report any change in the CRC's key administrative personnel within five days of the change.

1. Key administrative personnel include the:

a. CRC manager;

b. clinical director; and

c. nurse manager.

2. The CRC's notice to the department shall include the incoming individual's:

a. name;

b. date of appointment to the position; and

c. qualifications.

D. Change of Ownership (CHOW)

1. A CRC shall report a CHOW in writing to the department at least five days prior to the change. Within five days following the change, the new owner shall submit:

a. the legal CHOW document;

b. all documents required for a new license; and

c. the applicable nonrefundable licensing fee.

2. A CRC that is under license revocation, provisional licensure, or denial of license renewal may not undergo a CHOW.

3. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

E. Change in Physical Address

1. A CRC that intends to change the physical address of its geographic location shall submit:

a. a written notice to HSS of its intent to relocate;

b. a plan review request;

c. a new license application;

d. a nonrefundable license fee; and

e. any other information satisfying applicable licensing requirements.

2. In order to receive approval for the change of physical address, the CRC must:

a. have a plan review approval;

b. have approval from OSFM and OPH recommendation for license;

c. have an approved license application packet;

d. be in compliance with other applicable licensing requirements; and

e. have an on-site licensing survey prior to relocation of the center.

3. Upon approval of the requirements for a change in physical address, the department shall issue a new license to the CRC.

F. Any request for a duplicate license shall be accompanied by the applicable fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

41:106 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:473 (April 2021).

§5319. Renewal of License

A. A CRC license expires on the expiration date listed on the license, unless timely renewed by the CRC.

B. To renew a license, the CRC shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the current license. The license renewal application packet includes:

1. the license renewal application;

2. a current State Fire Marshal report;

3. a current OPH inspection report;

4. the non-refundable license renewal fee;

5. any other documentation required by the department; and

6. except for governmental entities or organizations, proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000;

b. general liability insurance of at least $500,000 per occurrence;

c. worker's compensation insurance in the amount as required by state law;

d. professional liability insurance of at least $100,000 per occurrence/$500,000 per annual aggregate, or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient's Compensation Fund (PCF):

i. if the CRC is not enrolled in the PCF, professional liability limits shall be $1,000,000 per occurrence/$3,000,000 per annual aggregate; and

e. the LDH-HSS shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent).

C. The department may perform an on-site survey and inspection of the center upon renewal.

D. Failure to submit a completed license renewal application packet prior to the expiration of the current license will result in the voluntary non-renewal of the CRC license upon the license's expiration.

E. The renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the center.

F. If a licensed CRC has been issued a notice of license revocation or suspension, and the center's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

G. Voluntary Non-Renewal of a License

1. If a center fails to timely renew its license, the license:

a. expires on the license's expiration date; and

b. is considered a non-renewal and voluntarily surrendered.

2. There is no right to an administrative reconsideration or appeal from a voluntary surrender or non-renewal of the license.

3. If a center fails to timely renew its license, the center shall immediately cease providing services, unless the center is actively treating clients, in which case the center shall:

a. within two days of the untimely renewal, provide written notice to HSS of the number of clients receiving treatment at the center;

b. within two days of the untimely renewal, provide written notice to each active client's prescribing physician and to every client, or, if applicable, the client's parent or legal guardian, of the following:

i. voluntary non-renewal of license;

ii. date of closure; and

iii. plans for the transition of the client;

c. discharge and transition each client in accordance with this Chapter within 15 days of the license's expiration date; and

d. within 30 days of the license's expiration date, notify HSS of the location where records will be stored in compliance with federal and state laws and the name, address, and phone number of the person responsible for the records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:106 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:473 (April 2021).

§5321. Licensing Surveys

A. The department may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing crisis receiving centers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. If deficiencies are cited, the department may require the center to submit an acceptable plan of correction.

C. The department may conduct a follow-up survey following any survey in which deficiencies were cited to ensure correction of the deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:107 (January 2015).

§5323. Complaint Surveys

A. Pursuant to R.S. 40:2009.13 et seq., the department has the authority to conduct unannounced complaint surveys on crisis receiving centers.

B. The department shall issue a statement of deficiency to the center if it finds a deficiency during the complaint survey.

C. Plan of Correction

1. Once the department issues a statement of deficiencies, the department may require the center to submit an acceptable plan of correction.

2. If the department determines that other action, such as license revocation, is appropriate, the center:

a. may not be required to submit a plan of correction; and

b. will be notified of such action.

D. Follow-up Surveys

1. The department may conduct a follow-up survey following a complaint survey in which deficiencies were cited to ensure correction of the deficient practices.

2. If the department determines that other action, such as license revocation, is appropriate:

a. a follow-up survey is not necessary; and

b. the center will be notified of such action.

E. Informal Reconsiderations of Complaint Surveys

1. A center that is cited with deficiencies found during a complaint survey has the right to request an informal reconsideration of the deficiencies. The center's written request for an informal reconsideration must be received by HSS within 10 calendar days of the center's receipt of the statement of deficiencies.

2. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as a desk review.

3. Correction of the violation or deficiency shall not be the basis for the reconsideration.

4. The center shall be notified in writing of the results of the informal reconsideration.

5. Except for the right to an administrative appeal provided in R.S. 40:2009.16, the informal reconsideration shall constitute final action by the department regarding the complaint survey, and there shall be no further right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:107 (January 2015).

§5325. Statement of Deficiencies

A. The CRC shall make any statement of deficiencies available to the public upon request after the center submits a plan of correction that is accepted by the department or 90 days after the statement of deficiencies is issued to the center, whichever occurs first.

B. Informal Reconsiderations

1. Unless otherwise provided in statute or in this Chapter, a CRC has the right to an informal reconsideration of any deficiencies cited as a result of a survey.

2. Correction of the violation, noncompliance or deficiency shall not be the basis for the reconsideration.

3. The center's written request for informal reconsideration must be received by HSS within 10 calendar days of the center's receipt of the statement of deficiencies.

4. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

5. HSS shall notify the center in writing of the results of the informal reconsideration.

6. Except as provided pursuant to R.S. 40:2009.13 et seq., and as provided in this Chapter:

a. the informal reconsideration decision is the final administrative decision regarding the deficiencies; and

b. there is no right to an administrative appeal of such deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:107 (January 2015).

§5327. Cessation of Business

A. Except as provided in §5407 and §5409 of these licensing regulations, a license shall be immediately null and void if a provider ceases to operate.

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

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

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

E. A CRC that intends to cease operations shall:

1. provide 30 days advance written notice to HSS and the active client, or if applicable, the client's parent(s), legal guardian, or designated representative; and

2. discharge and transition all clients in accordance with this Chapter.

F. The provider shall notify the department in writing 30 days prior to the effective date of the closure or cessation. In addition to the notice, the provider shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

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

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

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction;

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

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

H. Once the provider has ceased doing business, the provider shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:108 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:474 (April 2021).

§5329. Sanctions

A. The department may issue sanctions for deficiencies and violations of law, rules and regulations that may include, but are not limited to:

1. civil fines;

2. directed plans of correction;

3. provisional licensure; and/or

4. license revocation or denial of license renewal.

B. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the Administrative Procedure Act.

C. The department may deny an initial license, revoke a license or deny a license renewal for any of the following reasons, including but not limited to:

1. failure to be in compliance with the CRC licensing laws, rules and regulations;

2. failure to be in compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. cruelty or indifference to the welfare of the clients;

5. misappropriation or conversion of the property of the clients;

6. permitting, aiding or abetting the unlawful, illicit or unauthorized use of drugs or alcohol within the center of a program;

7. documented information of past or present conduct or practices of an employee or other staff which are detrimental to the welfare of the clients, including but not limited to:

a. illegal activities; or

b. coercion or falsification of records;

8. failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

9. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in Paragraph D.8 above;

10. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, client records or center records;

d. matters under investigation by the department or the Office of the Attorney General; or

e. information submitted for reimbursement from any payment source;

11. knowingly making a false statement or providing false, forged or altered information or documentation to DHH employees or to law enforcement agencies;

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

13. the CRC, an owner, officer, member, manager, administrator, medical director, managing employee, or clinical supervisor has pled guilty or nolo contendere to a felony, or is convicted of a felony, as documented by a certified copy of the record of the court;

14. failure to comply with all reporting requirements in a timely manner, as required by the department;

15. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview center staff or clients;

16. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

17. failure to allow or refusal to allow access to center or client records by authorized departmental personnel;

18. bribery, harassment, intimidation or solicitation of any client designed to cause that client to use or retain the services of any particular CRC;

19. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

20. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department; or

21. failure to uphold client rights that may have resulted or may result in harm, injury or death of a client.

D. If the department determines that the health and safety of a client or the community may be at risk, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. The department will provide written notification to the center if the imposition of the action will be immediate.

E. Any owner, officer, member, manager, director or administrator of such CRC is prohibited from owning, managing, directing or operating another CRC for a period of two years from the date of the final disposition of any of the following:

1. license revocation;

2. denial of license renewal; or

3. the license is surrendered in lieu of adverse action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:108 (January 2015).

§5331. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal

A. The department shall provide written notice to the CRC of the following:

1. license denial;

2. license revocation; or

3. denial of license renewal.

B. The CRC has the right to an administrative reconsideration of the license denial, license revocation or denial of license renewal.

1. If the CRC chooses to request an administrative reconsideration, the request must:

a. be in writing addressed to HSS;

b. be received by HSS within 15 calendar days of the center's receipt of the notice of the license denial, license revocation or denial of license renewal; and

c. include any documentation that demonstrates that the determination was made in error.

2. If a timely request for an administrative reconsideration is received, HSS shall provide the center with written notification of the date of the administrative reconsideration.

3. The center may appear in person at the administrative reconsideration and may be represented by counsel.

4. HSS shall not consider correction of a deficiency or violation as a basis for the reconsideration.

5. The center will be notified in writing of the results of the administrative reconsideration.

C. The administrative reconsideration process is not in lieu of the administrative appeals process.

D. The CRC has a right to an administrative appeal of the license denial, license revocation or denial of license renewal.

1. If the CRC chooses to request an administrative appeal, the request must:

a. be received by the DAL within 30 days of:

i. the receipt of the results of the administrative reconsideration; or

ii. the receipt of the notice of the license denial, revocation or denial of license renewal, if the CRC chose to forego its rights to an administrative reconsideration;

b. be in writing;

c. include any documentation that demonstrates that the determination was made in error; and

d. include the basis and specific reasons for the appeal.

2. The DAL shall not consider correction of a violation or a deficiency as a basis for the administrative appeal.

E. Administrative Appeals of License Revocations and Denial of License Renewals

1. If a timely request for an administrative appeal is received by the DAL, the center will be allowed to continue

to operate and provide services until the DAL issues a final administrative decision.

F. Administrative Appeals of Immediate License Revocations or Denial of License Renewals

1. If DHH imposes an immediate license revocation or denial of license renewal, DHH may enforce the revocation or denial of license renewal during the appeal process.

2. If DHH chooses to enforce the revocation or denial of license renewal during the appeal process, the center will not be allowed to operate and/or provide services during the appeal process.

G. If a licensed CRC has a pending license revocation, and the center's license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

H. Administrative Hearings of License Denials, Denial of License Renewals and License Revocations

1. If a timely administrative appeal is submitted by the center, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

2. If the final DAL decision is to reverse the license denial, denial of license renewal or license revocation, the center's license will be re-instated upon the payment of any outstanding fees or sanctions fees due to the department.

3. If the final DAL decision is to affirm the denial of license renewal or license revocation, the center shall:

a. discharge and transition any and all clients receiving services according to the provisions of this Chapter;

b. comply with the requirements governing cessation of business in this Chapter; and

c. notify HSS within 10 days of closure of the location where the records will be stored and the name, address and phone number of the person responsible for the records.

I. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new CRC, or the issuance of a provisional license to a licensed CRC.

J. Administrative Reconsiderations and Administrative Appeals of the Expiration of a Provisional Initial License or Provisional License

1. A CRC with a provisional initial license, or a provisional license that expires due to deficiencies cited at the follow-up survey, has the right to request an administrative reconsideration and/or an administrative appeal of the deficiencies cited at the follow-up survey.

2. The center's request for an administrative reconsideration must:

a. be in writing;

b. be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. include the basis and specific reasons for the administrative reconsideration.

3. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative reconsideration or for the administrative appeal.

4. The issue to be decided in the administrative reconsideration and the administrative appeal is whether the deficiencies were properly cited at the follow-up survey.

5. The CRC's request for an administrative appeal must:

a. be in writing;

b. be submitted to the DAL within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. include the basis and specific reasons for the appeal.

6. A center with a provisional initial license or a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge or transition clients unless the DAL or successor entity issues a stay of the expiration.

a. To request a stay, the center must submit its written application to the DAL at the time the administrative appeal is filed.

b. The DAL shall hold a contradictory hearing on the stay application. If the center shows that there is no potential harm to the center's clients, then the DAL shall grant the stay.

7. Administrative Hearing

a. If the CRC submits a timely request for an administrative hearing, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

b. If the final DAL decision is to remove all deficiencies, the department will reinstate the center's license upon the payment of any outstanding fees and settlement of any outstanding sanctions due to the department.

c. If the final DAL decision is to uphold the deficiencies, thereby affirming the expiration of the provisional license, the center shall discharge any and all clients receiving services in accordance with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:109 (January 2015).

Subchapter C. Organization and Administration

§5337. General Provisions

A. Purpose and Organizational Structure. The CRC shall develop and implement a statement maintained by the center that clearly defines the purpose of the CRC. The statement shall include:

1. the program philosophy;

2. the program goals and objectives;

3. the ages, sex and characteristics of clients accepted for care;

4. the geographic area served;

5. the types of services provided;

6. the admission criteria;

7. the needs, problems, situations or patterns addressed by the provider's program; and

8. an organizational chart of the provider which clearly delineates the lines of authority.

B. The CRC shall provide supervision and services that:

1. conform to the department's rules and regulations;

2. meet the needs of the client as identified and addressed in the client's treatment plan;

3. protect each client's rights; and

4. promote the social, physical and mental well-being of clients.

C. The CRC shall maintain any information or documentation related to compliance with this Chapter and shall make such information or documentation available to the department.

D. Required Reporting. The center shall report the following incidents in writing to HSS within 24 hours of discovery:

1. any disaster or emergency or other unexpected event that causes significant disruption to program operations;

2. any death or serious injury of a client:

a. that may potentially be related to program activities; or

b. who at the time of his/her death or serious injury was an active client of the center; and

3. allegations of client abuse, neglect, exploitation and misappropriation of client funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:110 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:474 (April 2021).

§5339. Governing Body

A. A crisis receiving center shall have the following:

1. an identifiable governing body with responsibility for and authority over the policies and operations of the center;

2. documents identifying the governing body's:

a. members;

b. contact information for each member;

c. terms of membership;

d. officers; and

e. terms of office for each officer.

B. The governing body of a CRC shall:

1. be comprised of one or more persons;

2. hold formal meetings at least twice a year;

3. maintain written minutes of all formal meetings of the governing body; and

4. maintain by-laws specifying frequency of meetings and quorum requirements.

C. The responsibilities of a CRC's governing body include, but are not limited to:

1. ensuring the center's compliance with all federal, state, local and municipal laws and regulations as applicable;

2. maintaining funding and fiscal resources to ensure the provision of services and compliance with this Chapter;

3. reviewing and approving the center's annual budget;

4. designating qualified persons to act as CRC manager, clinical director and nurse manager, and delegating these persons the authority to manage the center;

5. at least once a year, formulating and reviewing, in consultation with the CRC manager, clinical director and nurse manager, written policies concerning:

a. the provider's philosophy and goals;

b. current services;

c. personnel practices and job descriptions; and

d. fiscal management;

6. evaluating the performances of the CRC manager, clinical director and nurse manager at least once a year;

7. meeting with designated representatives of the department whenever required to do so;

8. informing the department, or its designee, prior to initiating any substantial changes in the services provided by the center;

9. ensuring statewide criminal background checks are conducted as required in this Chapter and state law; and

10. ensuring verification of the Louisiana Adverse Action website and the nurse aide registry for direct care staff as required in this Chapter and state law.

D. A governing body shall ensure that the CRC maintains the following documents:

1. minutes of formal meetings and by-laws of the governing body;

2. documentation of the center's authority to operate under state law;

3. all leases, contracts and purchases-of-service agreements to which the center is a party;

4. insurance policies;

5. annual operating budgets;

6. a master list of all the community resources used by the center;

7. documentation of ownership of the center;

8. documentation of all accidents, incidents, abuse/neglect allegations; and

9. a daily census log of clients receiving services.

E. The governing body of a CRC shall ensure the following with regards to contract agreements to provide services for the center.

1. The agreement for services is in writing.

2. Every written agreement is reviewed at least once a year.

3. The deliverables are being provided as per the agreement.

4. The center retains full responsibility for all services provided by the agreement.

5. All services provided by the agreement shall:

a. meet the requirements of all laws, rules and regulations applicable to a CRC; and

b. be provided only by qualified providers and personnel in accordance with this Chapter.

6. If the agreement is for the provision of direct care services, the written agreement specifies the party responsible for screening, orientation, ongoing training and development of and supervision of the personnel providing services pursuant to the agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:111 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:474 (April 2021).

§5341. Policies and Procedures

A. Each CRC shall develop, implement and comply with center-specific written policies and procedures governing all requirements of this chapter, including, but not limited to the following areas:

1. protection of the health, safety, and wellbeing of each client;

2. providing treatment in order for clients to achieve optimal stabilization;

3. access to care that is medically necessary;

4. uniform screening for patient placement and quality assessment, diagnosis, evaluation, and referral to appropriate level of care;

5. operational capability and compliance;

6. delivery of services that are cost-effective and in conformity with current standards of practice;

7. confidentiality and security of all client information, records and files;

8. prohibition of illegal or coercive inducement, solicitation and kickbacks;

9. client rights;

10. grievance process;

11. emergency preparedness;

12. abuse and neglect;

13. incidents and accidents, including medical emergencies;

14. universal precautions;

15. documentation of services;

16. admission, including descriptions of screening and assessment procedures;

17. transfer and discharge procedures;

18. behavior management;

19. infection control practices that meets current state and federal infection control guidelines;

20. transportation;

21. quality assurance;

22. medical and nursing services;

23. emergency care;

24. photography and video of clients; and

25. contraband.

B. A center shall develop, implement and comply with written personnel policies in the following areas:

1. recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff including volunteers;

2. written job descriptions for each staff position, including volunteers;

3. conducting staff health assessments that are consistent with OPH guidelines and indicate whether, when and how staff have a health assessment;

4. an employee grievance procedure;

5. abuse reporting procedures that require:

a. staff to report any allegations of abuse or mistreatment of clients pursuant to state and federal law; and

b. staff to report any allegations of abuse, neglect, exploitation or misappropriation of a client to DHH;

6. a non-discrimination policy;

7. a policy that requires all employees to report any signs or symptoms of a communicable disease or personal illness to their supervisor, CRC manager or clinical director as soon as possible to prevent the spread of disease or illness to other individuals;

8. procedures to ensure that only qualified personnel are providing care within the scope of the center's services;

9. policies governing staff conduct and procedures for reporting violations of laws, rules, and professional and ethical codes of conduct;

10. policies governing staff organization that pertain to the center's purpose, setting and location;

11. procedures to ensure that the staff's credentials are verified, legal and from accredited institutions; and

12. obtaining criminal background checks, adverse action, and registry checks.

C. A CRC shall comply with all federal and state laws, rules and regulations in the implementation of its policies and procedures.

D. Center Rules

1. A CRC shall:

a. have a clearly written list of rules governing client conduct in the center;

b. provide a copy of the center's rules to all clients and, where appropriate, the client's parent(s) or legal guardian(s) upon admission; and

c. post the rules in an accessible location in the center.

E. The facility shall develop, implement and comply with policies and procedures that:

1. give consideration to the client's chronological and developmental age, diagnosis, and severity of illness when assigning a sleeping area or bedroom;

2. ensure that each client has his/her own bed; and

3. prohibit mobile homes from being used as client sleeping areas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:111 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:474 (April 2021).

Subchapter D. Provider Operations

§5347. Client Records

A. The CRC shall ensure:

1. a single client record is maintained for each client according to current professional standards;

2. policies and procedures regarding confidentiality of records, maintenance, safeguarding and storage of records are developed, implemented and followed;

3. safeguards are in place to prevent unauthorized access, loss, and destruction of client records;

4. when electronic health records are used, the most up to date technologies and practices are used to prevent unauthorized access;

5. records are kept confidential according to federal and state laws and regulations;

6. records are maintained at the center where the client is currently active and for six months after discharge;

7. six months post-discharge, records may be transferred to a centralized location for maintenance;

8. client records are directly and readily accessible to the clinical staff caring for the client;

9. a system of identification and filing is maintained to facilitate the prompt location of the client's record;

10. all record entries are dated, legible and authenticated by the staff person providing the treatment, as appropriate to the media;

11. records are disposed of in a manner that protects client confidentiality;

12. a procedure for modifying a client record in accordance with accepted standards of practice is developed, implemented and followed;

13. an employee is designated as responsible for the client records;

14. disclosures are made in accordance with applicable state and federal laws and regulations; and

15. client records are maintained at least 6 years from discharge.

B. Record Contents. The center shall ensure that client records, at a minimum, contain the following:

1. the treatment provided to the client;

2. the client's response to the treatment;

3. other information, including:

a. all screenings and assessments;

b. provisional diagnoses;

c. referral information;

d. client information/data such as name, race, sex, birth date, address, telephone number, social security number, school/employer, and next of kin/emergency contact;

e. documentation of incidents that occurred;

f. attendance/participation in services/activities;

g. treatment plan that includes the initial treatment plan plus any updates or revisions;

h. lab work (diagnostic laboratory and other pertinent information, when indicated);

i. documentation of the services received prior to admission to the CRC as available;

j. consent forms;

k. physicians' orders;

l. records of all medicines administered, including medication types, dosages, frequency of administration, the individual who administered each dose and response to medication given on an as needed basis;

m. discharge summary;

n. other pertinent information related to client as appropriate; and

4. legible progress notes that are documented in accordance with professional standards of practice and:

a. document implementation of the treatment plan and results;

b. document the client's level of participation; and

c. are completed upon delivery of services by the direct care staff to document progress toward stated treatment plan goals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:112 (January 2015).

§5349. Client Funds and Possessions

A. The CRC shall:

1. maintain and safeguard all possessions, including money, brought to the center by clients;

2. maintain an inventory of each client's possessions from the date of admission; and

3. return all possessions to the client upon the client's discharge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:113 (January 2015).

§5351. Quality Improvement Plan

A. A CRC shall have a quality improvement (QI) plan that:

1. assures that the overall function of the center is in compliance with federal, state, and local laws;

2. is meeting the needs of the citizens of the area;

3. is attaining the goals and objectives established in the center's mission statement;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual outcomes and individual satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan;

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QI plan shall include:

1. a sample review of client case records on a quarterly basis to ensure that:

a. individual treatment plans are up to date;

b. records are accurate, complete and current; and

c. the treatment plans have been developed and implemented as ordered;

2. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients that includes, but is not limited to:

a. review and resolution of grievances;

b. incidents resulting in harm to client or elopement;

c. allegations of abuse, neglect and exploitation; and

d. seclusion and restraint;

3. a process to correct problems identified and track improvements; and

4. a process of improvement to identify or trigger further opportunities for improvement.

C. The QI plan shall establish and implement an internal evaluation procedure to:

1. collect necessary data to formulate a plan; and

2. hold quarterly staff committee meetings comprised of at least three staff members, one of whom is the CRC

manager, nurse manager or clinical director, who evaluate the QI process and activities on an ongoing basis.

D. The CRC shall maintain documentation of the most recent 12 months of the QI activity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:113 (January 2015).

Subchapter E. Personnel

§5357. General Requirements

A. The CRC shall maintain an organized professional staff who is accountable to the governing body for the overall responsibility of:

1. the quality of all clinical care provided to clients;

2. the ethical conduct and professional practices of its members;

3. compliance with policies and procedures approved by the governing body; and

4. the documented staff organization that pertains to the center's setting and location.

B. The direct care staff of a CRC shall:

1. have the appropriate qualifications to provide the services required by its clients' treatment plans; and

2. not practice beyond the scope of his/her license, certification or training.

C. The CRC shall ensure that:

1. qualified direct care staff members are present with the clients as necessary to ensure the health, safety and well-being of clients;

2. staff coverage is maintained in consideration of:

a. acuity of the clients being serviced;

b. the time of day;

c. the size, location, physical environment and nature of the center;

d. the ages and needs of the clients; and

e. ensuring the continual safety, protection, direct care and supervision of clients;

3. all direct care staff have current certification in cardiopulmonary resuscitation; and

4. applicable staffing requirements in this Chapter are maintained.

D. Criminal Background Checks

1. For any CRC that is treating minors, the center shall obtain a criminal background check on all staff. The background check must be conducted within 90 days prior to hire or employment in the manner required by R.S. 15:587.1.

2. For any CRC that is treating adults, the center shall obtain a statewide criminal background check on all unlicensed direct care staff by an agency authorized by the Office of State Police to conduct criminal background checks. The background check must be conducted within 90 days prior to hire or employment.

3. A CRC that hires a contractor to perform work which does not involve any contact with clients is not required to conduct a criminal background check on the contractor if accompanied at all times by a staff person when clients are present in the center.

E. The CRC shall review the Louisiana state nurse aide registry and the Louisiana direct service worker registry included in the Louisiana Adverse Action website, or its successor, to ensure that each unlicensed direct care staff member prior to hire or employment and at least annually thereafter, does not have a negative finding on either registry.

F. Prohibitions

1. The center providing services to minors is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a person who supervises minors or provides direct care to minors who:

a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of a felony involving:

i. violence, abuse or neglect against a person;

ii. possession, sale, or distribution of illegal drugs;

iii. sexual misconduct and/or any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

iv. misappropriation of property belonging to another person; or

v. a crime of violence;

b. has a finding placed on the Louisiana state nurse aide registry or the Louisiana direct service worker registry.

2. The center providing services to adults is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who:

a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of a felony involving:

i. abuse or neglect of a person;

ii. possession, sale, or distribution of a controlled dangerous substance

(a). within the last five years; or

(b). when the employee/contractor is under the supervision of the Louisiana Department of Public Safety and Corrections, the U.S. Department of Probation and Parole or the U.S. Department of Justice;

iii. sexual misconduct and/or any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

iv. misappropriation of property belonging to another person;

(a). within the last five years; or

(b). when the employee is under the supervision of the Louisiana Department of Public Safety and Corrections, the U.S. Department of Probation and Parole or the U.S. Department of Justice; or

v. a crime of violence;

b. has a finding placed on the Louisiana state nurse aide registry or the Louisiana direct service worker registry on the Louisiana Adverse Action website, or its successor.

G. Orientation and In-Service Training

1. All staff shall receive orientation prior to providing services and/or working in the center.

2. All direct care staff shall receive orientation, at least 40 hours of which is in crisis services and intervention training.

3. All direct care staff and other appropriate personnel shall receive in-service training at least once a year, at least twelve hours of which is in crisis services and intervention training.

4. All staff shall receive in-service training according to center policy at least once a year and as deemed necessary depending on the needs of the clients.

5. The content of the orientation and in-service training shall include the following:

a. confidentiality;

b. grievance process;

c. fire and disaster plans;

d. emergency medical procedures;

e. organizational structure and reporting relationships;

f. program philosophy;

g. personnel policies and procedures;

h. detecting and mandatory reporting of client abuse, neglect or misappropriation;

i. an overview of mental health and substance abuse, including an overview of behavioral health settings and levels of care;

j. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

k. side effects and adverse reactions commonly caused by psychotropic medications;

l. basic skills required to meet the health needs and challenges of the client;

m. components of a crisis cycle;

n. recognizing the signs of anxiety and escalating behavior;

o. crisis intervention and the use of non-physical intervention skills, such as de-escalation, mediation conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations;

p. therapeutic communication;

q. client's rights;

r. duties and responsibilities of each employee;

s. standards of conduct required by the center including professional boundaries;

t. information on the disease process and expected behaviors of clients;

u. levels of observation;

v. maintaining a clean, healthy and safe environment and a safe and therapeutic milieu;

w. infectious diseases and universal precautions;

x. overview of the Louisiana licensing standards for crisis receiving centers;

y. basic emergency care for accidents and emergencies until emergency medical personnel can arrive at center; and

z. regulations, standards and policies related to seclusion and restraint, including the safe application of physical and mechanical restraints and physical assessment of the restrained client.

6. The in-services shall serve as a refresher for subjects covered in orientation.

7. The orientation and in-service training shall:

a. be provided only by staff who are qualified by education, training, and experience;

b. include training exercises in which direct care staff members successfully demonstrate in practice the techniques they have learned for managing the delivery of patient care services; and

c. require the direct care staff member to demonstrate competency before providing services to clients.

I. Staff Evaluation

1. The center shall complete an annual performance evaluation of all employees.

2. The center's performance evaluation procedures for employees who provide direct care to clients shall address the quality and nature of the employee's relationships with clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:113 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:474 (April 2021).

§5359. Personnel Qualifications and Responsibilities

A. A CRC shall have the following minimum staff:

1. a CRC manager who:

a. has a minimum of a master's degree in a human services field or is a licensed registered nurse;

b. has at least one year of qualifying experience in the field of behavioral health;

c. is a full time employee; and

d. has the following assigned responsibilities:

i. supervise and manage the day to day operation of the CRC;

ii. review reports of all accidents/incidents occurring on the premises and identify hazards to the clinical director;

iii. participate in the development of new programs and modifications;

iv. perform programmatic duties and/or make clinical decisions only within the scope of his/her licensure; and

v. shall not have other job responsibilities that impede the ability to maintain the administration and operation of the CRC;

2. a clinical director who is:

a. a physician licensed in the state of Louisiana with expertise in managing psychiatric and medical conditions in accordance with the LSBME; or

b. a psychiatric and mental health nurse practitioner who has an unrestricted APRN license with prescriptive authority, and who is in collaborative practice with a Louisiana licensed physician for consultation in accordance with the Louisiana State Board of Nursing (LSBN) requirements;

c. responsible for developing and implementing policies and procedures and oversees clinical services and treatment;

d. on duty as needed and on call and available at all times;

3. a nurse manager who:

a. holds a current unrestricted license as a registered nurse (RN) in the state of Louisiana;

b. shall be a full time employee;

c. has been a RN for a minimum of five years;

d. has three years of qualifying experience providing direct care to patients with behavioral health diagnoses and at least one year qualifying experience providing direct care to medical/surgical inpatients;

e. has the following responsibilities:

i. develop and ensure implementation of nursing policies and procedures;

ii. provide oversight of nursing staff and the services they provide;

iii. ensure that any other job responsibilities will not impede the ability to provide oversight of nursing services;

4. authorized licensed prescriber who:

a. shall be either:

i. a physician licensed in the state of Louisiana with expertise in managing psychiatric and medical conditions in accordance with the LSBME; or

ii. a psychiatric and mental health nurse practitioner who has an unrestricted license and prescriptive authority and a licensed physician on call at all times to be available for consultation;

b. is on call at all times;

c. is responsible for managing the psychiatric and medical care of the clients;

5. licensed mental health professionals (LMHPs):

a. the center shall maintain a sufficient number of LMHPs to meet the needs of its clients;

b. there shall be at least one LMHP on duty during hours of operation;

c. the LMHP shall have one year of qualifying experience in direct care to clients with behavioral health diagnoses and shall have the following responsibilities:

i. provide direct care to clients and may serve as primary counselor to specified caseload;

ii. serve as a resource person for other professionals and unlicensed personnel in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities, and discharge planning; and

iv. function as the client's advocate in all treatment decisions;

6. nurses:

a. the center shall maintain licensed nursing staff to meet the needs of its clients;

b. all nurses shall have:

i. a current nursing license from the state of Louisiana;

ii. at least one year qualifying experience in providing direct care to clients with a behavioral health diagnosis; and

iii. at least one year qualifying experience providing direct care to medical/surgical inpatients.

c. the nursing staff has the following responsibilities:

i. provide nursing services in accordance with accepted standards of practice, the CRC policies and the individual treatment plans of the clients;

ii. supervise non-licensed clinical personnel;

iii. each CRC shall have at least one RN on duty at the CRC during hours of operation; and

iv. as part of orientation, all nurses shall receive 24 hours of education focusing on psychotropic medications, their side effects and possible adverse reactions. All nurses shall receive training in psychopharmacology for at least four hours per year.

B. Optional Staff

1. The CRC shall maintain non-licensed clinical staff as needed who shall:

a. be at least 18 years of age;

b. have a high school diploma or GED;

c. provide services in accordance with CRC policies, documented education, training and experience, and the individual treatment plans of the clients; and

d. be supervised by the nursing staff.

2. Volunteers

a. The CRC that utilizes volunteers shall ensure that each volunteer:

i. meets the requirements of non-licensed clinical staff;

ii. is screened and supervised to protect clients and staff;

iii. is oriented to facility, job duties, and other pertinent information;

iv. is trained to meet requirements of duties assigned;

v. is given a written job description or written agreement;

vi. is identified as a volunteer;

vii. is trained in privacy measures; and

viii. is required to sign a written confidentiality agreement.

b. The facility shall designate a volunteer coordinator who:

i. has the experience and training to supervise the volunteers and their activities; and

ii. is responsible for selecting, evaluating and supervising the volunteers and their activities.

3. If a CRC utilizes student interns, it shall ensure that each student intern:

a. has current registration with the appropriate Louisiana board when required or educational institution, and is in good standing at all times;

b. provides direct client care utilizing the standards developed by the professional board;

c. provides care only under the direct supervision of an individual authorized in accordance with acceptable standards of practice; and

d. provides only those services for which the student has been properly trained and deemed competent to perform.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:115 (January 2015).

§5361. Personnel Records

A. A CRC shall maintain a personnel file for each employee and direct care staff member in the center. Each record shall contain:

1. the application for employment and/or resume, including contact information and employment history for the preceding five years, if applicable;

2. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

3. any required medical examinations or health screens;

4. evidence of current applicable professional credentials/certifications according to state law or regulations;

5. annual performance evaluations to include evidence of competency in performing assigned tasks;

6. personnel actions, other appropriate materials, reports and notes relating to the individual's employment;

7. the staff member's starting and termination dates;

8. proof of orientation, training and in-services;

9. results of criminal background checks, if required;

10. job descriptions and performance expectations;

11. a signed attestation annually by each member of the direct care staff indicating that he/she has not been convicted of or pled guilty or nolo contendere to a crime, other than traffic violations; and

12. written confidentiality agreement signed by the personnel every twelve months.

B. A CRC shall retain personnel files for at least three years following termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:116 (January 2015).

Subchapter F. Admission, Transfer and Discharge

§5367. Admission Requirements

A. A CRC shall not refuse admission to any individual on the grounds of race, national origin, ethnicity or disability.

B. A CRC shall admit only those individuals whose needs, pursuant to the screening, can be fully met by the center.

C. A CRC shall expect to receive individuals who present voluntarily to the unit and/or individuals who are brought to the unit under an OPC, CEC, or PEC.

D. The CRC shall develop and implement policies and procedures for diverting individuals when the CRC is at capacity, that shall include:

1. notifying emergency medical services (EMS), police and the OBH or its designee in the service area;

2. conducting a screening on each individual that presents to the center; and

3. safely transferring the presenting individual to an appropriate provider;

E. Pre-Admission Requirements

1. Prior to admission, the center shall attempt to obtain documentation from the referring emergency room, agency, facility or other source, if available, that reflects the client's condition.

2. The CRC shall conduct a screening on each individual that presents for treatment that:

a. is performed by a RN who may be assisted by other personnel;

b. is conducted within 15 minutes of entering the center;

c. determines eligibility and appropriateness for admission;

d. assesses whether the client is an imminent danger to self or others; and

e. includes the following:

i. taking vital signs;

ii. breath analysis and urine drug screen

iii. brief medical history including assessment of risk for imminent withdrawal; and

iv. clinical assessment of current condition to determine primary medical problem(s) and appropriateness of admission to CRC or transfer to other medical provider;

F. Admission Requirements

1. The CRC shall establish the CRC's admission requirements that include:

a. availability of appropriate physical accommodations;

b. legal authority or voluntary admission; and

c. written documentation that client and/or family if applicable, consents to treatment.

2. The CRC shall develop, implement and comply with admission criteria that, at a minimum, include the following inclusionary and exclusionary requirements:

a. inclusionary: the client is experiencing a seriously acute psychological/emotional change which results in a marked increase in personal distress and exceeds the abilities and resources of those involved to effectively resolve it;

b. exclusionary: the client is experiencing an exacerbation of a chronic condition that does not meet the inclusionary criteria listed in §5367.F.2.a.

3. If the client qualifies for admission into the CRC, the center shall ensure that a behavioral health assessment is conducted:

a. by an LMHP;

b. within four hours of being received in the unit unless extenuating or emergency circumstances preclude the delivery of this service within this time frame; and

c. includes the following:

i. a history of previous emotional, behavioral and substance use problems and treatment;

ii. a social assessment to include a determination of the need for participation of family members or significant others in the individual's treatment; the social, peer-group, and environmental setting from which the person comes; family circumstances; current living situation; employment history; social, ethnic, cultural factors; and childhood history; current or pending legal issues including charges, pending trial, etc.;

iii. an assessment of the individual's ability and willingness to cooperate with treatment;

iv. an assessment for any possible abuse or neglect; and

v. review of any laboratory results, results of breath analysis and urine drug screens on patients and the need for further medical testing.

4. The CRC shall ensure that a nursing assessment is conducted that is:

a. begun at time of admission and completed within 24 hours; and

b. conducted by a RN with the assistance of other personnel.

5. The center shall ensure that a physical assessment is conducted by an authorized licensed prescriber within 12 hours of admission that includes:

a. a complete medical history;

b. direct physical examination; and

c. documentation of medical problems.

6. The authorized license prescriber, LMHP and/or RN shall conduct a review of the medical and psychiatric records of current and past diagnoses, laboratory results, treatments, medications and dose response, side-effects and compliance with:

a. the review of data reported to clinical director;

b. synthesis of data received is incorporated into treatment plan by clinical director.

G. Client/Family Orientation. Upon admission or as soon as possible, each facility shall ensure that a confidential and efficient orientation is provided to the client and the client's designated representative, if applicable, concerning:

1. visitation;

2. physical layout of the center;

3. safety;

4. center rules; and

5. all other pertinent information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:116 (January 2015).

§5369. Discharge, Transfer and Referral Requirements

A. The CRC shall develop, implement and comply with policies and procedures that address when and how clients will be discharged and referred or transferred to other providers in accordance with applicable state and federal laws and regulations.

B. Discharge planning shall begin upon admission.

C. The CRC shall ensure that a client is discharged:

1. when the client's treatment goals are achieved, as documented in the client's treatment plan;

2. when the client's issues or treatment needs are not consistent with the services the center is authorized or able to provide; or

3. according to the center's established written discharge criteria.

D. Discharge Plan. Each CRC client shall have a written discharge plan to provide continuity of services that includes:

1. the client's transfer or referral to outside resources, continuing care appointments, and crisis intervention assistance;

2. documented attempts to involve the client and the family or an alternate support system in the discharge planning process;

3. the client's goals or activities to sustain recovery;

4. signature of the client or, if applicable, the client's parent or guardian, with a copy provided to the individual who signed the plan;

5. name, dosage and frequency of client's medications ordered at the time of discharge;

6. prescriptions for medications ordered at time of discharge; and

7. the disposition of the client's possessions, funds and/or medications, if applicable.

E. The discharge summary shall be completed within 30 days and include:

1. the client's presenting needs and issues identified at the time of admission;

2. the services provided to the client;

3. the center's assessment of the client's progress towards goals;

4. the circumstances of discharge; and

5. the continuity of care recommended following discharge, supporting documentation and referral information.

F. Transfer Process. The CRC responsible for the discharge and transfer of the client shall:

1. request and receive approval from the receiving facility prior to transfer;

2. notify the receiving facility prior to the arrival of the client of any significant medical/psychiatric conditions/complications or any other pertinent information that will be needed to care for the client prior to arrival; and

3. transfer all requested client information and documents upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:117 (January 2015).

Subchapter G. Program Operations

§5375. Treatment Services

A. A CRC shall:

1. operate 24 hours per day seven days a week;

2. operate no more than 24 licensed beds;

3. operate no more than 36 chairs/recliners for observation and crisis stabilization

4. provide services to either adults or minors but not both; and

5. provide services that include, but are not limited to:

a. emergency screening;

b. assessment;

c. crisis intervention and stabilization;

d. 24-hour observation;

e. medication administration; and

f. referral to the most appropriate and least restrictive setting available consistent with the client's needs.

B. Short Term Stay. A CRC shall admit clients for a short term stay with an estimated length of 3-7 days. If a greater length of stay is needed, the CRC shall maintain documentation of clinical justification for the extended stay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:118 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:474 (April 2021).

§5377. Laboratory Services

A. The CRC shall have laboratory services available to meet the needs of its clients, including the ability to:

1. obtain STAT laboratory results as needed at all times;

2. conduct a dipstick urine drug screen; and

3. conduct a breath analysis for immediate determination of blood alcohol level.

B. The CRC shall maintain a CLIA certificate for the laboratory services provided on-site.

C. The CRC shall ensure that all contracted laboratory services are provided by a CLIA clinical laboratory improvement amendment (CLIA) certified laboratory.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:118 (January 2015).

§5379. Pharmaceutical Services and Medication Administration

A. The CRC may provide pharmaceutical services on-site at the center or off-site pursuant to a written agreement with a pharmaceutical provider.

B. All compounding, packaging, and dispensing of medications shall be accomplished in accordance with Louisiana laws and Board of Pharmacy regulations and be performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

C. The CRC shall ensure that a mechanism exists to:

1. provide pharmaceutical services 24 hours per day; and

2. obtain STAT medications, as needed, within an acceptable time frame, at all times.

D. CRCs that utilize off-site pharmaceutical providers pursuant to a written agreement shall have:

1. a physician who assumes the responsibility of procurement and possession of medications; and

2. an area for the secure storage of medication and medication preparation in accordance with Louisiana Board of Pharmacy rules and regulations.

E. A CRC shall maintain:

1. a site-specific Louisiana controlled substance license in accordance with the Louisiana Uniform Controlled Dangerous Substance Act; and

2. a United States Drug Enforcement Administration controlled substance registration for the facility in accordance with title 21 of the *United States Code*.

F. The CRC shall develop, implement and comply with written policies and procedures in accordance with applicable federal, state and local laws and ordinances that govern:

1. the safe administration and handling of all prescription and non-prescription medications;

2. the storage, recording and control of all medications;

3. the disposal of all discontinued and/or expired medications and containers with worn, illegible or missing labels;

4. the use of prescription medications including:

a. when medication is administered, medical monitoring occurs to identify specific target symptoms;

b. a procedure to inform clients, staff, and where appropriate, client's parent(s), legal guardian(s) or designated representatives, of each medication's anticipated results, the potential benefits and side-effects as well as the potential adverse reaction that could result from not taking the medication as prescribed;

c. involving clients and, where appropriate, their parent(s) or legal guardian(s), and designated representatives in decisions concerning medication; and

d. staff training to ensure the recognition of the potential side effects of the medication;

5. the list of abbreviations and symbols approved for use in the facility;

6. recording of medication errors and adverse drug reactions and reporting them to the client's physician or authorized prescriber, and the nurse manager;

7. the reporting of and steps to be taken to resolve discrepancies in inventory, misuse and abuse of controlled substances in accordance with federal and state law;

8. provision for emergency pharmaceutical services;

9. a unit dose system; and

10. procuring and the acceptable timeframes for procuring STAT medications when the medication needed is not available on-site.

G. The CRC shall ensure that:

1. medications are administered by licensed health care personnel whose scope of practice includes administration of medications;

2. any medication is administered according to the order of an authorized licensed prescriber;

3. it maintains a list of authorized licensed prescribers that is accessible to staff at all times;

4. all medications are kept in a locked illuminated clean cabinet, closet or room at temperature controls according to the manufacturer's recommendations, accessible only to individuals authorized to administer medications;

5. medications are administered only upon receipt of written orders, electromechanical facsimile, or verbal orders from an authorized licensed prescriber;

6. all verbal orders are signed by the licensed prescriber within 72 hours;

7. medications that require refrigeration are stored in a refrigerator or refrigeration unit separate from the refrigerators or refrigeration units that store food, beverages, or laboratory specimens;

8. all prescription medication containers are labeled to identify:

a. the client's full name;

b. the name of the medication;

c. dosage;

d. quantity and date dispensed;

e. directions for taking the medication;

f. required accessory and cautionary statements;

g. prescriber's name; and

h. the expiration date;

9. medication errors, adverse drug reactions, and interactions with other medications, food or beverages taken by the client are immediately reported to the client's physician or authorized licensed prescriber, supervising pharmacist and nurse manager with an entry in the client's record;

10. all controlled substances shall be kept in a locked cabinet or compartment separate from other medications;

11. current and accurate records are maintained on the receipt and disposition of controlled substances;

12. controlled substances are reconciled:

a. at least twice a day by staff authorized to administer controlled substances; or

b. by an automated system that provides reconciliation;

13. discrepancies in inventory of controlled substances are reported to the nurse manager and the supervising pharmacist in accordance with federal and state laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:118 (January 2015).

§5381. Transportation

A. The CRC shall establish, implement and comply with policies and procedures to:

1. secure emergency transportation in the event of a client's medical emergency; and

2. provide non-emergent medical transportation to the clients as needed.

B. The facility shall have a written agreement with a transportation service in order to provide non-emergent transport services needed by its clients that shall require all vehicles used to transport CRC clients are:

1. maintained in a safe condition;

2. properly licensed and inspected in accordance with state law;

3. operated at a temperature that does not compromise the health, safety and needs of the client;

4. operated in conformity with all applicable motor vehicle laws;

5. current liability coverage for all vehicles used to transport clients;

6. all drivers of vehicles that transport CRC clients are properly licensed to operate the class of vehicle in accordance with state law; and

7. the ability to transport non-ambulatory clients in appropriate vehicles if needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:119 (January 2015).

§5383. Food and Diet

A. The CRC shall ensure that:

1. all dietary services are provided under the direction of a Louisiana licensed and registered dietician either directly or by written agreement;

2. menus are approved by the registered dietician;

3. meals are of sufficient quantity and quality to meet the nutritional needs of clients, including religious and dietary restrictions;

4. meals are in accordance with Federal Drug Administration (FDA) dietary guidelines and the orders of the authorized licensed prescriber;

5. at least three meals plus an evening snack are provided daily with no more than 14 hours between any two meals;

6. meals are served in a manner that maintains the safety and security of the client and are free of identified contraband;

7. all food is stored, prepared, distributed, and served under safe and sanitary conditions in accordance with the *Louisiana Sanitary Code*;

8. all equipment and utensils used in the preparation and serving of food are properly cleaned, sanitized and stored in accordance with the *Louisiana Sanitary Cod*e; and

9. if meals are prepared on-site, they are prepared in an OPH approved kitchen.

B. The CRC may provide meal service and preparation pursuant to a written agreement with an outside food management company. If provided pursuant to a written agreement, the CRC shall:

1. maintain responsibility for ensuring compliance with this Chapter;

2. provide written notice to HSS and OPH within 10 calendar days of the effective date of the contract;

3. ensure that the outside food management company possesses a valid OPH retail food permit and meets all requirements for operating a retail food establishment that serves a highly susceptible population, in accordance with the special requirements for highly susceptible populations as promulgated in the current *Louisiana Sanitary Code* provisions governing food display and service for retail food establishments; and

4. ensure that the food management company employs or contracts with a licensed and registered dietician who serves the center as needed to ensure that the nutritional needs of the clients are met in accordance with the authorized licensed prescriber's orders and acceptable standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:119 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:475 (April 2021).

Subchapter H. Client Rights

§5389. General Provisions

A. The CRC shall develop, implement and comply with policies and procedures that:

1. protect its clients' rights;

2. respond to questions and grievances pertaining to these rights;

3. ensure compliance with clients' rights enumerated in R.S. 28:171; and

4. ensure compliance with minors' rights enumerated in the *Louisiana Children's Code*.

B. A CRC's client and, if applicable, the client's parent(s) or legal guardian or chosen designated representative, have the following rights:

1. to be informed of the client's rights and responsibilities at the time of or shortly after admission;

2. to have a family member, chosen representative and/or his or her own physician notified of admission at the client's request to the CRC;

3. to receive treatment and medical services without discrimination based on race, age, religion, national origin, gender, sexual orientation, disability, marital status, diagnosis, ability to pay or source of payment;

4. to be free from abuse, neglect, exploitation and harassment;

5. to receive care in a safe setting;

6. to receive the services of a translator or interpreter, if applicable, to facilitate communication between the client and the staff;

7. to be informed of the client's own health status and to participate in the development, implementation and updating of the client's treatment plan;

8. to make informed decisions regarding the client's care in accordance with federal and state laws and regulations;

9. to consult freely and privately with the client's legal counsel or to contact an attorney at any reasonable time;

10. to be informed, in writing, of the policies and procedures for initiation, review and resolution of grievances or client complaints;

11. to submit complaints or grievances without fear of reprisal;

12. to have the client's information and medical records, including all computerized medical information, kept confidential in accordance with federal and state statutes and rules/regulations;

13. to be provided indoor and/or outdoor recreational and leisure opportunities;

14. to be given a copy of the center's rules and regulations upon admission or shortly thereafter;

15. to receive treatment in the least restrictive environment that meets the client's needs;

16. to be subject to the use of restraint and/or seclusion only in accordance with federal and state law, rules and regulations;

17. to be informed of all estimated charges and any limitations on the length of services at the time of admission or shortly thereafter;

18. to contact DHH at any reasonable time;

19. to obtain a copy of these rights as well as the address and phone number of DHH and the Mental Health Advocacy Service at any time; and

20. to be provided with personal hygiene products, including but not limited to, shampoo, deodorant, toothbrush, toothpaste, and soap, if needed.

C. A copy of the clients' right shall be posted in the facility and accessible to all clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:120 (January 2015).

§5391. Grievances

A. The facility shall develop, implement and comply with a written grievance procedure for clients designed to allow clients to submit a grievance without fear of retaliation. The procedure shall include, but not be limited to:

1. process for filing a grievance;

2. a time line for responding to the grievance;

3. a method for responding to a grievance; and

4. the staff responsibilities for addressing and resolving grievances.

B. The facility shall ensure that:

1. the client and, if applicable, the client's parent(s) or legal guardian(s), is aware of and understands the grievance procedure; and

2. all grievances are addressed and resolved to the best of the center's ability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:120 (January 2015).

Subchapter I. Physical Environment

§5397. Interior Space

A. The CRC shall:

1. have a physical environment that protects the health, safety and security of the clients;

2. have routine maintenance and cleaning programs in all areas of the center;

3. be well-lit, clean, and ventilated;

4. conduct a risk assessment of each client and the physical environment of the facility in order to ensure the safety and well-being of all clients admitted to the facility;

5. maintain its physical environment, including, but not limited to, all equipment, fixtures, plumbing, electrical, and furnishings, in good order and safe condition in accordance with manufacturer's recommendations;

6. maintain heating, ventilation and cooling systems in good order and safe condition to ensure a comfortable environment; and

7. ensure that electric receptacles in client care areas are tamper-resistant or equipped with ground fault circuit interrupters.

B. Common Area. The CRC shall have designated space:

1. to be used for group meetings, dining, visitation, leisure and recreational activities;

2. that is at least 25 square feet per client and no less than 150 square feet exclusive of sleeping areas, bathrooms, areas restricted to staff and office areas; and

3. that contains tables for eating meals.

C. Bathrooms

1. Each bathroom to be used by clients shall contain:

a. a lavatory with:

i. paper towels or an automatic dryer;

ii. a soap dispenser with soap for individual use; and

iii. a wash basin with hot and cold running water;

b. tubs and/or showers that:

i. have hot and cold water;

ii. have slip proof surfaces; and

iii. allow for individual privacy;

c. toilets:

i. an adequate supply of toilet paper;

ii. with seats; and

iii. that allow for individual privacy;

d. a sink, tub or shower and toilet for the number of clients and in accordance with the *Louisiana Sanitary Code*;

e. shatterproof mirrors secured to the walls at convenient heights;

f. plumbing, piping, ductwork, and that are recessed or enclosed in order to be inaccessible to clients; and

g. other furnishings necessary to meet the clients' basic hygienic needs.

2. A CRC shall have at least one separate toilet and lavatory facility for the staff.

D. Sleeping Areas and Bedroom(s)

1. A CRC that utilizes a sleeping area for multiple clients shall:

a. ensure that the sleeping area has at least 60 square feet per bed of clear floor area and does not contain or utilize bunk beds; and

b. shall maintain at least one separate bedroom.

2. Bedrooms. A CRC that utilizes individual bedrooms shall ensure that each bedroom:

a. accommodates no more than one client; and

b. has at least 80 square feet of clear floor area.

3. The CRC shall ensure that each client:

a. has sufficient separate storage space for clothing, toilet articles and other personal belongings of clients;

b. has sheets, pillow, bedspread, towels, washcloths and blankets that are:

i. intact and in good repair;

ii. systematically removed from use when no longer usable;

iii. clean;

iv. provided as needed or when requested unless the request is unreasonable;

c. is given a bed for individual use that:

i. is no less than 30 inches wide;

ii. is of solid construction;

iii. has a clean, comfortable, impermeable, nontoxic and fire retardant mattress; and

iv. is appropriate to the size and age of the client.

E. Administrative and Staff Areas

1. The CRC shall maintain a space that is distinct from the client common areas that serves as an office for administrative functions.

2. The CRC shall have a designated space for nurses and other staff to complete tasks, be accessible to clients and to observe and monitor client activity within the unit.

F. Counseling and Treatment Area

1. The CRC shall have a designated space to allow for private physical examination that is exclusive of sleeping areas and common spaces.

2. The CRC shall have a designated space to allow for private and small group discussions and counseling sessions between individual clients and staff that is exclusive of sleeping areas and common space.

3. The CRC may utilize the same space for the counseling area and examination area.

G. Seclusion Room

1. The CRC shall have at least one seclusion room that:

a. is for no more than one client; and

b. allows for continual visual observation and monitoring of the client either:

i. directly; or

ii. by a combination of video and audio;

c. has a monolithic ceiling;

d. is a minimum of 80 square feet; and

e. contains a stationary restraint bed that is secure to the floor;

f. flat walls that are free of any protrusions with angles;

g. does not contain electrical receptacles.

H. Kitchen

1. If a CRC prepares meals on-site, the CRC shall have a full service kitchen that:

a. includes a cooktop, oven, refrigerator, freezer, hand washing station, storage and space for meal preparation;

b. complies with OPH regulations;

c. has the equipment necessary for the preparation, serving, storage and clean-up of all meals regularly served to all of the clients and staff;

d. contains trash containers covered and made of metal or United Laboratories-approved plastic; and

e. maintains the sanitation of dishes.

2. A CRC that does not provide a full service kitchen accessible to staff 24 hours per day shall have a nourishment station or a kitchenette, restricted to staff only, in which staff may prepare nourishments for clients, that includes:

a. a kitchen sink;

b. a work counter;

c. a refrigerator;

d. storage cabinets;

e. equipment for preparing hot and cold nourishments between scheduled meals; and

f. space for trays and dishes used for non-scheduled meal service.

3. A CRC may utilize ice making equipment if the ice maker:

a. is self-dispensing; or

b. is in an area restricted to staff only.

I. Laundry

1. The CRC shall have an automatic washer and dryer for use by staff when laundering clients' clothing.

2. The CRC shall have:

a. provisions to clean and launder soiled linen, other than client clothing, either on-site or off-site by written agreement;

b. a separate area for holding soiled linen until it is laundered; and

c. a clean linen storage area.

J. Storage:

1. the CRC shall have separate and secure storage areas that are inaccessible to clients for the following:

a. client possessions that may not be accessed during their stay;

b. hazardous, flammable and/or combustible materials; and

2. records and other confidential information.

K. Furnishings

1. The CRC shall ensure that its furnishings are:

a. designed to suit the size, age and functional status of the clients;

b. in good repair;

c. clean;

d. promptly repaired or replaced if defective, run-down or broken.

L. Hardware, Fixtures and other Protrusions

1. If grab bars are used, the CRC shall ensure that the space between the bar and the wall shall be filled to prevent a cord from being tied around it.

2. All hardware as well as sprinkler heads, lighting fixtures and other protrusions shall be:

a. recessed or of a design to prohibit client access; and

b. tamper-resistant.

3. Towel bars, shower curtain rods, clothing rods and hooks are prohibited.

M. Ceilings

1. The CRC shall ensure that the ceiling is:

a. no less than 7.5 feet high and secured from access; or

b. at least 9 feet in height; and

c. all overhead plumbing, piping, duct work or other potentially hazardous elements shall be concealed above the ceiling.

N. Doors and Windows

1. All windows shall be fabricated with laminated safety glass or protected by polycarbonate, laminate or safety screens.

2. Door hinges shall be designed to minimize points for hanging.

3. Except for specifically designed anti-ligature hardware, door handles shall point downward in the latched or unlatched position.

4. All hardware shall have tamper-resistant fasteners.

5. The center shall ensure that outside doors, windows and other features of the structure necessary for safety and comfort of individuals:

a. are secured for safety;

b. prohibit clients from gaining unauthorized egress;

c. prohibit an outside from gaining unauthorized ingress;

d. if in disrepair, not accessible to clients until repaired; and

e. repaired as soon as possible.

6. The facility shall ensure that all closets, bedrooms and bathrooms for clients that are equipped with doors do not have locks and can be readily opened from both sides.

O. Observation Area(s)

1. The CRC shall have one or more spaces for the placement of chair/recliners in an observation area. This space may be of a permanent configuration or may be re-arranged based on the needs of the clients in the CRC. There shall be at least three feet between each chair and at least six feet at the foot of each chair/recliner. The head of the chair/recliner may be positioned at a wall.

P. Smoking

1. The CRC shall prohibit smoking in the interior of the center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:121 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:475 (April 2021).

§5399. Exterior Space Requirements

A. The CRC shall maintain all exterior areas to prevent elopement, injury, suicide and the introduction of contraband, and shall maintain a perimeter security system designed to monitor and control visitor access and client egress.

B. The facility shall maintain all exterior areas and structures of the facility in good repair and free from any reasonably foreseeable hazard to health or safety.

C. The facility shall ensure the following:

1. garbage stored outside is secured in non-combustible, covered containers and are removed on a regular basis;

2. trash collection receptacles and incinerators are separate from any area accessible to clients and located as to avoid being a nuisance;

3. unsafe areas, including steep grades, open pits, swimming pools, high voltage boosters or high speed roads are fenced or have natural barriers to protect clients;

4. fences that are in place are in good repair;

5. exterior areas are well lit; and

6. the facility has appropriate signage that:

a. is visible to the public;

b. indicates the facility's legal or trade name;

c. clearly states that the CRC provides behavioral health services only; and

d. indicates the center is not a hospital or emergency room.

D. A CRC with an outdoor area to be utilized by its clients shall ensure that the area is safe and secure from access and egress.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:122 (January 2015).

Chapter 54. Crisis Receiving Centers

Subchapter A. Safety and Emergency Preparedness

§5401. General Safety Provisions

A. The CRC shall provide additional supervision when necessary to provide for the safety of all clients.

B. The CRC shall:

1. prohibit weapons of any kind on-site;

2. prohibit glass, hand sanitizer, plastic bags in client-care areas;

3. ensure that all poisonous, toxic and flammable materials are:

a. maintained in appropriate containers and labeled as to the contents;

b. securely stored in a locked cabinet or closet;

c. are used in such a manner as to ensure the safety of clients, staff and visitors; and

d. maintained only as necessary;

4. ensure that all equipment, furnishing and any other items that are in a state of disrepair are removed and inaccessible to clients until replaced or repaired; and

5. ensure that when potentially harmful materials such as cleaning solvents and/or detergents are used, training is provided to the staff and they are used by staff members only.

C. The CRC shall ensure that a first aid kit is available in the facility and in all vehicles used to transport clients.

D. The CRC shall simulate fire drills and other emergency drills at least once a quarter while maintaining client safety and security during the drills.

E. Required Inspections. The CRC shall pass all required inspections and keep a current file of reports and other documentation needed to demonstrate compliance with applicable laws and regulations.

F. The CRC shall have an on-going safety program to include:

1. continuous inspection of the facility for possible hazards;

2. continuous monitoring of safety equipment and maintenance or repair when needed;

3. investigation and documentation of all accidents or emergencies; and

4. fire control, evacuation planning and other emergency drills.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:123 (January 2015).

§5403. Infection Control

A. The CRC shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases.

B. The CRC shall have an active Infection Control Program that requires:

1. reporting of infectious disease in accordance with current OPH and federal guidelines;

2. monitoring of:

a. the spread of infectious disease;

b. hand washing;

c. staff and client education; and

d. incidents of specific infections in accordance with OPH guidelines;

3. corrective actions;

4. a designated infection control coordinator who:

a. has education and/or experience in infection control;

b. develops and implements policies and procedures governing the infection control program that is compliant with most recently published/current state and federal infection control guidelines in preparation for, during, and after a public health emergency or disaster;

c. takes universal precautions, including proper handwashing and face masks, as needed; and

d. strictly adheres to all sanitation requirements;

5. the CRC shall maintain a clean and sanitary environment and shall ensure that:

a. supplies and equipment are available to staff;

b. there is consistent and constant monitoring and cleaning of all areas of the facility;

c. the methods used for cleaning, sanitizing, handling and storing of all supplies and equipment prevent the transmission of infection;

d. directions are posted for sanitizing both kitchen and bathroom and laundry areas;

e. showers and bathtubs are to be sanitized by staff between client usage;

f. clothing belonging to clients must be washed and dried separately from the clothing belonging to other clients; and

g. laundry facilities are used by staff only;

h. food and waste are stored, handled, and removed in a way that will not spread disease, cause odor, or provide a breeding place for pests.

C. The CRC may enter into a written contract for housekeeping services necessary to maintain a clean and neat environment.

D. Each CRC shall have an effective pest control plan.

E. After discharge of a client, the CRC shall:

1. clean the bed, mattress, cover, bedside furniture and equipment;

2. ensure that mattresses, blankets and pillows assigned to clients are intact and in a sanitary condition; and

3. ensure that the mattress, blankets and pillows used for a client are properly sanitized before assigned to another client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:123 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:475 (April 2021).

§5405. Emergency Preparedness

A. The CRC shall have a written emergency preparedness plan to:

1. maintain continuity of the center's operations in preparation for, during and after an emergency or disaster;

2. manage the consequences of all disasters or emergencies that disrupt the center's ability to render care and treatment, or threaten the lives or safety of the clients; and

3. comply with recently published/current state and federal infection control guidelines in preparation for, during, and after a public health emergency or disaster.

B. The CRC shall:

1. post exit diagrams describing how to clear the building safely and in a timely manner;

2. have a clearly labeled and legible master floor plan(s) that indicates:

a. the areas in the facility that are to be used by clients as shelter or safe zones during emergencies;

b. the location of emergency power outlets and whether they are powered;

c. the locations of posted, accessible, emergency information; and

d. what will be powered by emergency generator(s), if applicable;

3. train its employees in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for all personnel.

C. The CRC's emergency preparedness plan shall include the following information, at a minimum:

1. if the center evacuates, the plan shall include:

a. provisions for the evacuation of each client and delivery of essential services to each client;

b. the center's method of notifying the client's family or caregiver, if applicable, including:

i. the date and approximate time that the facility or client is evacuating;

ii. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

iii. a telephone number that the family or responsible representative may call for information regarding the client's evacuation;

c. provisions for ensuring that supplies, medications, clothing and a copy of the treatment plan are sent with the client, if the client is evacuated;

d. the procedure or methods that will be used to ensure that identification accompanies the client including:

i. current and active diagnosis;

ii. medication, including dosage and times administered;

iii. allergies;

iv. special dietary needs or restrictions; and

v. next of kin, including contact information if applicable;

e. transportation or arrangements for transportation for an evacuation;

2. provisions for staff to maintain continuity of care during an emergency as well as for distribution and assignment of responsibilities and functions;

3. the delivery of essential care and services to clients who are housed in the facility or by the facility at another location, during an emergency or disaster;

4. the determination as to when the facility will shelter in place and when the facility will evacuate for a disaster or emergency and the conditions that guide these determinations in accordance with local or parish OSHEP;

5. if the center shelters in place, provisions for seven days of necessary supplies to be provided by the center prior to the emergency, including drinking water or fluids and non-perishable food.

D. The center shall:

1. follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency;

2. if the state, parish or local OHSEP orders a mandatory evacuation of the parish or the area in which the agency is serving, shall ensure that all clients are evacuated according to the facility's emergency preparedness plan;

3. not abandon a client during a disaster or emergency;

4. review and update its emergency preparedness plan at least once a year;

5. cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and shall provide information as requested;

6. monitor weather warnings and watches as well as evacuation order from local and state emergency preparedness officials;

7. upon request by the department, submit a copy of its emergency preparedness plan for review;

8. upon request by the department, submit a written summary attesting to how the plan was followed and executed to include, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:124 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:475 (April 2021).

§5407. Inactivation of License due to a Declared Disaster or Emergency

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

1. submits written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

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

b. the CRC intends to resume operation as a CRC in the same service area; and

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

NOTE: Pursuant to these provisions, an extension of the 60-day deadline for initiation of request may be granted at the discretion of the department.

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

e. lists the clients and the location of the discharged or transferred clients;

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

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

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

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

C. In order to obtain license reinstatement, a CRC with a department-issued notice of inactivation of license shall:

1. submit a written license reinstatement request to HSS 60 days prior to the anticipated date of reopening that includes:

a. the anticipated date of reopening, and a request to schedule a licensing survey;

b. a completed licensing application and other required documents with licensing fees, if applicable; and

c. written approvals for occupancy from OSFM and OPH recommendation for license.

2. The CRC shall resume operating in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766.

D. Upon receiving a completed written request to reinstate a CRC license and other required documentation, the department shall conduct a licensing survey.

E. If the CRC meets the requirements for licensure and the requirements under this Subsection, the department shall issue a notice of reinstatement of the center's license.

F. During the period of inactivation, the department prohibits:

1. a change of ownership (CHOW) in the CRC; and

2. an increase in the licensed capacity from the CRC's licensed capacity at the time of the request to inactivate the license.

G. The provisions of this Section shall not apply to a CRC which has voluntarily surrendered its license.

H. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the CRC license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 28:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:124 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:475 (April 2021).

§5409. Inactivation of License due to a Non-Declared Emergency or Disaster

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

1. the CRC shall submit written notification to the HSS within 30 days of the date of the non-declared emergency or disaster stating that:

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

b. the facility intends to resume operation as a CRC in the same service area;

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

d. the inactivation due to a non-declared emergency or disaster does not exceed one year receipt of notice of approval of renovation/construction plans by OSFM and OPH as required;

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

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

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

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

B. Upon receiving a completed written request to temporarily inactivate the CRC license due to a non-declared emergency or disaster, the department shall issue a notice of inactivation of license to the CRC.

C. Upon the CRC's receipt of the department's approval of request to inactivate the license, the CRC shall have 90 days to submit plans for the repairs, renovations, rebuilding, or replacement of the CRC to OSFM and OPH as required.

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

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

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

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

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

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

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

H. The provisions of this Section shall not apply to a CRC that has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the CRC license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180.14.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:476 (April 2021).

Chapter 55. Day Developmental Training Centers

§5501. Glossary

Administrator—the person appointed by the governing body, in writing, who is responsible for the overall management of the facility and enforces the rules and regulations as set forth by the governing body and appropriate federal, state and local agencies.

Agency—any division of government that may have contact with a facility for reasons of certification, funding, placement, licensing, etc.

Agency—the term *agency* whenever capitalized specifically refers to the Department of Health and Human Resources.

Chemical Restraint—the use of any drug or chemical to limit over activity or aggressiveness which might be harmful to the resident or other persons.

DHHR—the Louisiana Department of Health and Human Resources.

Direct-Care Staff—those employees that work directly with individuals under care on a full-time basis. Direct care staff includes, but is not limited to, house parents, attendants, and education and training staff. Administrative personnel, housekeeping and maintenance personnel and consultants shall not be included.

Facility—a physical plant and an administrative organizational structure whose primary concern is providing special therapy, training, education or protective care to handicapped persons. The term *facility* shall include only those structures providing care and/or training to five or more persons and shall include residential, day-care, group homes and special schools.

Individual-Person-Child-Student—used interchangeably to indicate those that are receiving care and/ or treatment.

In-Service Training Program—an ongoing training process for all staff members in all areas of concern to the facility.

Interdisciplinary Teams—a. team composed of both professional and non-professional staff members from all areas of service.

Living Unit—that portion of the facility devoted to the personal needs of individuals in a residential facility.

Multidisciplinary Teams—a. team composed only of professional staff members.

Resident—those persons receiving residential care at the facility.

State-Approved Evaluation Team—an evaluation team approved by any funding agency of the state of Louisiana.

Training—an ordered design leading to a specific end result. Training services are differentiated from educational services by their emphasis on those skills universally needed to function at a minimum level as part of society.

Treatment Plan or Program (Plan of Care)—a written plan setting forth measurable goals or behaviorally stated objectives and prescribing an integrated program of individually designed activities, experiences or therapies necessary to achieve such goals or objectives.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5503. Licensure Procedure

A. Application for license is made by applying in writing to the Licensing and Certification Division, Department of Health and Human Resources, P.O. Box 3767, Baton Rouge, Louisiana 70821. This means that the applicant is requesting that the facility be surveyed for licensure. As soon as possible, a surveyor will visit the facility to determine compliance. At the same time, inspections by the Fire and Health Departments will be requested by the Licensing and

Certification Division. Copies of these inspection reports which indicate approval by the Fire and Health Departments must be received by the Licensing and Certification Division.

B. Any deficiencies found by the surveyor will be discussed with the administrator and/or the governing body of the facility. Within 10 days after official notification of deficiencies noted in the survey, the administrator and/or governing body must reply in writing as to how the deficiencies will be corrected and the dates on which these corrections will be effected. This procedure is also applicable to the relicensure process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5505. Relicensure Procedure

A. Ordinarily, licenses are issued for a period of one year. Two months before the expiration date application for relicensure must be made to the Licensing and Certification Division on forms supplied by that office. The relicensure survey is the same procedure as that of the initial.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5507. Appeal Procedure

A. If the license is refused, suspended or revoked because a facility is not suitable, is not properly managed, as such, or does not meet minimum requirements for licensure, the procedure is as follows:

1. The secretary, Department of Health and Human Resources, by registered letter, shall advise the facility administrator of the reasons for refusal, suspension, or revocation, and its right of appeal.

2. Within 30 days after receipt of such notice, the facility administrator may request in writing a hearing in order to appeal the decision.

3. The secretary shall set a hearing to be held within 30 days after receipt of such request. The hearing shall be held in the immediate vicinity of the appellant or other location specified by him.

4. The secretary, or his representative, shall conduct the hearing. Within 10 days after the hearing, he shall advise the appellant, by registered letter, of his decision, either confirming or reversing the original decision. If the license is refused, suspended or revoked, the facility shall be given 30 days to meet those standards delineated by the licensing agent.

5. If the facility is unable to meet the standards within this time frame, funding received from the Department of Health and Human Resources shall be discontinued.

B. The licensing standards will be used to license all facilities where DHHR funds are used to care for handicapped persons. Included are those facilities which are specially designed to care for a particular type of handicap, such as mental retardation, mental illness and learning disabilities. Since these types of handicaps may require specialized standards in certain areas, separate appendices containing standards in these areas have been formulated.

C. All facilities must meet the general standards. Additionally, each facility must meet the standards in the appendix that applies to the primary type of handicap in which the facility specializes. Should none of the appendices be perfectly suited to the type of disability cared for by the facility, the facility must, nonetheless, meet the additional standards contained in the appendix which most nearly meets the needs of that type of disability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5509. General Standards

A. The following standards must be met by all facilities regardless of the type of disability with which they are primarily concerned.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5511. Compliance with Federal, State and Local Laws

A. When state or applicable local law provides for licensing of facilities of this nature, the facility must be licensed pursuant to such law.

B. The facility must be in conformity with federal, state and local laws, codes and regulations pertaining to health and safety, including procurement, dispensing, administration, safeguarding and disposal of medication and controlled substances; fire and safety regulations; building construction, maintenance and equipment standards; education and training; labor laws and regulations; sanitation; communicable and reportable diseases and postmortem procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5513. Disclosure of Ownership

A. Any facility which is funded, either directly or indirectly, by the Department of Health and Human Resources must supply to the Licensing and Certification Section full and complete information and promptly report any changes which would affect the current accuracy of such information, as to identify:

1. of each person having (directly or indirectly) an ownership interest of 10 percent or more;

2. in case a facility is organized as a corporation, of each officer and director of the corporation;

3. in case a facility is organized as a partnership, of each partner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5515. Governing Body and Administration

A. A governing body of the facility shall exercise general direction and shall establish policies concerning the operation of the facility and the welfare of the individuals served.

B. The governing body shall establish appropriate qualifications for the administrator in terms of education, experience, personal factors, and skills.

C. The administrator shall make arrangements so that a particular individual is responsible for the administrative direction of the facility at all times.

D. A table of organization shall provide for and show the major operating programs of the facility, with staff division and the administrative personnel in charge of program and division, and their lines of authority, responsibility, and communication.

E. The administration of the facility shall provide for effective participation and communication between the staff and individuals attending the facility. Standing committees appropriate to the facility, such as human rights, infection control, admission and dismissal, interdisciplinary, etc., shall be constituted and shall meet regularly. Committees shall include the participation of direct-care staff and the persons served, whenever appropriate. Minutes and reports of staff meetings, and of standing and at hoc committee meetings shall include records of recommendation and their implementation, and shall be kept and filed.

F. There shall be an active program of ready, open, and honest communication with the children and their families. The facility shall maintain active means of keeping the families or surrogates informed of activities related to the children that may be of interest to them or of significant changes in the child's condition. Communication to the facility from a child's relatives shall be promptly and appropriately handled and answered. Close relatives and parent surrogates shall be permitted to visit at any reasonable hour, and without prior notice unless contraindicated by the child's needs. Steps shall be taken, however, so that the privacy and rights of the other individuals are not infringed by this practice. Parents shall be permitted to visit all parts of the facility that provide services to the children. Frequent and informal visits home shall be encouraged and the regulations of the facility shall facilitate rather than inhibit such visitations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5517. General Policies and Practices

A. The facility shall have written philosophy, objectives and goals that are available to the staff, consumer representatives, the interested public and appropriate state agencies. In addition to the philosophy and objectives of the facility, this written policy must contain the facility's goals for the individuals it cares for and its concept of its relationship to parents or their surrogates.

B. The facility shall have a written statement of policies and procedures concerning the rights of the individuals that assures their civil rights.

C. The facility shall have a written statement of policies and procedures concerning the admittance of individuals of all races that would prohibit discrimination.

D. The facility shall have written policies and procedures that protect the individual's financial interests, provide for counseling concerning use of large sums accrued, protect such funds, and permit normalized possession and use of money earned through work payment programs.

E. Policies and procedures in the major operating units (personnel, education and training, resident living, medical, pharmacy, dental, nursing, physical therapy, occupational therapy, speech and audiology, social services, recreation, psychiatric and psychological services, food and nutrition, etc.) of the facility shall be described in manuals that are current, relevant, available, and followed.

F. Written policy shall prohibit mistreatment, neglect, or abuse. Alleged violations shall be reported immediately, and there shall be evidence that:

1. all alleged violations are thoroughly investigated;

2. the results of such investigation are reported to the administrator or his designated representative within 24 hours of the report of the incident;

3. the results of such investigation shall also be reported to the appropriate funding office which then has the right to make its own investigation or to refer the problem to the Licensing and Certification Section for that office to investigate;

4. either the facility, the funding agency or the Licensing and Certification Section may impose appropriate sanctions if the allegations are substantiated.

G. The facility shall meet all state and federal wage and hour regulations in regard to employment of persons admitted to the facility. Wages earned by persons who are eligible for and receiving state funds shall be reported to the state agency and the facility shall not accept or solicit these funds from persons admitted to the facility. The state may require that these earnings be applied toward the cost of care of the person.

H. The facility shall not coerce persons funded by the state to engage in any type of solicitation for funds, equipment, etc., for utilization by the persons in care or the facility. The state funding agency and parent/guardian must be notified before an individual voluntarily engages in these types of activities.

I. The facility must maintain full financial records which are certified annually and forthwith submit them to the state funding agency. These records shall be subject to audit at any reasonable time by the Department of Health and Human Resources, the Louisiana legislative auditor, the Department of Health, Education and Welfare, and any authorized representative of the state. All income sources shall be identified, all expenses verified, and other information made available as necessary in order to determine the actual cost per person per day for services available. These records shall be maintained.

J. The facility shall have written policies and procedures which safeguard information regarding individuals funded by the state agency, which shall include prohibition of announcement or publication of names or pictures of such persons without the prior written consent of agency and parent/guardian. Confidential information shall not be released to or discussed with an outside source other than the Department of Health and Human Resources and direct collateral services providers without the prior express written consent of the parent/guardian and agency.

K. If the facility conducts research, it shall follow and comply with the statement of assurances on researh involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that department.

L. The facility shall release information to an organization or individual engaged in research only for purposes directly and previously approved by the state funding agency with assurances that the information will be used only for the purpose for which it is provided, that it will not be released to persons not connected with the study under consideration, and that the final product of the research will not reveal any information that may serve to identify any person funded by the state without written consent of such person and the state agency.

M. Each individual funded by state shall be entitled to receive and send sealed mail, without any form of censorship or invasion of privacy, unless, in the case of a person who is emotionally disturbed, a restriction on incoming mail is recommended by a qualified professional as being necessary to prevent serious harm to the person, and such restriction is prescribed in writing by that qualified professional for a definite period not to exceed one month, in conjunction with therapy being received by the person. In the event that such a restriction is prescribed, a letter may be censored only after a qualified professional has reviewed the contents of that letter and determined that withholding of the letter from that person is necessary to prevent serious harm to the person; the entire letter must be withheld; a copy of the withheld letter must be returned to the sender, along with notification that the letter was withheld and the reasons for the censorship; the facility must retain copies of both the letter withheld and the notification letter sent to the sender, in conformity with the above, and the facility must maintain a log listing all letters withheld; and the facility must make available copies of the letters and log, described in the above, to DHHR and authorized state and federal representative, upon request. Anything in this paragraph to the contrary notwithstanding, it shall be the duty of the institution to furnish to each person all materials and assistance reasonably necessary to facilitate sending and reading mail.

N. Under appropriate supervision, each individual funded by state shall be provided with suitable opportunities for interaction with members of the opposite sex, except where a qualified professional responsible for the formulation of a particular person's treatment plan writes an order to the contrary and explains the reasons therefore.

O. The following rules shall govern performance of work by individuals funded by agency: No person shall be required to perform work of any kind that involves the operation and maintenance of an institution, nor shall privileges or release from an institution be conditioned upon performance of any work. However, a person may be required to perform vocational training tasks, provided each task is part of the person's individual treatment plan and has been approved as a program activity by a professional responsible for supervising the individual's program, supervised by a qualified professional, and not continued for longer than six months, unless it is specifically reinstated by the person's treatment plan. A person may be required to perform without compensation such housekeeping tasks as would be performed by a person in a natural home, foster home or group home, provided that the person's individual treatment plan does not forbid such work. In no case, however, may a person be required to perform housekeeping tasks for more than 12 other people.

1. An individual may voluntarily engage in work during non-program hours, provided that the person's individual treatment plan does not forbid it, the particular work has been approved by the qualified professional responsible for supervising the implementation of the person's treatment plan, the particular work is supervised by qualified staff, and the conditions of employment and the compensation are in full compliance with all applicable federal laws.

2. No person funded by the state shall be involved in the care, feeding, clothing, training or supervision of other individuals unless the qualified professional responsible for supervising the implementation of the person's treatment plan certifies in writing in the person's record that the particular task will not in any way endanger the life or health or be detrimental to the development of the particular individuals who receive such care.

P. Each individual funded by state shall have the unrestricted right, consistent with reasonable institutional regulations, to visits by and to his parents, foster family or

tutor. Visits by and to other persons shall be limited only to the extent that a special restriction is required by the person's individual treatment plan as necessary to prevent serious harm to the individual. The reasons for any such restriction must be explained in writing. The written order must be reviewed at the end of 30 days and shall be renewed only by the interdisciplinary team. Reasons for renewal must be recorded in the person's records.

Q. Each individual funded by state shall have the right to telephone communication with his parents or tutor to the extent consistent with reasonable institutional regulatiojs. The person shall also have the right to telephone communication with others except to the extent that an appropriately qualified professional responsible for formulation of a particular person's habilitation plan writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semi-annually if any restrictions are to be continued.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5519. Personnel Policies

A. The hiring, assignment, and promotion of employees shall be based on their qualifications and abilities, without regard to sex, race, color, creed, age, ethnic or national origin. Written job descriptions shall be available for all positions. Licensure, certification, or standards such as are required in community practice shall be required for all comparable positions in the facility. These ethical standards of professional conduct, as developed by professional societies, shall be recognized as applying in the facility. There shall be an authorized procedure, consistent with due process, for suspension and/or dismissal of an employee for cause. The facility's personnel policies and practices are in writing and are available to all its employees.

B. Staffing shall be sufficient so that the facility is not dependent upon the use of residents or volunteers for productive services. There shall be a written policy to protect residents from exploitation when engaged in productive work.

C. Appropriate to the size and nature of the facility there shall be a staff training program that includes:

1. orientation for all new employees to acquaint them with the philosophy, organization, program practices, and goals of the facility;

2. inservice training for employees who have not achieved the desired level of competence and continuous inservice training to update and improve the skills and competencies of all employees;

3. supervisory and management training for all employees in, or candidates for, supervisory positions;

4. an individual designated the responsibility for staff development and training;

5. minutes of training sessions which indicate the subjects covered in the session, the names of the staff members in attendance and the date of the session;

6. written policies must be in effect to insure that employees with symptoms or signs of communicable disease are not permitted to work.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5521. Admission and Release

A. No individual whose needs cannot be met by the facility shall be admitted to it. The needs of these individuals shall be determined by an evaluation team approved by the funding agency. The number of individuals admitted to the facility shall not exceed its rated capacity and its provisions for adequate programming. The facility shall admit only those individuals who have had a comprehensive evaluation by an appropriate state-approved evaluation team covering physical, emotional, social, and cognitive factors.

B. The regulations and procedures concerning admission, readmission, and release shall be summarized and available.

C. Procedures shall be established so that parents or guardians who request the release of their child are counseled concerning the advantages and disadvantages of such release. When the facility wishes to dismiss or transfer an individual, there shall be written evidence of the reason for the transfer, and, except in an emergency, 30 days prior knowledge, and ordinarily the written consent of the student's parents and the funding agency. At the time of any permanent release or transfer, there shall be recorded a summary of findings, progress, and plans, if any.

D. In the event of any unusual occurrence, including serious illness or accident, impending death, or death, the student's next of kin, or the person who functions in that capacity (a guardian or citizen advocate) shall be notified promptly. Also, the funding agency will be notified at this same time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5523. General Staffing Provisions

A. To conduct the direct-care program, staff personnel shall be sufficient, appropriately qualified, and adequately trained. All direct-care personnel shall be administratively responsible to a person whose training and experience is appropriate to the program.

B. There shall be at least one direct-care staff person on duty in any area of the facility where children are present or are expected to be present.

C. The number of appropriate direct-care staff will be determined by a consideration of the following factors:

1. the number of children;

2. the type and severity of their handicaps;

3. the amount of time that the children are under the care of the facility;

4. the type of program offered by the facility.

D. Regardless of the organization or design of the facility, the overall direct care staff ratio shall be 5 to 16 unless program needs justify otherwise. This means 5 direct care staff on duty each day to every 16 persons in care. For example, there should be present and on duty, on every day of the year, at least one direct care person for each eight residents on the first shift, one direct care person for each eight residents on the second shift, and one direct care person for each 16 residents on the third shift.

E. The above direct care ratio may be waived by the certifying agency if the facility has documented evidence that there is not a need for staff in these numbers and that the health and safety of the residents would not be impaired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5525. Staff Responsibilities and Activities

A. The facility shall develop a program that is based on each person growing at his own rate, yet keeping general development in mind. The facility shall create an atmosphere in which self-confidence and ability can be cultivated. The program shall be geared to meet the individual needs of those served.

B. Within the period of one month after admission there shall be, by professional as well as direct-care staff, a review and updating of the preadmission evaluation and a treatment plan shall be developed for the individual by this time. The above-mentioned review must be recorded in the individual's record and a written interpretation of the review made to the direct-care and special services staff responsible for carrying out the treatment plan.

C. Six months after admission of each person to a facility and at least annually thereafter, a comprehensive psychological, social, educational and medical diagnosis and evaluation shall be prepared for that person, and his treatment plan shall be reviewed and adjusted as necessary by an appropriate interdisciplinary team of the facility. This review and evaluation shall include consideration of the advisability of the continued stay in the program and alternative programs. Where possible, the person's parents shall be involved in the planning and decision making for programming. Also, these reviews shall be interpreted to the individual, when appropriate. The results of this annual review shall be recorded in the individual's record and a written interpretation of the review, in layman's terms, made to the direct-care and the special services personnel responsible for carrying out the individual's program. His parents or his surrogates and the funding agency will also get copies of this review.

D. There shall be a schedule of the day's plan of activities, providing flexibility and changes, as deemed necessary. The program of activities shall be adhered to with reasonable closeness but shall accommodate and have due regard to individual differences among those served. The program shall provide time and material for both vigorous and quiet activity for children to share or do alone as well as indoor and outdoor play and rest periods. Regular time should be allowed for routines such as washing, lunch, rest, snacks, and putting away toys. For children under 6 years of age, quiet play, story telling, or quiet music should precede the lunch hour, which then should be followed by the rest period.

E. The aims and activities of the facility shall be shared with parents or guardians by planned individual conferences and group meetings at least quarterly with written minutes kept.

F. There shall be planned daily activities and exercise periods for multiple handicapped and non-ambulatory individuals who shall be rendered mobile whenever possible by various methods and devices.

G. All individuals shall have planned periods out of doors on a year- round basis.

H. There shall be a written statement of policies and procedures for the control and discipline of individuals in care that is available to parents or guardians and the funding agency, and which is, where appropriate, for mulcted with participation of the individuals cared for by the facility. This policy shall not permit corporal punishment or seclusion (defined as the placement of a person alone in a locked room) to be used.

I. The staff shall not mistreat or abuse those in care in any way.

J. Normal time-out procedures may be utilized, such as turning a student’s chair away from the class, or having the student move to another part of the room.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5527. Health, Hygiene and Grooming

A. All persons, both residential and day-care, shall be trained to exercise maximum independence in health, hygiene, and grooming practices, as appropriate (including bathing, brushing teeth, shampooing combing and brushing hair, shaving and caring for toenails and fingernails, except where detrimental to the individual's treatment plan.

B. Anyone who does not eliminate appropriately and independently, shall be engaged in a toilet training program

unless to do so would be detrimental to his treatment plan. The training program shall be applied systematically and regularly. Records shall be kept of the progress of each person receiving toilet training. Those who are incontinent shall be immediately bathed or cleansed upon voiding and soiling, unless specifically contraindicated by the training program in which they are enrolled, an all soiled items shall be changed.

C. These procedures shall be established for persons in residential care:

1. monthly weighing, with greater frequency for those with special needs;

2. quarterly measurement of height, until the age of maximum growth;

3. maintenance of weight and height records; and

4. assuring that residents maintain normal weights.

D. Orders prescribing bed rest or prohibiting persons in residential care from being taken out-of-doors shall be reviewed by a physician at least every three days.

E. Provisions shall be made for persons in residential care to furnish, maintain in good repair, and encourage the use of dentures, eyeglasses, hearing aids, braces, and so forth, prescribed by appropriate specialists.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5529. Food and Nutrition

A. When meals are provided to day-care students:

1. the food service for such meals shall include menu planning, storing and handling of food, food preparation, and food serving. The food and food service shall maintain sanitary standards in compliance with state and local regulations;

2. a nourishing, well-balanced diet shall be provided to all persons. Modified diets shall be prescribed or approved by the attending physician and planned, prepared, and served by persons who have received adequate instruction. These diets must be periodically reviewed and adjusted as needed;

3. the food and nutrition needs of the individuals shall be met in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, activity, and disability, through a nourishing, well-balanced diet unless contraindicated by medical needs;

4. denial of a nutritionally adequate meal shall not be used as a punishment;

5. menus shall be written in advance and shall provide for a sufficient variety of foods served in adequate amounts. Menus shall be written so that meals will not be the same for the same day of the week, to keep every Monday from being known as "red beans and rice day". Menus shall be adjusted for seasonal changes. Records of menus as served shall be filed and maintained for at least 30 days;

6. food shall be served in appropriate quantity, at appropriate temperature, in a form consistent with the developmental level of the student, and with appropriate utensils. Food served to students and not consumed shall be discarded;

7. all students, including the mobile nonambulatory, shall eat or be fed in dining rooms, except where contraindicated for health reasons, or by decision of the team responsible for the student's program. Table service shall be provided for all who can and will eat at a table, including students in wheelchairs. The dining areas shall be equipped with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each student;

8. students shall be provided with systematic training to develop appropriate eating skills, utilizing adaptive equipment where it serves the developmental process.

B. When meals are not provided to day care students by the facility (students bring own lunch):

1. the food service shall include:

a. mid-morning snack;

b. adequate refrigeration;

c. supply of food or provision made for obtaining food for students who forget to or do not bring their own lunch.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5531. Medical Services

A. The consultation services of a licensed physician shall be made available not only for emergencies, but for overall counseling for all health aspects of the center.

B. This physician shall visit the facility at least twice a year and on the outbreak of any epidemic to review the health practices of the center, and to make pertinent recommendations.

C. The medical consultant of the facility will cooperate with the local public health agency in supervising all the health conditions and practices of the facility's program:

1. to approve the facility's written statement regarding the procedures described above;

2. to make recommendations regarding diet, rest, or any other aspects of the program affecting the health of the students;

3. to certify to the facility in writing once a year either that the health aspects of care in the facility conform to the procedure the physician and the local health agency have approved, or that certain irregularities exist. Those reports

shall be the basis of the Licensing and Certification study of health aspects of care.

D. The medical consultant and operator should prepare a written statement outlining the procedures governing:

1. routine health inspection that can be given by the staff;

2. treatment of first aid that may be given without specific orders from a physician;

3. circumstances under which a physician should be called;

4. action to be taken by the center in case of emergency or suspected illness.

E. Each person shall have an annual physical examination and a statement from the physician or health unit that he is in good health and free from communicable disease.

F. Upon arrival each day, the student shall be checked for possible signs of illness, colds, skin infection and contagious skin disease. If there are signs of communicable disease, the student shall not be permitted to attend the facility until he is in good health.

G. If symptoms of communicable diseases develop while the student is in care of the facility, he shall be placed in isolation and prevented from mingling with others until a physician or registered nurse has been consulted and has pronounced it safe for him to be with other students.

H. When a student has been sick with a highly communicable disease, such as mumps, whooping cough, measles, ringworm or impetigo, a physician or nurse must certify that he is in sufficiently good health and that he can return to the facility.

I. If a student develops symptoms of illness or suffers an accident while under the care of the facility, the parent shall be notified as soon as possible. If the symptoms are severe and the parent is not available, medical advice shall be sought from the child's or the facility's physician.

J. If students in the facility are known to have been exposed to a communicable disease, prompt notice shall be given to the parents of all attending the facility.

K. The facility shall keep on hand first-aid equipment approved by its medical consultant.

L. No drug of any type, including aspirin, should be given by the staff unless prescribed by the student's or facility's physician.

M. When it is necessary for the student to be given medication while at the facility, directions must be given in writing, by the physician. Medicine containers must be plainly marked with student's name and directions for administering and kept in a safe place out of the student's reach.

N. There shall be an agreement with the local health unit or a physician's office for consultation with a nurse when necessary.

O. Students shall be provided with nursing services according to their needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5533. Services for Education, Training and Habilitation

A. In those instances where the Department of Education has assumed the responsibility for the educational services at a facility or has imposed licensing requirements for special schools, the standards governing educational service shall be established by the Department of Education and shall supersede the standards set forth below.

B. Students of grossly different ages, developmental levels, and social needs shall not be grouped in close physical or social proximity, unless such grouping is planned to promote the growth and development of all those grouped together. Students who are mobile-nonambulatory, deaf, blind, epileptic, and so forth, shall be integrated with peers of comparable social and intellectual development, and shall not be segregated on the basis of their handicaps.

C. All residential facilities shall provide educational, training and habilitation services as appropriate to the needs of the individuals admitted either directly or through arrangements with agency approved outside resources, including the public school system.

D. The residential facility which provides these services directly shall have an educational, training and habilitation staff which is in a ratio of one staff member to five persons. However, the staff members providing these services may also be used in other capacities by the facility when not engaged in classroom training. The above-mentioned ratio may be waived by the certifying agency if the facility has documented evidence that there is not a need for training staff in these numbers and that the educational, training, and habilitation needs of the individuals would not be impaired.

E. All day-care facilities shall provide directly for educational, training and habilitation services appropriate to the needs of the person. There shall be at least one training staff member for every five persons in day-care facilities. The above-mentioned ratio may be waived by the certifying agency if the facility has documented evidence that there is not a need for training staff in these numbers and that the educational, training, and habilitation needs of the individuals would not be impaired.

F. Training and habilitation services shall be available to all students.

G. The educational services should be structured to develop proficiency in the following areas:

1. communication skills;

2. computational skills;

3. language arts;

4. aesthetic and cultural development;

5. physical education and recreation;

6. motor development (perceptual and fitness);

7. pre-academic education;

8. academic education;

9. pre-vocational education;

10. vocational education.

H. The program must be designed as a whole to maximize the student's human abilities, to enhance his ability to cope with his environment, to enable him to develop and realize his fullest potential and to equip him to live as normally as possible.

I. Individual evaluations of students shall:

1. be based upon the use of empirically reliable and valid instruments, whenever such tools are available; and

2. provide the basis for prescribing an appropriate program of experiences for the student.

J. Physicians shall participate when appropriate:

1. in the continuing interdisciplinary evaluation of individual residents for the purpose of initiation, monitoring, and follow-up of individualized habitation programs; and

2. in the development for each person of a detailed written statement of treatment goals, encompassing the areas of physical and mental health, education, and functional and social competence, and in the development of a treatment plan, detailing the various habilitation modalities that are to be applied in order to achieve the specified goals with clear designation of responsibility for implementation.

K. Nursing services shall include as appropriate:

1. registered nurse participation in:

a. the evaluation study, treatment plan, and placement of the individual at the time of admission to the facility;

b. the periodic re-evaluation of the type, extent, and quality of services and programming;

c. the development of discharge plans; and

d. the referral to appropriate community resources;

2. development of a written plan for each student to provide for nursing services as a part of the total habilitation program.

L. The educational, training and habilitation program for each student shall be determined according to the handicapping conditions of the student, based upon complete and relevant diagnostic and prognostic data, and stated in specific behavioral terms that permit the progress of the individual to be assessed.

M. There shall be evidence of educational, training and habilitation services activities designed to meet the objective set for every student in these areas. There shall be a functional educational, training, and rehabilitation record for each student maintained by, and available to, the staff members in this area. Appropriate educational, training and habilitation programs shall be provided students with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff.

N. There shall be available sufficient, appropriately qualified educational, training and habilitation personnel, and necessary supporting staff, to carry out the programs. Supervision of delivery of these services shall be the responsibility of a person who is a professional qualified in the area of the particular disability that is the primary handicap of the student. For facilities caring primarily for learning disable children, the supervisor of delivery of these services shall be the responsibility of a person qualified at the master's level in the area of special educational services. The above-mentioned supporting staff shall possess the necessary background to meet the educational, training and habilitation needs of the persons served.

O. There shall be evidence of equipment generally accepted as necessary to providing educational, training and habilitation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5535. Social Services

A. Social services, as part of an interdisciplinary spectrum of services, shall be provided through the use of social work methods directed toward:

1. maximizing the social functioning of each person;

2. enhancing the coping capacity of his family; and

3. assenting and safeguarding the human and civil rights of the individual and his family and fostering the human dignity and personal worth of each individual.

B. Social workers shall participate, when appropriate, in the continuing interdisciplinary evaluation of individual students for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs.

C. During the person's admission to, and residence in, the facility, or while he is receiving services from the facility, social workers shall, as appropriate, provide liaison between him, the facility, the family, and the community, so as to:

1. help the staff to:

a. individualize and understand the needs of the individual and his family in relation to each other;

b. understand social factors in the person's day-to-day behavior, including his relationship with the staff; and

c. prepare the individual for changes in his living situation;

2. help the family to develop constructive and personally meaningful ways to support his experience in the facility, through:

a. counseling concerned with problems associated with changes in family structure and functioning;

b. referral to specific services, as appropriate; and

3. help the family to participate in planning for his return to home or other community placement.

D. There shall be available sufficient, appropriately qualified staff, either full-time or through arrangement, and necessary supporting personnel to carry out the various social service activities. Social workers providing service to the facility shall be graduates of a master's program in an accredited school of social work. Social work assistants or aides employed by the facility shall work under the supervision of, or get consultation from, a social worker who is a graduate of a master's program of an accredited school of social work.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5537. Physical and Occupational Therapy Services

A. If a facility admits persons that have a need for either physical or occupational therapy, those services shall be provided. These services may be provided either directly or through arrangements with an outside resource or with consultation from a qualified therapist. Therapy shall be done through personal contact between therapists and the persons in care or indirectly through contact between therapists and other persons involved with the individual.

B. Physical therapy and/or occupational therapy staff shall provide treatment training programs that are designed to preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living. Also, to prevent, insofar as possible, irreducible or progressive disabilities, through means such as the use of orthotic and prosthetic appliances, assistant and adaptive devices, positioning, behavior adaptions, and sensory stimulation.

C. The therapist shall function closely with the individual's primary physician and with other medical specialists. Treatment-training progress shall be regularly recorded, evaluated periodically, and used as the basis for continuation or change of the person's program.

D. Evaluation results, treatment objectives, plans, procedures and continuing observations of treatment progress shall be recorded accurately, summarized and communicated to all physicians and other staff involved. These reports shall be used in evaluating progress and included in the individual's record.

E. There shall be available sufficient, appropriately qualified staff, and supporting personnel, to carry out the various physical and occupational therapy services in accordance with stated goals and objectives. Physical and occupational therapy personnel shall be assigned responsibilities in accordance with their qualification, delegated authority commensurate with their responsibilities and provided appropriate professional direction and consultation.

F. To provide efficient and effective physical and occupational therapy services, there shall be adequate space, facilities, equipment, supplies and resources.

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5539. Speech Pathology and Audiology

A. If a facility admits persons with a need for speech pathology and/or audiology services, these shall be rendered as appropriate through:

1. direct contact between speech pathologists, audiologists and the students; and

2. working with other personnel, such as teachers and direct-care staff, in implementing communication improvement programs in environmental settings.

B. Speech pathology and audiology services available to the facility shall include:

1. screening and evaluation of the persons in care with respect to speech and hearing functions;

2. comprehensive audiological assessment of all persons, as indicated by screening results, to include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and to include assessment of the use of visual cues;

3. assessment of the use of amplification;

4. provision for procurement, maintenance and replacement of hearing aids, as specified by a qualified audiologist;

5. comprehensive speech and language evaluation of each person, as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;

6. participation in the continuing interdisciplinary evaluation of individuals for purposes of initiation, monitoring, and follow-up of individualized habilitation programs;

7. treatment services interpreted as an extension of the evaluation process, that include:

a. direct counseling with the persons in care;

b. consultation with appropriate staff for speech improvement and speech education activities; and

c. collaboration with appropriate staff to develop specialized programs for developing the communication skills of individuals in comprehensive (for example, speech, reading, auditory training, and hearing aid utilization) as well as expression (for example, improvement in articulation, voice, rhythm, and language); and

8. participation in in-service training programs for direct-care and other staff. Evaluation and assessment results shall be reported accurately and systematically, and in such manner as to, where appropriate, provide information useful to other staff working directly with the resident; and provide evaluative and summary reports for inclusion in the individual's record.

C. There shall be available sufficient, appropriately qualified staff, and necessary supporting personnel to carry out the various speech pathology and audiology services, in accordance with stated goals and objectives. Staff who assume independent responsibilities for clinical services shall be licensed, if applicable, by the state in which practicing, and:

1. shall be eligible for a certificate of clinical competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association under its requirements in effect on the publication of this provision; or

2. meet the educational requirements for certification, and be in the process of accumulating the supervised experience required for certification.

Adequate, direct and continuing supervision shall be provided personnel, volunteers, or supportive personnel utilized in providing clinical services.

D. To provide efficient and effective speech pathology and audiology services, there shall be adequate space, facilities, equipment and supplies.

E. Speech pathology and/or audiology services, when needed, shall be provided through any reasonable arrangement including, but not limited to, consultation with a speech pathologist/audiologist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5541. Recreation Services

A. Recreational services shall be coordinated with other services and programs which are provided, in order to make fullest possible use of the facility's resources and to maximize benefits to all concerned.

B. Records concerning those in care shall include periodic surveys of their recreation interests and the extent and level of each person's participation in the activities program.

C. There shall be sufficient, appropriately qualified recreation staff and necessary supporting staff to carry out the various recreation services in accordance with stated goals and objectives. Personnel conducting the recreation program shall have at least demonstrated proficiency and experience in conducting activities in one or more program areas.

D. Recreation areas and facilities shall be designated and constructed or modified so as to be easily accessible to all persons regardless of their disabilities. This area shall be of such a design or location as to be safe and not be a hazard.

E. Recreation equipment and supplies in sufficient quantity and variety shall be provided to carry out the stated objectives of the activities programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5543. Design and Equipage

A. Plant

1. The Day Care Center shall be constructed, equipped, and maintained to insure the safety of all concerned. It is structurally sound and satisfies the following.

a. The facility complies with all applicable state and local codes governing constructions.

b. Fire resistant and flame-spread ratings of construction, materials, and finishes comply with current state and local fire protection codes and ordinances.

c. Fire extinguishers are conveniently located on each floor and in special hazard areas such as boiler rooms, kitchens, laundries, and storage rooms. Fire regulations are prominently posted and carefully observed.

d. Unless the facility is of fire resistant construction, individuals physically handicapped or mentally retarded are not permitted to occupy floors above the street level.

e. The building shall be maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building.

B. Space Required

1. Indoor Space

a. There shall be a minimum of 35 square feet of space per student. Kitchens, bathrooms, halls used as passageways, family bedrooms, lockers, laundry rooms, built-in cabinets and any other quarters with furniture used as family living space shall not be considered as floor space available for students.

b. There shall be open shelves within easy reach of the students for the storage of play material and closed shelves for the storage of school supplies and equipment.

c. There shall be individual space for students' clothing, such as lockers or low hooks.

d. The rooms used primarily for the students should be located so as to receive the maximum amount of sunlight and shall be well ventilated and lighted.

2. Outdoor Space

a. There shall be outdoor play space provided for the students; there shall be a minimum of 75 square feet for each student in the group at any one time. The minimum outdoor play space shall be available for at least one-half the number of students in care.

b. The outdoor play space shall be enclosed in such a manner as to protect the children from traffic hazards and to prevent the children from leaving the premises without proper supervision. For centers located away from streets or other hazards, enclosing of the outside play space may be waived.

c. The outdoor play space shall be kept free of broken glass and other debris. The grounds will be well groomed at all times.

d. Equipment and placement of equipment shall be such that it will not be dangerous to the life or health of the person using it.

3. Furnishings and Equipment

a. Chairs and tables shall be adequate in number to serve the students. They shall be of a size suitable to the group in care.

b. Each child under 6 years of age shall be provided with a cot or bed or pallet for rest periods. If beds or cots are provided, the beds or cots shall be at least 18" apart.

c. Individual bedding, sufficient to maintain warmth, shall be provided either by the parents or the school. Covers shall be laundered as needed and always upon change of occupancy.

4. Environmental Hygiene

a. Minimum Toilet Facilities. There shall be adequate, separate toilet facilities for male and female students.

b. Hand Washing Facilities. There shall be adequate lavatories to meet the needs of the students. There shall also be a soap dispenser and individual towels, preferably paper towels.

c. Drinking Fountains. Drinking fountains, when available, shall be of a type approved by the State Board of Health. If a fountain is not available, disposable paper cups must be used.

d. Refrigeration. Adequate refrigeration for food must be maintained. Refrigerators should be kept at 50 degrees Fahrenheit or below. Drink or milk bottles must not be submerged in liquid. Where food is prepared in the facility, adequate means of washing and sanitizing dishes and utensils shall be provided. All food, especially meats, milk, eggs, and seafood must be obtained from approved sources.

5. Heating

a. An approved heating system for the building must be used. All gas heaters or stoves must be vented to the outside air. Open fireplaces and accessible heaters must be screened or guarded to protect against burn accidents.

6. Safety Aspects

a. Stairwells shall be kept free of obstruction and fire exit doors maintained and in working order, and swing to the egress. All stairways shall be equipped with handrails.

b. Materials harmful to children, such as cleaning materials, cleaning solvents, detergents, and matches shall be kept out of the reach of students. Medication shall be stored separately and in locked facilities.

c. All gas appliances shall be solidly connected with rigid piping and installed in accordance with the rules and regulations of the local building code. All unused gas connections shall be removed or properly capped. No open electric sockets or loose electric wires shall be within the reach of the persons cared for.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5545. Safety and Sanitation

A. There shall be a written staff organization plan and detailed written procedures for meeting all potential emergencies and disasters pertinent to the area, such as fire, severe weather, and missing persons. These plans and procedures shall be posted at suitable locations throughout the facility.

B. Evacuation drills shall be held at least quarterly for each shift of facility personnel, in residential facilities. (Monthly for day-care facilities).

C. Drills shall be held under varied conditions in order to insure that all personnel are trained to perform assigned tasks and that all personnel are familiar with the use of the firefighting equipment in the facility.

D. Evacuation drills shall include actual evacuation of all persons to safe areas during at least one drill each year, on each shift. There shall be special provisions for the evacuation of the physically handicapped. There shall be a written, filed report and evaluation of each evacuation drill.

E. Paint used inside the facility shall be lead-free. Old paint or plaster containing lead shall have been removed, or covered in such manner that is not accessible to those in care.

F. The facility shall be accessible to and functional for those cared for, the staff, and the public. All necessary accommodations must be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities of coordination, as well as other disabilities.

G. Necessary accommodations shall include:

1. the facility grounds must be graded to the same level as the primary entrance so that the building is accessible to the physically handicapped;

2. the width and grade of walks used by handicapped individuals and the public, must be designed so that they can be utilized by the handicapped;

3. if the facility has a parking lot, a properly designated parking space available near the building, allowing room for the physically handicapped to get in and out of an automobile onto a surface suitable for wheeling and walking, must be provided;

4. all ramps shall be designed so that they can be negotiated by individuals in wheelchairs;

5. there shall be a primary entrance usable by persons in wheelchairs;

6. doors used by the handicapped and the public shall be of sufficient width and so equipped and of a weight to permit persons in wheelchairs to open them with a single effort;

7. stairs that may be used by the physically handicapped shall be of a height and design that allows such individuals to negotiate them without assistance;

8. stairs shall be equipped with handrails, at least one of which must extend past the top and bottom steps;

9. there shall be an appropriate number of toilet rooms accessible to and usable by the handicapped;

10. there shall be an appropriate number of water fountains accessible to and usable by the handicapped;

11. there shall be an appropriate number of public telephones accessible to and usable by the handicapped;

12. switches and controls of frequent or essential use shall be within reach of wheelchair users;

13. the facility shall provide appropriate means for the blind to identify rooms, facilities, and hazardous areas;

14. safeguards shall be taken to eliminate hazards for the handicapped;

15. closets assigned to physically handicapped residents shall be accessible to and usable by him;

16. beds assigned to residents in wheelchairs shall be of a height that permits them to get in and out of bed unassisted.

H. The certification agency may waive in existing building, for such periods as deemed appropriate, any of these standards which, if rigidly enforced, would result in unreasonable hardship upon the facility, but only if such waiver will not affect the health and safety of the persons cared for.

I. There shall be records that document strict compliance with the sanitation, health, and environmental safety codes of the state or local authorities having primary jurisdiction over the facility. Written reports of inspections by state or local authorities and records of action taken on their recommendations, shall be kept on file at the facility.

J. The facility shall have an appropriate and written preventive maintenance program. There shall be sufficient personnel to accomplish the required engineering and maintenance functions, either directly or through arrangements. The following standards must be met in addition to the general standards by all facilities caring primarily for mentally retarded persons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5547. Records

A. A complete record shall be maintained for each individual that is adequate for:

1. planning and continuous evaluation of the individual's habilitation and educational program;

2. furnishing documentary evidence of the individual's progress and of this response to his habilitation programs; and

3. protecting the legal rights of the individual facility, and staff.

B. All entries in the individual's records shall be legible, dated, and authenticated by the signature and identification of the person making the entry.

C. Symbols and abbreviations are to be used in record entries only if a legend is provided to explain them.

D. The following information shall be entered in the individual's record at the time of admission to the facility:

1. identification data on the individual; including name, date and place of birth, date of admission, citizenship status, Social Security number, legal status, sex, race, height, weight, color of hair, color of eyes, identifying marks, and a recent photograph;

2. the individual's family history; including the parents' names, their birthdates and birth places, their marital status, their educational backgrounds, religious affiliations, and their employment records;

3. the individual's medical history, both physical and mental, including any prior institutionalization;

4. the type and legal status of the individual's admission to the facility and his legal competency statusl

5. the sources of the individual's support, including Social Security, veterans' benefits, other forms of governmental assistance or insurance;

6. reports on the pre-admission evaluation and any other histories, evaluations, and examinations;

7. the immunization record. If immunization records are not complete, a statement from a physician with reasons for incomplete immunization;

8. written authorizations for field trips, photos, emergency medical assistance, inclusion in research projects, etc.

E. Other information which shall be included in the individual's record is as follows:

1. his grievances, if any;

2. any inventory of his life skills;

3. records of subsequent physical or mental examinations;

4. a copy of his plan and any modifications thereto and an appropriate summary to guide the facility's staff in implementing his program;

5. a monthly summary of his response to his program, prepared by qualified professionals involved in the treatment, including an analysis of the successes and failures of the plan and a recommendation for any modification deemed necessary. A summary of the person's response to his program shall be forwarded at least quarterly to the funding agency;

6. a copy of the plan for the individual which will take effect when he leaves the facility and a summary of the steps that have been taken to implement that program;

7. the history and present status with respect to medication and a record of any seizures, illnesses, treatments thereof, and immunizations;

8. a signed order by the appropriate qualified professional for any physical restraints and a record of all periods of justification and authorization for each;

9. a summary of family visits and contracts, as well as attendance and leaves, from the facility;

10. a description of any extraordinary incident or accident in the facility involving the individual to be entered by a staff member noting his personal knowledge of the incident or accident or other source of information, including any reports of investigations or mistreatment of the individual, as required elsewhere in these standards.

F. At the time of discharge or transfer from the facility, a discharge summary shall be prepared and shall be available to the parents or the funding agency. With the permission of the parent, the discharge summary shall also be forwarded to any facility which the student attends subsequently.

G. The records for each individual shall be readily available to the appropriate qualified professionals and staff members who are directly involved with the particular individual.

H. The parent, tutor, or guardian of the child shall also be permitted access to these records.

I. All information contained in an individual's record shall be considered privileged and confidential.

J. The record is the property of the facility, whose responsibility it is to secure the record against loss, defacement, tampering, or use by unauthorized persons.

K. There shall be written policies governing access to duplication of and dissemination of information from the record.

L. Written consent of the individual, if competent and of the age of majority, or his guardian shall be required for the release of information to persons not otherwise authorized to receive it.

M. The individual's records shall be maintained in an organized manner appropriate to the needs of the facility and the individual served.

N. Records shall be retained for a period consistent with the statute of limitations, of the Department of Health, Education, and Welfare regulations.

O. There shall be available sufficient, appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing, checking, indexing, filing, and prompt retrieval of records and record data.

The following standards must be met in addition to the general standards by all facilities caring primarily for mentally ill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5549. Staff Composition and Organization

A. The psychiatric facility shall be responsible for evaluating and ensuring that the fundamental needs of the persons in care are provided for. To meet this responsibility, the facility shall have available the services of a sufficient number of appropriately qualified mental health professionals. These shall include but are not limited to qualified psychiatrists, qualified psychologists, and qualified social workers. When these qualified professionals are not available on a full-time basis, arrangements shall be made to obtain their services on at least a continuing consulting basis. Their authority and participation shall be such that they are able to assume professional responsibility for supervising and reviewing the needs of the individuals and the services being provided.

B. In addition, there shall be a sufficient number of other qualified mental health professionals and paraprofessionals as necessary to carry out the particular clinical programs provided by the facility and to provide quality clinical services. They include but are not limited to other physicians; child psychiatric nurses; child care workers; educators; speech, hearing, and language specialists; activity therapists, recreational therapists; and vocational counselors. There shall be an adequate number of administrative personnel to provide the necessary support for the administrative and clinical programs.

C. The composition of the staff shall be determined by the facility, based on an assessment of the needs of the persons being served, the facility's goals, the programs provided, and all applicable federal, state, and local laws and

regulations. Factors to be considered in determining appropriate staff composition include (1) number of persons in care, (2) type and severity of handicap, (3) amount of time the persons are in the care of the facility, and (4) the type of program offered by the facility. Many identical or similar services or functions may be rendered competently by individuals of various professionals.

D. The facility shall develop a staffing pattern which shall provide for adequate staff coverage at all times. Special attention shall be paid to the time of day when additional attention or supervision is required, e.g., upon awakening in the morning, during meals, late afternoon play, transitions between activities and bedtime. Staffing on nights, weekends, and holidays shall be adequate to maintain continuity of programs and care. The ratio of direct-care staff shall not, however, be less than that set out in the general standards.

E. There shall be at least one direct care staff person on duty in any area of the facility where persons are present or are expected to be present.

F. The qualified professional staff shall have the responsibility for determining which staff members shall be assigned specific treatment responsibilities. Those individuals, whether professional or paraprofessional, who are assigned specific treatment responsibilities shall have training or experience and demonstrated competence, or they shall be supervised by a professional who is qualified by experience to supervise such specific treatment. Before any member of the staff is assigned responsibility for carrying out any individual or group treatment services, the qualified professional responsible for the person(s) shall develop and implement policies which will ensure adequate supervision where indicated.

G. The residential psychiatric facility shall have coverage by qualified child psychiatrists, psychiatrists or other physicians on a 24 hour basis each day of the week that the facility is in operation. The on-call physician(s) shall be readily available by phone or page. Medical care shall be available to any resident within 30 minutes. Each physician providing coverage shall have had training or experience in caring for those with mental or emotional disorders and shall be familiar with the programs of the facility and the persons residing there.

H. The facility's written staff organization plan shall delineate all clinical staff members who are assigned responsibility, on any shift, for supervision of other staff involved in direct care.

I. The facility shall have an organizational chart which specifies the relationships among the governing body, the director, the administrative staff, the clinical staff, and supporting services; their respective areas of responsibility; the lines of authority involved; and the types of formal liaison between the administrative and clinical staff. The organizational chart shall also reflect medical responsibility for the care of all individuals.

J. The administrative and clinical staff shall be organized to carry out effectively the policies and programs of the facility.

K. The organizational chart shall reflect relationships with affiliate agencies which provide services by these standards.

L. The organizational plan shall be reviewed at least annually.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5551. Records

A. Records shall be written and maintained in order to:

1. serve as a basis for planning for the individual in care;

2. provide a means of communication among all appropriate staff who are involved in the treatment;

3. justify and substantiate the adequacy of the evaluation and to form the basis for the ongoing development of the treatment plan;

4. facilitate continuity of treatment and enable the staff to determine, at a future date, what the individual's condition was at a specific time and what procedures were used;

5. furnish documentary evidence of ordered and supervised treatments, observations of the person's behavior, and responses to treatment;

6. serve as a basis for review, study, and evaluation of the treatment rendered;

7. protect the legal rights of the person, the facility, and staff;

8. provide data, when appropriate, for use in research and education.

B. Where parents or other family members are involved in the treatment program, appropriate documentation shall exist for them although there may not have to be a separate record for each family member involved.

C. While form and detail of the record may vary, all records shall contain all pertinent information and each person's record shall contain at least:

1. identification data and consent forms; when these are unobtainable, reasons shall be noted;

2. source of referral;

3. reason for referral, e.g., chief complaint, presenting problem;

4. record of the complete evaluation;

5. initial formulation and diagnosis based upon the evaluation;

6. written treatment plan. The treatment plan should include:

a. a diagnostic statement including psychiatric diagnosis as well as pertinent social and medical diagnostic information;

b. a statement of identified problems;

c. long and short-term treatment goes related to the problems;

d. treatment modalities to be utilized;

e. identification of persons assigned to carry out treatment;

f. signatures of the physician authorizing the treatment plan:

i. the treatment plan shall be modified as frequently as patient assessment indicates the need for change. It shall be reviewed at least every three months. The treatment plan shall reflect appropriate multi-disciplinary input by the staff, and shall reflect evidence of participation in the planning and approval of the plan by a qualified psychiatrist. Procedures that place the patient at physical risk or cause pain shall require special justification. Rationale for their use shall be specified in the treatment plan and shall be specifically reviewed and approved by a qualified psychiatrist;

7. history and record of all medications prescribed;

8. record of all medications administered by facility staff, including type of medication, dosages, frequency of administration, and person who administered each dose;

9. specific signed physician's authorization for any treatment which may place the individual at physical risk or cause pain (including physical restraint or seclusion) and detailed record of the cause of such treatment;

10. immunization record, record of adverse reactions and sensitivities to specific drugs;

11. documentation of course of treatment and all evaluations and examinations through progress notes;

12. a monthly summary of the person's response to his program prepared by qualified professionals involved in the treatment, including an analysis of the successes and failures of the plan and a recommendation for any modifications deemed necessary;

13. a summary of family visits and contacts as well as attendance and leaves from the facility and all consultations with the family;

14. all other appropriate information obtained from outside sources pertaining to the patient and reports of all extraordinary incidents or accidents;

15. discharge summary; and

16. plan for follow-up and documentation of its implementation.

D. Identification data and consent forms shall include the individual's name, address, home telephone number, date of birth, sex, Social Security number, race, height, color of hair and eyes, identifying marks, next of kin, school and grade or employment information, date initial contact and/or admission to the facility, legal status and legal documents, and other identifying data as indicated.

E. Identifying data on person's family shall include parents' names, their birthdate, their marital status, educational background, religious affiliations, and employment records. Additionally, the names, birthdates, educational and employment records of siblings shall be included where possible.

F. If the child or adolescent is in legal custody of individuals other than his parents, information on his guardian shall be included identical to that on the parent.

G. A recent photograph of the patient shall be included in the record.

H. Other information which shall be included in the individual's record is as follows:

1. the individual's medical history, both physical and mental, including any prior evaluations, examinations, and institutionalizations;

2. the sources of the individual's support, including Social Security, veteran's benefits, other forms of governmental assistance or insurance;

3. written authorization for field trips, photos, emergency medical assistance, inclusion in research projects, etc.;

4. the individual's grievances, if any;

5. an inventory of the individual's life skills.

I. Progress notes shall include regular notations by staff members, consultation reports and signed entries by authorized, identified staff. Notes and entries should contain all pertinent and meaningful observations and information. Progress notes by the clinical staff shall:

1. document a chronological picture of the patient's clinical course;

2. document all treatment rendered to the patient;

3. document the implementation of the treatment plan;

4. describe each change of the individual's conditions, responses of the person and his family to any significant events.

J. The discharge summary shall reflect the general observations and understanding of the individual's condition initially, during treatment, and at the time of discharge, and shall include a final appraisal of his fundamental needs. All relevant discharge diagnosis shall be recorded and coded in the standard nomenclature of the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

K. Entries in the person's records shall be made by all staff having pertinent information regarding the individual. Authors shall clearly sign and date each entry. Signature shall include position title. When mental health trainees are involved in the person's care, documented evidence shall be in the clinical record to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final diagnosis—psychiatric, physical, and social—shall be recorded in full, and without the use of either symbols or abbreviations.

L. A facility shall have written policies and procedures regarding records which shall provide that:

1. all records shall be confidential, current, and accurate;

2. all records are the property of the facility and are maintained for the benefit of the person in care, the staff, and the facility;

3. the facility is responsible for safeguarding the information in the record against loss, defacement, tampering, or use by unauthorized persons;

4. the facility shall protect the confidentiality of information and communications among staff members and those in care;

5. except as required by law, the written consent of the individual, family or other legally responsible parties is required for the release of information;

6. records may be removed from the facility only according to the policies of the facility or as required by law and with authorization for release, appropriate records should be made available to any facility which the person subsequently attends as well as to his parents or legal guardians and to state agencies having responsibility for the care of the person.

M. There shall be evidence that all staff have received training, as part of new staff orientation and with periodic update, regarding the effective maintenance of confidentiality. This refers to discussions regarding patients inside and outside the facility as well as to records. Verbal confidentiality shall be discussed as part of employee training.

N. Appropriate records shall be directly and readily accessible to the staff caring for the person. The facility shall maintain a system of identification and filing to facilitate the prompt location of records.

O. There shall be written policies regarding the permanent storage, disposal/and/or destruction of records.

P. Records shall be retained for a period consistent with the prescriptive period of the state of Louisiana and consistent with the statute of limitations, of the Department of Health, Education, and Welfare regulations.

The following standards must be met in addition to the general standards by all facilities caring primarily for learning disabled persons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§5553. Records

A. A complete record shall be maintained for each individual that is adequate for:

1. planning and continuous evaluation of the individual's habilitation and educational program;

2. furnishing documentary evidence of the individual's progress and of his response to his habilitation program; and

3. protecting the legal rights of the individual facility, and staff.

B. All entries in the individual's record shall be legible, dated, and authenticated by the signature and identification of the person making the entry.

C. Symbols and abbreviations are to be used in record entries only if a legend is provided to explain them.

D. The following information shall be entered in the individual's record at the time of admission to the facility:

1. identification data on the individual, including name, date, and place of birth, date of admission, citizenship status, Social Security number, legal status, sex, race, height, weight, color of hair, color of eyes, identifying marks and a recent photograph;

2. the individual's family history, including the parents' names, their birthdates and birthplaces, their marital status, their educational backgrounds, religious affiliations, and their employment records;

3. the individual's medical history, both physical and mental, including any prior institutionalization;

4. the type and legal status of the individual's admission to the facility and his legal competency status;

5. the sources of the individual's support, including Social Security, veteran's benefits, other forms of governmental assistance or insurance;

6. reports on the pre-admission evaluation and any other histories, evaluations, and examinations;

7. the immunization record. If immunization records are not complete, a statement from a physician with reasons for incomplete immunization;

8. written authorizations for field trips, photos, emergency medical assistance, inclusion in research projects, etc.

E. Other information which shall be included in the individual's record is as follows:

1. his grievance, if any;

2. any inventory of his life skills;

3. records of subsequent physical or mental examinations;

4. a copy of his plan and any modifications thereto and an appropriate summary to guide the facility's staff in implementing his program;

5. a monthly summary of his response to this program, prepared by qualified professionals involved in the treatment, including an analysis of the successes and failures of the plan and a recommendation for any modifications deemed necessary. A summary of the person's response to his program shall be forwarded at least quarterly to the funding agency;

6. a copy of the plan for the individual which will take effect when he leaves the facility and a summary of the steps that have been taken to implement that program;

7. the history and present status with respect to medication and a record of any seizures, illnesses, treatments thereof, and immunizations;

8. a signed order by the appropriate qualified professional for any physical restraints and a record of all periods of justification and authorization for each;

9. a summary of family visits and contacts, as well as attendance and leaves, from the facility;

10. a description of any extraordinary incident or accident in the facility involving the individual to be entered by a staff member noting his personal knowledge of the incident or accident or other source of information, including any reports of investigations of mistreatment of the individual, as required elsewhere in these standards.

11. periodic updating of the information recorded at the time of admission.

F. At the time of discharge or transfer from the facility, a discharge summary shall be prepared and shall be available to the parents or the funding agency. With the permission of the parent, the discharge summary shall also be forwarded to any facility which the student attends subsequently.

G. The records for each individual shall be readily available to the appropriate qualified professionals and staff members who are directly involved with the particular individual.

H. The parent, tutor, or guardian of the child shall also be permitted access to these records.

I. All information contained in an individual's record shall be considered privileged and confidential.

J. The record is the property of the facility, whose responsibility it is to secure the record against loss, defacement, tampering, or use by unauthorized persons.

K. There shall be written policies governing access to duplication of and dissemination of information from the record.

L. Written consent of the individual, if competent and of the age of majority, or his guardian shall be required for the release of information to persons not otherwise authorized to receive it.

M. The individual's words shall be maintained in an organized manner appropriate to the needs of the facility and the individual served.

N. Records shall be retained for a period consistent with the prescriptive period of the state of Louisiana and consistent with the statute of limitations, of the Department of Health, Education, and Welfare regulations.

O. There shall be available sufficient appropriately qualified staff and necessary supporting personnel to facilitate the accurate processing checking, indexing, filing and prompt retrieval of records and record data.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

Chapter 56. Behavioral Health Service Providers

Subchapter A. General Provisions

§5601. Introduction

A. Pursuant to R.S. 40:2151-2161, the Department of Health (LDH) hereby establishes licensing standards for behavioral health service (BHS) providers. The purpose of these Chapters is to provide for the development, establishment and enforcement of statewide licensing standards for the care of clients receiving services from BHS providers, to ensure the maintenance of these standards, and to regulate conditions of these providers through a program of licensure that shall promote safe and adequate treatment of clients of BHS providers.

B. In addition to the requirements stated herein, all licensed BHS providers shall comply with applicable local, state, and federal laws and regulations.

C. The following providers shall be licensed under the BHS provider license:

1. substance abuse/addiction treatment facilities;

2. mental health clinics; and

3. any other entity that meets the definition of a BHS provider.

D. Licensed substance abuse/addiction treatment facilities and mental health clinics have one year from the date of promulgation of the final Rule to comply with all of the provisions herein.

NOTE: Existing licensed substance abuse/addiction treatment facilities and mental health clinics shall be required to apply for a BHS provider license at the time of renewal of their current license(s).

E. The following entities shall be exempt from the licensure requirements for BHS providers:

1. hospitals licensed under R.S. 40:2100 et seq.;

2. crisis receiving centers licensed under 40:2180.11 et seq.;

3. nursing homes licensed under R.S. 40:2009.3 et seq.;

4. psychiatric residential treatment facilities and therapeutic group homes licensed under R.S. 40:2009;

5. facilities or services operated by the federal government;

6. federally qualified health care centers (FQHCs) certified by the federal government;

7. community mental health centers (CMHCs) certified by the federal government, that provide CMHC services allowed by the federal government;

8. home and community-based service (HCBS) providers providing HCBS services under a license issued pursuant to R.S. 40:2120.1 et seq.;

9. an individual licensed mental health professional (LMHP), whether incorporated or unincorporated, or a group practice of LMHPs, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

10. an individual licensed physician, or a group of licensed physicians, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

11. an individual licensed physician assistant, or a group practice of licensed physician assistants, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

12. school-based health clinics/centers that are certified by the Department of Health, Office of Public Health, and enrolled in the Medicaid Program;

13. a health care provider or entity solely providing case management or peer support services, or a combination thereof;

14. a health care provider that meets all of the following criteria:

a. was an accredited mental health rehabilitation provider enrolled in the Medicaid Program as of February 28, 2012;

b. was enrolled with the statewide management organization for the Louisiana Behavioral Health Partnership (LBHP) as of March 1, 2012;

c. maintains continuous, uninterrupted accreditation through an LDH authorized accreditation organization;

d. maintained continuous, uninterrupted enrollment with the statewide management organization for the LBHP, and maintains continuous, uninterrupted enrollment with Medicaid managed care entities as of December 1, 2015;

NOTE: This exemption from licensure encompasses those mental health rehabilitation providers performing mental health rehabilitation services as previously regulated by the Medicaid Mental Health Rehabilitation Program. It does not include a mental health rehabilitation provider that performs other services that were not previously regulated under the Medicaid Mental Health Rehabilitation Program (e.g. addiction services, inpatient services, residential services). If a mental health rehabilitation provider performs behavioral health services in addition to those previously regulated under the Medicaid Mental Health Rehabilitation Program, the provider shall be licensed according to these licensing rules.

15. an individual licensed advanced practice registered nurse, or a group practice of licensed advanced practice registered nurses, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;

16. rural health clinics (RHCs) providing RHC services under a license issued pursuant to R.S. 40:2197; and

17. facilities or services operated by the Department of Public Safety and Corrections, Corrections Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1682 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1379 (July 2017).

§5603. Definitions

Abuse—the infliction of physical or mental injury or the causing of the deterioration of an individual by means including, but not limited to, sexual *abuse*, or exploitation of funds or other things of value to such an extent that his health or mental or emotional well-being is endangered. Injury may include, but is not limited to: physical injury, mental disorientation, or emotional harm, whether it is caused by physical action or verbal statement or any other act or omission classified as abuse by Louisiana law, including, but not limited to, the *Louisiana Children's Code*.

Accredited—the process of review and acceptance by an accreditation body.

Active Client—a client that is being treated for addictive disorders at least every 90 days or a client that is being treated for mental health disorders at least every 180 days.

Addictionologist—a licensed physician who is either of the following:

1. certified by the American Board of Psychiatry and Neurology with a subspecialty in addiction psychiatry; or

2. certified by the American Board of Addiction Medicine.

Addiction Outpatient Treatment Program (ASAM Level I)—an outpatient program that offers comprehensive, coordinated, professionally directed and defined addiction treatment services that may vary in level of intensity and may be delivered in a wide variety of settings. Services are

provided in regularly scheduled sessions of fewer than nine contact hours a week.

Administrative Procedure Act (APA)—R.S. 49:950 et seq.

Admission—the formal acceptance of an individual for assessment and/or therapeutic services provided by the BHS provider.

Adolescent—an individual 13 through 17 years of age.

ADRA—Addictive Disorder Regulatory Authority.

Adult—an individual 18 years of age or older.

Advance Practice Registered Nurse (APRN)—a licensed registered nurse who meets the criteria for an *advanced practice registered nurse* as established by the Louisiana State Board of Nursing and is licensed as an *APRN* and in good standing with the Louisiana State Board of Nursing.

Ambulatory Detoxification with Extended on-site Monitoring (ASAM Level II-D)—an organized outpatient addiction treatment service that may be delivered in an office setting or health care or behavioral health services provider by trained clinicians who provide medically supervised evaluation, detoxification and referral services. The services are designed to treat the client's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the client's entry into ongoing treatment and recovery. The services are provided in conjunction with intensive outpatient treatment services (level II.1).

ASAM—American Society of Addiction Medicine.

Authorized Licensed Prescriber—a physician, physician assistant, nurse practitioner, or medical psychologist licensed in the state of Louisiana and with full prescriptive authority who is authorized by the BHS provider to prescribe treatment to clients of the specific BHS provider at which he/she practices.

Behavioral Health Service (BHS) Provider or *Provider*—a facility, agency, institution, person, society, corporation, partnership, unincorporated association, group, or other legal entity that provides behavioral health services, presents itself to the public as a *provider* of behavioral health services.

Behavioral Health Services—mental health services, substance abuse/addiction treatment services, or a combination of such services, for adults, adolescents and children. Such services may be provided in a residential setting, in a clinic setting on an outpatient basis, or in a home or community setting.

Building and Construction Guidelines—structural and design requirements applicable to the BHS provider which does not include occupancy requirements.

Business Location—the licensed location and office of the BHS provider that provides services only in the home and/or community.

Case Management—the coordination of services, agencies, resources, or people within a planned framework of action toward the achievement of goals established in the treatment plan that may involve liaison activities and collateral contracts with other providers.

Certified Addiction Counselor (CAC)—pursuant to R.S. 37:3387.1, any person who, by means of his specific knowledge acquired through formal education and practical experience, is qualified to provide addictive disorder counseling services and is certified by the ADRA as a *CAC*. The *CAC* may not practice independently and may not render a diagnostic impression.

Change of Ownership (CHOW)—the sale or transfer whether by purchase, lease, gift or otherwise of a BHS provider by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a BHS provider or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the BHS provider.

Child—an individual under the age of 13.

Client—any person who has been accepted for treatment or services, including rehabilitation services, furnished by a provider licensed pursuant to this Chapter.

Client Education—information that is provided to clients and groups concerning alcoholism and other drug abuse, positive lifestyle changes, mental health promotion, suicide prevention and intervention, safety, recovery, relapse prevention, self-care, parenting, and the available services and resources. Educational group size is not restricted and may be offered as an outreach program.

Client Record—a single complete record kept by the provider which documents all treatment provided to the client and actions taken by the provider on behalf of the client. The record may be electronic, paper, magnetic material, film or other media.

Clinical Services—treatment services that include screening, assessment, treatment planning, counseling, crisis mitigation and education.

Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)—a residential program that offers continuous observation, monitoring, and treatment by clinical staff designed to treat clients experiencing substance-related disorders who have clinically-relevant social and psychological problems, such as criminal activity, impaired functioning and disaffiliation from mainstream values, with the goal of promoting abstinence from substance use and antisocial behavior and affecting a global change in clients' lifestyles, attitudes and values.

Clinically Managed Low Intensity Residential Treatment Program (ASAM Level III.1)—a residential program that offers at least five hours a week of a combination of low-intensity clinical and recovery-focused services for substance-related disorders. Services may include individual, group and family therapy, medication management and medication education, and treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility

and reintegrating the client into the worlds of work, education and family life (e.g., halfway house).

Clinically Managed Medium-Intensity Residential Treatment Program (ASAM Level III.3)—a residential program that offers at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services in a structured recovery environment to support recovery from substance-related disorders; is frequently referred to as extended or long term care.

Clinically Managed Residential Detoxification or Social Detoxification (ASAM LEVEL III.2D)—an organized residential program utilizing 24 hour active programming and containment provided in a non-medical setting that provides relatively extended, sub-acute treatments, medication monitoring observation, and support in a supervised environment for a client experiencing non-life threatening withdrawal symptoms from the effects of alcohol/drugs and impaired functioning and who is able to participate in daily residential activities.

Community Psychiatric Support and Treatment (CPST)—goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the client's individualized treatment plan. These supports and interventions are designed to improve behavioral health outcomes by utilizing evidence-based driven care.

Compulsive Gambling—persistent and recurrent maladaptive gambling behavior that disrupts personal, family, community, or vocational pursuits, and is so designated by a court, or diagnosed by a licensed physician or LMHP.

Controlled Dangerous Substance—any substance defined, enumerated, or included in federal or state statute or regulations or any substance which may hereafter be designated as a *controlled dangerous substance* by amendment of supplementation of such regulations or statute. The term shall not include distilled spirits, wine, malt beverages, or tobacco.

Core Services—the essential and necessary elements required of every BHS provider, when indicated, including assessment, orientation, client education, consultation with professionals, counseling services, referral, crisis mitigation, medication management, rehabilitation services, and treatment.

Counselor in Training (CIT)—a person currently registered with the Addictive Disorder Regulatory Authority (ADRA) and pursuing a course of training in substance abuse/addiction treatment counseling which includes educational hours, practicum hours, and direct, on-site supervision.

Crime of Violence—an offense listed as a *crime of violence* in R.S. 14:2.

Crisis Intervention—face to face intervention provided to a client who is experiencing a psychiatric crisis. The services are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation with referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

Crisis Mitigation Services—a BHS provider's assistance to clients during a crisis that provides 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services.

Deemed Status—following the issuance of an initial license, the department's acceptance of the BHS provider's accreditation as compliance with this Chapter in lieu of on-site licensing surveys.

Department—the Louisiana Department of Health (LDH) or any office or agency thereof designated by the secretary to administer the provisions of this Chapter.

Dependent Children—any child/adolescent under the age of 18 that relies on the care of a parent or legal guardian.

Diagnosis—the act of identifying a disease or behavioral health disorder as defined by the current version of the Diagnostic and Statistical Manual (DSM). A *diagnosis* is determined by a qualified LMHP or physician based on comprehensive assessment of physical evidence (if related to diagnosis), signs and symptoms, clinical and psycho-social evidence, and individual/family history.

Direct Care Staff—any member of the staff, including an employee, contractor or volunteer, that provides the services delineated in the comprehensive treatment plan. Food services, maintenance, and clerical staff are not considered as *direct care staff*.

Disaster or *Emergency*—a local, community-wide, regional or statewide declared health crisis or event.

Dispense or *Dispensing*—the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient. *Dispense* necessarily includes a transfer of possession of a drug or device to the patient or the patient's agent.

Dispensing Physician—any physician in the state of Louisiana who is registered as a *dispensing physician* with the Louisiana State Board of Medical Examiners and who dispenses to his/her patients any drug, chemical, or medication, except a bona fide medication sample.

Division of Administrative Law (DAL)—the Louisiana Department of State Civil Service, Division of Administrative Law or its successor.

Exploitation—act or process to use (either directly or indirectly) the labor or resources of an individual or organization for monetary or personal benefit, profit, or gain.

Facility Need Approval (FNA)—the letter of approval from the Office of Behavioral Health which is required for licensure applicants for opioid treatment programs prior to

applying for a BHS provider license or the letter of approval from the Facility Need Review Committee within the department which is required for licensure applicants for PSR or CPST services prior to applying for a BHS provider license.

FDA—the United States Food and Drug Administration.

Financial Viability—the provider seeking licensure is able to provide verification and continuous maintenance of all of the following pursuant to R.S. 40:2153:

1. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

2. general and professional liability insurance of at least $500,000; and

3. workers' compensation insurance.

Geographic Service Area—the geographic area and location that a BHS provider's license allows services to be provided; for purposes of this licensing rule, geographic service area shall be as follows:

1. for providers operated by a human service district or authority, the geographic service area shall be the parishes and jurisdiction of the district or authority as defined in statute; and

2. for all other BHS providers, the geographic service area shall be the parish in which that provider has its business office and any contiguous parishes.

Grievance—a formal or informal written or verbal complaint that is made to the provider by a client or the client's family or representative regarding the client's care, abuse or neglect when the complaint is not resolved by staff present at the time of the complaint.

Health Standards Section (*HSS*)—the licensing and certification section of the Department of Health.

High Risk Behavior—includes substance abuse, gambling, violence, academic failure, delinquency behavior, and mental health issues such as depression, anxiety, and suicidal ideations.

Human Services District or Authority—an existing or newly created local governmental entity with local accountability and management of behavioral health and developmental disabilities services as well as any public health or other services contracted to the district by the department.

Human Services Field—an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior.

Intensive Outpatient Treatment Program (*ASAM Level II.1*)—professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting, including individual, group, family counseling and psycho-education on recovery as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis mitigation coverage and orientation to community-based support groups. Services may be offered during the day, before or after work or school, in the evening or on a weekend, and the program shall provide nine or more hours of structured programming per week for adults and six or more hours of structured programming per week for children/adolescents.

LDH Authorized Accreditation Organization—any organization authorized by LDH to accredit behavioral health providers.

Level of Care—intensity of services provided by the provider.

Licensed Addiction Counselor (LAC)—any person who, by means of his specific knowledge, acquired through formal education and practical experience, is qualified to provide addiction counseling services and is licensed by the ADRA as a licensed addiction counsel or pursuant to R.S. 37:3387.

Licensed Clinical Social Worker (LCSW)—a person duly licensed to independently practice clinical social work under R.S. 37:2702 et seq.

Licensed Marriage and Family Therapist (LMFT)—a person to whom a license has been issued and who is licensed to perform the professional application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals, couples and families. An *LMFT* is not permitted to diagnose a behavioral health disorder under his/her scope of practice under state law.

Licensed Mental Health Professional (LMHP)—an individual who is currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts and the individual's professional license, as one of the following:

1. medical psychologist;

2. licensed psychologist;

3. licensed clinical social worker (LCSW);

4. licensed professional counselor (LPC);

5. licensed marriage and family therapist (LMFT);

6. licensed addiction counselor (LAC);

7. advance practice registered nurse (APRN); or

8. licensed rehabilitation counselor (LRC).

Licensed Professional Counselor—any person who holds himself out to the public for a fee or other personal gain, by any title or description of services incorporating the words "*licensed professional counselor*" or any similar term, and who offers to render professional mental health counseling services denoting a client-counselor relationship in which the counselor assumes responsibility for knowledge, skill and ethical considerations needed to assist individuals, groups, organizations, or the general public, and who implies that he is licensed to practice mental health counseling.

Licensed Psychologist—any person licensed as a psychologist pursuant to R.S. 37:2352.

Licensed Rehabilitation Counselor (LRC)—any person who holds himself out to the public, for a fee or other personal gain, by any title or description of services incorporating the words "licensed professional vocational rehabilitation counselor" or any similar terms, and who offers to render professional rehabilitation counseling services denoting a client-counselor relationship in which the counselor assumes responsibility for knowledge, skill, and ethical considerations needed to assist individuals, groups, organizations, or the general public, and who implies that he is licensed to engage in the practice of rehabilitation counseling. An *LRC* is also known as a licensed professional vocational rehabilitation counselor. An *LRC* is not permitted to provide assessment or treatment services for substance abuse/addiction, mental health or co-occurring disorders under his/her scope of practice under state law.

Master's-Prepared—an individual who has completed a master's degree in social work or counseling, but has not met the requirements for licensing by the appropriate state board.

Medical Psychologist—a licensed psychological practitioner who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the Louisiana State Board of Medical Examiners.

Medically Managed Residential Detoxification (Medically Supported Detoxification) (ASAM Level III.7D)—a residential program that provides 24-hour observation, monitoring and treatment delivered by medical and nursing professionals to clients whose withdrawal signs and symptoms are moderate to severe and thus require residential care, but do not need the full resources of an acute care hospital.

Medically Monitored Intensive Residential Treatment Program (ASAM Level III.7)—a residential program that provides a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment to clients with co-occurring psychiatric and substance disorders whose disorders are so severe that they require a residential level of care but do not need the full resources of an acute care hospital. The program provides 24 hours of structured treatment activities per week, including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, and habilitative and rehabilitation services.

Medication Administration—preparation and/or giving of a legally prescribed individual dose of medication to a client by qualified staff including observation and monitoring of a client's response to medication.

Mental Health Clinic—an entity through which outpatient behavioral health services are provided, including screening, diagnosis, management or treatment of a mental disorder, mental illness, or other psychological or psychiatric condition or problem and 24-hour emergency services that are provided either directly or through formal affiliation with other agencies by an interdisciplinary team of mental health professionals and subordinates in accordance with a plan of treatment or under the direction of a psychiatrist or another qualified physician with psychiatric consultation.

Mental Health Rehabilitation (MHR)—an outpatient healthcare program provider of any psychosocial rehabilitation (PSR), crisis intervention (CI) and/or community psychiatric support and treatment (CPST) services that promotes the restoration of community functioning and well-being of an individual diagnosed with a mental health or mental or emotional disorder. The MHR provider utilizes evidence based supports and interventions designed to improve individual and community outcomes.

Mental Health Rehabilitation Services (*MHRS*)—outpatient services for adults with serious mental illness and children with emotional/behavioral disorders which are medically necessary to reduce the disability resulting from mental illness and assist in the recovery and resiliency of the recipient. These services are home and community-based and are provided on an as needed basis to assist recipients in coping with the symptoms of their illness. The intent of MHRS is to minimize the disabling effects on the individual's capacity for independent living and to prevent or limit the periods of inpatient treatment.

Mental Health Service—a service related to the screening, diagnosis, management, or treatment of a mental disorder, mental illness, or other psychological or psychiatric condition or problem.

Minor—any person under the age of 18.

Mothers with Dependent Children Program or *Dependent Care Program*—a program that is designed to provide substance abuse/addiction treatment to mothers with dependent children who remain with the parent while the parent is in treatment.

Neglect—the failure to provide the proper or necessary medical care, nutrition or other care necessary for a client's well-being or any other act or omission classified as *neglect* by Louisiana law.

Non-Ambulatory—unable to walk or accomplish mobility without assistance.

Non-Prescription Medication—medication that can be purchased over-the-counter without an order from a licensed practitioner.

Nurse—any registered *nurse* licensed and in good standing with the Louisiana State Board of Nursing or any practical *nurse* licensed and in good standing with the Louisiana State Board of Practical Nurse Examiners.

OBH—the LDH Office of Behavioral Health.

Off-Site—a parent facility's alternate program that provides behavioral health services on a routine basis in a geographic location that:

1. is detached from the parent provider;

2. is owned by, leased by or donated or loaned to the parent provider for the purpose of providing behavioral health services; and

3. has a sub-license issued under the parent facility's license.

OHSEP—Office of Homeland Security and Emergency Preparedness.

On Call—immediately available for telephone consultation and less than one hour from ability to be on duty.

On Duty—scheduled, present and awake at the site to perform job duties.

OPH—the LDH Office of Public Health.

Opioid Treatment Program—a program that engages in medication-assisted opioid treatment of clients with an opioid agonist treatment medication.

OSFM—the Louisiana Department of Public Safety and Corrections, Office of State Fire Marshal.

Outpatient Clinic—a BHS provider that provides behavioral health services on-site at the provider's geographic location but is not a residential provider.

Outpatient Services—behavioral health services offered in an accessible non-residential setting to clients whose physical and emotional status allows them to function in their usual environment.

Parent Facility—the main building or premises of a behavioral health service provider where services are provided on-site and administrative records are maintained.

Partial Hospital Program (*PHP-ASAM Level II.5*)—an organized outpatient service that delivers treatment to adolescents and adults. This level encompasses services that meet the multidimensional instability and complex needs of people with addiction and co-occurring conditions which do not require 24-hour care.

Physical Environment—the BHS provider's licensed exterior and interior space where BH services are rendered.

Physician—an individual who is currently licensed and in good standing in the state of Louisiana to practice medicine in Louisiana and who is acting within the scope of all applicable state laws and the individual's professional license.

Physician Assistant—an individual who is currently approved and licensed by and in good standing with the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed by and registered with the Louisiana State Board of Medical Examiners to supervise a *physician assistant*, and who is acting within the scope of all applicable state laws and the individual's professional license.

Plan Review—the process of obtaining approval for construction plans and specifications for the BHS provider.

Prescription Medication—medication that requires an order from a licensed practitioner and that can only be dispensed by a pharmacist on the order of a licensed practitioner or a dispensing physician and requires labeling in accordance with R.S. 37:1161 et seq.

Professional Board(s)—the entity responsible for licensure or certification for specific professions (e.g., nursing, counselors, social workers, physicians, etc.).

Psychosocial Rehabilitation (PSR)—face to face intervention with the client designed to assist with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with his/her mental illness.

Qualifying Experience—experience used to qualify for any position that is counted by using 1 year equals 12 months of full-time work.

Recovery Focused Services—services such as life skills training, job readiness, self-help meetings, parenting skills, training and recreation activities that should be coordinated with clinical services.

Referral—the BHS provider identifies needed services not provided by the provider and assists the client/family to optimally utilize the available support systems and community resources to meet the client's needs.

Registered Addiction Counselor (*RAC*)—pursuant to R.S. 37:3387.2, any person who, by means of his/her specific knowledge acquired through formal education and practical experience, is qualified to provide addictive disorder counseling services and is registered by the ADRA as a RAC. The RAC may not practice independently and may not render a diagnostic impression.

Rehabilitative Services—services intended to promote the maximum reduction of symptoms and/or restoration of the client to his/her best age-appropriate functional level according to an individualized treatment plan.

Residential Treatment Program—a planned regimen of 24-hour professionally-directed evaluation, observation, monitoring and treatment of behavioral health conditions according to a treatment plan.

Secretary—the secretary of the Department of Health or his/her designee.

Self-Administration—the client's preparation and direct application of a medication to his/her own body by injection, inhalation, ingestion or any other means.

Shelter in Place—a provider's decision to stay on-site rather than evacuate during a disaster or emergency.

Site/Premises—a single identifiable geographical location owned, leased, or controlled by a provider where any element of treatment is offered or provided. Multiple buildings may be contained in the license only if they are connected by walk-ways and not separated by public streets, or have different geographical addresses.

Staff—individuals who provide services for the provider including employees, contractors, consultants and volunteers.

State Opioid Authority (SOA)—the agency or other appropriate officials designated by the governor or his/her designee, to exercise the responsibility and authority within the state for governing the treatment of opiate addiction with an opioid drug. The *state opioid authority* for the state of Louisiana is the Office of Behavioral Health.

Stock Medication—any medication obtained through a pharmacy or pharmacy contract that is not designated for a specific client.

Substance Abuse/Addiction Treatment Service—a service related to the screening, diagnosis, management, or treatment for the abuse of or addiction to controlled dangerous substances, drugs or inhalants, alcohol, problem gambling or a combination thereof; may also be referred to as *substance use disorder service*.

Take-Home Dose(*s*)—a dose of opioid agonist treatment medication dispensed by a dispensing physician or pharmacist to a client for unsupervised use, including for use on Sundays, state and federal holidays, and emergency closures per LDH directive.

Therapeutic Counseling Services or Sessions—individual or group therapeutic treatment that teaches skills to assist clients, families, or groups in achieving objectives through exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions and decision making and problem solving. *Therapeutic counseling sessions* consist of no more than 15 clients and last at least 15 minutes.

Treatment—the application of planned procedures to identify and change patterns of behaviors that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

Treatment Plan—the provider's documentation of the client's issues, needs, ongoing goals and objectives of care based on admission information and updated based on the client's response to treatment.

Unlicensed Professional (UP)—for purposes of this Rule, any unlicensed behavioral health professional who cannot practice independently or without supervision by a LHMP. This includes but is not limited to CACs, RACs and unlicensed addiction counselors, social workers or psychologists.

Volunteer—an individual who offers services on behalf of the provider for the benefit of the provider willingly and without pay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1682 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1380 (July 2017), LR 46:587 (April 2020).

Subchapter B. Licensing

§5605. General Provisions

A. All BHS providers shall be licensed by the LDH. It shall be unlawful to operate as a BHS provider without a license issued by the department.

B. A BHS provider license authorizes the provider to provide behavioral health services.

C. A BHS provider license shall:

1. be issued only for the person/entity and premises named in the license application;

2. be valid only for the BHS provider to which it is issued and only for one geographic address of that provider approved by LDH;

3. be valid for up to one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;

4. expire on the expiration date listed on the license, unless timely renewed by the BHS provider;

5. be invalid if sold, assigned, donated or transferred, whether voluntary or involuntary;

6. be posted in a conspicuous place on the licensed premises at all times;

7. be valid for only one geographic service area; and

8. enable the BHS provider to render delineated behavioral health services within its geographic service area as defined in Section 5603.

D. To be considered operational and retain licensed status, the BHS provider shall meet the following applicable operational requirements.

1. A BHS provider providing on-site services shall:

a. have established operational hours for a minimum of 20 hours per week, as indicated on the license application or change notification approved by LDH;

b. have services available and the required direct care staff on duty at all times during operational hours to meet the needs of the clients;

c. be able to accept referrals during operational hours; and

d. at any time that the BHS provider has an interruption in services or a change in the licensed location due to an emergency situation, the provider shall notify the HSS no later than the next business day.

2. A BHS provider providing services only in the home and community shall:

a. have a business location which conforms to the provisions of §5691.B of this Chapter;

b. have at least one employee on duty at the business location during stated hours of operation; and

c. have direct care staff and professional services staff employed and available to be assigned to provide services to persons in their homes or in the community upon referral for services.

E. The licensed BHS provider shall abide by any state and/or federal law, rule, policy, procedure, manual or memorandum pertaining to BHS providers.

F. Provider Names. A BHS provider is prohibited from using:

1. the same name as another provider;

2. a name that resembles the name of another provider;

3. a name that may mislead the client or public into believing it is owned, endorsed or operated by the state of Louisiana when it is not.

G. Off-Sites. A licensed BHS provider may have an off-site location with the approval of HSS that meets the following requirements.

1. The off-site may share a name with the parent facility if a geographic indicator (e.g. street, city or parish) is added to the end of the off-site name.

2. Each off-site shall be licensed as an off-site under the parent facility's license.

3. The off-site shall have written established operating hours.

4. The off-site shall operate within the same geographic service area, as defined in Section 5603, as the parent facility.

5. A residential off-site shall be reviewed under the plan review process.

6. An initial survey may be required prior to opening a residential off-site.

7. An off-site shall have staff to comply with all requirements in this Chapter and who are present during established operating hours to meet the needs of the clients.

8. Personnel records and client records may be housed at the parent facility.

9. Clients who do not receive all treatment services at an off-site may receive the services at the parent facility or be referred to another licensed provider that provides those services.

10. The off-site may offer fewer services than the parent facility and/or may have less staff than the parent facility.

11. The off-site together with the parent facility provides all core functions of a BHS provider and meets all licensing requirements of a BHS provider.

H. Plan Review

1. Plan review is required for outpatient clinics and residential BHS provider locations where direct care services or treatment will be provided, except for the physical environment of a substance abuse/addiction treatment facility or licensed mental health clinic at the time of this Chapter's promulgation.

2. Notwithstanding the provisions in this Section, any entity that will operate as a BHS provider and is required to go through plan review shall complete the plan review process and obtain approval for its construction documents in accordance with:

a. R.S. 40:1574;

b. the current *Louisiana Administrative Code* (LAC) provisions;

c. OSFM requirements; and

d. the requirements for the provider's physical environment in Subchapter H of this Chapter.

3. Any change in the type of the license shall require review for requirements applicable at the time of licensing change.

4. Upon plan review approval, the provider shall submit the following to the department:

a. a copy of the final construction documents approved by OSFM; and

b. OSFM's approval letter.

I. Waivers

1. The secretary of the LDH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of or otherwise required under the provisions of the *LAC Title 51, Public Health Sanitary Code* or the OSFM.

2. In order to request a waiver, the provider shall submit a written request to HSS that demonstrates:

a. how client safety and quality of care are not compromised by the waiver;

b. the undue hardship imposed on the provider if the waiver is not granted; and

c. the provider's ability to completely fulfill all other requirements of service.

3. The department will make a written determination of each waiver request.

4. Waivers are not transferable in a change of ownership or geographic change of location, and are subject to review or revocation upon any change in circumstances related to the waiver.

J. The BHS provider shall maintain and make available to the department any information or records related to compliance with this Chapter.

K. The BHS provider shall permit designated representatives of the department, in performance of their duties, to:

1. inspect all areas of the BHS provider's operations; and

2. conduct interviews with any provider staff member, client or other person as necessary.

L. An owner, officer, member, manager, administrator, clinical director, medical director, managing employee or clinical supervisor is prohibited from being a BHS provider, who has been convicted of or entered a guilty or nolo contendere plea to a felony related to:

1. violence, abuse or neglect against a person;

2. sexual misconduct and/or any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

3. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

4. the misappropriation of property belonging to another person;

5. a crime of violence;

6. an alcohol or drug offense, unless the offender has:

a. completed his/her sentence, including the terms of probation or parole, at least five years prior to the ownership of or working relationship with the provider; and

b. been sober per personal attestation for the last two years;

7. possession or use of a firearm or deadly weapon;

8. Medicare or Medicaid fraud; or

9. fraud or misappropriation of federal or state funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2162.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1687 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1380 (July 2017), LR 46:588 (April 2020).

§5606. License Restrictions

A. A BHS provider shall provide only those services or modules:

1. specified on its license; and

2. only to clients residing in the provider's designated geographic service area or at the provider's licensed location.

B. A BHS provider may apply for a waiver from the Health Standards Section (HSS) to provide home or community services to a client residing outside of the provider's designated geographic service area only under the following conditions:

1. A waiver may be granted by HSS if there is no other BHS provider in the client's service area that is licensed and that has the capacity to provide the required services to the client.

2. The provider shall submit a written waiver request to HSS.

3. The written waiver request shall be specific to one client and shall include the reasons for which the waiver is requested.

4. HSS shall approve or deny the waiver request within 30 days of receipt of the written waiver request, and shall provide written notice to the provider via mail or electronic transmission (email or facsimile).

5. The provider shall notify the client of HSS's decision.

C. The provider shall not provide services to a client residing outside of the provider's designated geographic service area unless the provider has received a written waiver request approval from HSS.

D. There is no appeal from a decision by HSS to deny a waiver request under this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2162.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 46:588 (April 2020).

§5607. Initial Licensure Application Process

A. Any entity, organization or person seeking to operate as a BHS provider shall submit a completed initial license application packet to the department for approval. Initial BHS provider licensure application packets are available from HSS.

B. The completed initial licensing application packet shall include:

1. a completed BHS provider licensure application;

2. the non-refundable licensing fee established by statute;

3. the plan review approval letter from OSFM, if applicable;

4. the on-site inspection report with approval for occupancy by the OSFM, if applicable;

5. the health inspection report with recommendation for licensure from the Office of Public Health;

6. a current (within 90 days prior to the submission of the application packet) statewide criminal background check, including sex offender registry status, on all owners and managing employees;

7. except for governmental entities, proof of financial viability;

8. an organizational chart and names, including position titles of key administrative personnel and governing body;

9. a legible floor sketch or drawing of the premises to be licensed;

10. a letter of intent detailing the type of BHS provider operated by the licensee and the types of services or specializations that will be provided by the BHS provider (e.g. addiction treatment program, mental health program, residential provider, outpatient provider, opioid treatment program);

11. if operated by a corporate entity, such as a corporation or a limited liability company, current proof of registration and status with the Louisiana Secretary of State; and

12. any other documentation or information required by the department for licensure including, but not limited to, documentation for opioid treatment programs, such as a copy of the OBH FNA letter.

C. Deadline for Submitting Initial Licensure Application for Unlicensed Agencies

1. Any unlicensed agency that is a provider of any psychosocial rehabilitation, crisis intervention and/or community psychiatric support and treatment services prior to the promulgation of this Rule and is required to be licensed as a BHS provider has 180 days from the promulgation of this Rule to submit an initial licensing application packet to HSS.

2. Any such unlicensed agency may continue to operate without a license during the licensing process until the department acts upon the initial license application and any and all appeal processes associated with the initial licensure is complete or the delay for taking an appeal has expired, whichever is later.

3. The department has the authority to issue a cease and desist order and pursue legal action for failure to comply with the deadline for submitting an initial licensure application. The cease and desist order shall require immediate discharge of all current clients and no new clients shall be admitted.

D. If the initial licensing packet is incomplete, the applicant shall:

1. be notified of the missing information; and

2. have 90 days from receipt of the notification to submit the additional requested information; if not submitted, the application shall be closed.

E. Once the initial licensing application is approved by the department, notification of such approval shall be forwarded to the applicant.

F. The applicant shall notify the department of initial licensing survey readiness within the required 90 days of receipt of application approval. If an applicant fails to notify the department of initial licensing survey readiness within 90 days, the application shall be closed.

G. If an initial licensing application is closed, an applicant who seeks to operate as a BHS provider shall submit:

1. a new initial licensing packet;

2. non-refundable licensing fee; and

3. facility need approval, if applicable

H. Applicants shall be in compliance with all applicable federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the BHS provider will be issued an initial license to operate.

I. A BHS provider is prohibited from providing behavioral health services to clients during the initial application process and prior to obtaining a license, unless the applicant qualifies as one of the following facilities:

1. a licensed mental health clinic;

2. a licensed substance abuse/addiction treatment facility; or

3. an agency that is a provider of psychosocial rehabilitation, community psychiatric support and treatment, and/or crisis intervention services.

J. Off-Sites. In order to operate an off-site, the provider shall submit:

1. a request for opening an off-site location;

2. a completed application, including established operational hours;

3. payment of applicable fees;

4. current on-site inspection reports from OSFM and OPH; and

5. for any residential off-site, plan review approval from OSFM.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1688 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1381 (July 2017).

§5609. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial licensing survey shall be announced and conducted on-site to ensure compliance with the licensing laws and standards.

B. In the event that the initial licensing survey finds that the provider is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department may issue a full license to the provider.

C. In the event that the initial licensing survey finds that the provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, that

present a potential threat to the health, safety, or welfare of the clients, the department shall deny the initial license. If the department denies an initial license, the applicant for a BHS provider license shall discharge the clients receiving services.

D. In the event that the initial licensing survey finds that the BHS provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, and the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients, the department may:

1. issue a provisional initial license for a period not to exceed six months; and/or

2. conduct a follow-up survey following the initial licensing survey to ensure correction of the deficiencies.

a. Follow-up surveys to the initial licensing surveys are unannounced surveys.

b. If all deficiencies are corrected on the follow-up survey, a full license may be issued.

c. If the provider fails to correct the deficiencies, the initial license may be denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1689 (September 2015).

§5611. Types of Licenses

A. The department has the authority to issue the following types of licenses.

1. Initial License

a. The department may issue a full license to the BHS provider when the initial licensing survey indicates the provider is compliant with:

i. all licensing laws and regulations;

ii. all other required statutes, laws, ordinances, rules, regulations; and

iii. fees.

b. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, or suspended.

2. Provisional Initial License. The department may issue a provisional initial license to the BHS provider when the initial licensing survey finds that the BHS provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients.

a. The provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

b. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license may be issued.

c. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a client are cited, the provisional license may expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and the appropriate licensing fees.

3. Renewal License. The department may issue a renewal license to a licensed BHS provider that is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended.

4. Provisional License. The department may issue a provisional license to a licensed BHS provider for a period not to exceed six months.

a. A provisional license may be issued for one of the following reasons:

i. more than five deficiencies cited during any one survey;

ii. four or more validated complaints in a consecutive 12-month period;

iii. a deficiency resulting from placing a client at risk for serious harm or death;

iv. failure to correct deficiencies within 60 days of notification of such deficiencies or at the time of a follow-up survey; or

v. failure to be in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

b. The department may extend the provisional license for an additional period not to exceed 90 days in order for the provider to correct the deficiencies.

c. The provider shall:

i. submit a plan of correction to the department for approval; and

ii. correct all noncompliance or deficiencies prior to the expiration of the provisional license.

d. The department may conduct a follow-up survey, either on-site or by administrative review, of the BHS provider prior to the expiration of the provisional license.

e. If the follow-up survey determines that the BHS provider has corrected the deficiencies and has maintained compliance during the period of the provisional license, the department may issue a license that will expire on the expiration date of the most recent renewal or initial license.

f. The provisional license may expire if:

i. the provider fails to correct the deficiencies by the follow-up survey; or

ii. the provider is cited with new deficiencies at the follow-up survey indicating a risk to the health, safety or welfare of a client.

g. If the provisional license expires, the provider shall be required to begin the initial licensing process by submitting the following:

i. a new initial licensing application packet;

ii. a non-refundable licensing fee; and

iii. facility need approval, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1690 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1381 (July 2017).

§5613. Changes in Licensee Information or Personnel

A. A BHS provider shall report in writing to HSS within five days of any change of the following:

1. BHS provider's entity name;

2. business name;

3. mailing address;

4. telephone number; or

5. email address of the administrator.

B. Any change to the BHS provider's name or doing business as name requires the nonrefundable fee for the issuance of an amended license with the new name.

C. A BHS provider shall report in writing to the HSS any change in the provider's key administrative personnel within five days of the change.

1. Key administrative personnel include the following:

a. administrator;

b. medical director;

c. clinical director; and

d. clinical supervisor.

2. The BHS provider's written notice to HSS shall include the individual's:

a. name;

b. hire date; and

c. qualifications.

D. Change of Ownerships

1. A BHS provider shall report a change of ownership (CHOW) in writing to HSS within five days following the change. The new owner shall submit the following:

a. the legal CHOW document;

b. all documents required for a new license; and

c. the applicable nonrefundable licensing fee.

2. A BHS provider that is under license revocation, provisional licensure or denial of license renewal may not undergo a CHOW.

3. If there are any outstanding fees, fines or monies owed to the department by the existing licensed entity, the CHOW will be suspended until payment of all outstanding amounts.

4. Once all application requirements are completed and approved by the department, a new license may be issued to the new owner.

E. Change in Geographic Location

1. A BHS provider that seeks to change its geographic location shall submit:

a. written notice to HSS of its intent to relocate;

b. a plan review request, if applicable;

c. a new license application;

d. the nonrefundable license fee; and

e. other applicable licensing requirements.

2. In order to receive approval for the change of geographic location, the BHS provider shall have:

a. plan review approval, if required;

b. approval from the OSFM and the OPH recommendation for licensure of the new geographic location;

c. an approved license application packet;

d. compliance with other applicable licensing requirements; and

e. an on-site licensing survey prior to relocation of the provider.

3. Upon approval of the requirements for a change in geographic location, the department may issue a new license to the BHS provider.

F. Any request for a duplicate license shall be accompanied by the required fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1690 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1381 (July 2017).

§5615. Renewal of License

A. A BHS provider license shall expire on the expiration date listed on the license, unless timely renewed by the BHS provider.

B. To renew a license, the BHS provider shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the

current license. The license renewal application packet shall include:

1. the license renewal application;

2. a current OSFM report (for on-site and residential services);

3. a current OPH inspection report (for on-site and residential services);

4. the non-refundable license renewal fee as established by statute;

5. except for governmental entities, proof of financial viability;

6. payment of any outstanding fees, fines or monies owed to the department; and

7. any other documentation required by the department.

C. The department may perform an on-site survey and inspection of the provider upon renewal.

D. Failure to submit a completed license renewal application packet prior to the expiration of the current license may result in the voluntary non-renewal of the BHS provider license upon the license expiration.

E. The renewal of a license does not affect any sanction, civil monetary penalty or other action imposed by the department against the provider.

F. If a licensed BHS provider has been issued a notice of license revocation or suspension, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

G. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license:

a. expires on the license's expiration date; and

b. is considered a non-renewal and voluntarily surrendered.

2. There is no right to an administrative reconsideration or appeal for a voluntary surrender or non-renewal of the license.

3. If a provider fails to timely renew its license, the provider shall immediately cease providing services. If the provider is actively treating clients, the provider shall:

a. within two days of voluntary non-renewal, provide written notice to HSS of the number of clients receiving treatment;

b. within two days of voluntary non-renewal, provide written notice to each active client's prescribing physician and to every client, or, if applicable, the client's parent or legal guardian, of the following:

i. voluntary non-renewal of license;

ii. date of closure; and

iii. plans for the transition of the client;

c. discharge and transition each client in accordance with this Chapter within 15 days of the license's expiration date; and

d. provide written notice to HSS of the location where client and personnel records will be stored and the name, address and telephone number of the person responsible for the records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1691 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1381 (July 2017).

§5617. Deemed Status

A. A licensed BHS provider may request deemed status once the provider becomes accredited by an LDH authorized accreditation organization, or if the applicant has achieved accreditation prior to initial licensure and becomes licensed.

B. The department may approve the deemed status request and accept accreditation in lieu of periodic licensing surveys when the provider provides documentation to the department that shows:

1. the accreditation is current and was obtained through the LDH authorized accreditation organization;

2. all behavioral health services provided under the BHS provider license are accredited; and

3. the accrediting organization's findings.

C. If deemed status is approved, accreditation will be accepted as evidence of satisfactory compliance with this Chapter in lieu of conducting periodic relicensure surveys.

D. To maintain deemed status, the provider shall submit a copy of current accreditation documentation with its annual license renewal application.

E. The department may conduct unannounced complaint investigations on all behavioral health service providers, including those with deemed status.

F. The department may rescind deemed status and conduct a licensing survey for the following:

1. any valid complaint within the preceding 12 months;

2. an addition of services;

3. a change of ownership;

4. issuance of a provisional license in the preceding 12-month period;

5. deficiencies identified in the preceding 12-month period that placed clients at risk for harm;

6. treatment or service resulting in death or serious injury; or

7. a change in geographic location.

G. The provider shall notify HSS upon change in accreditation status within two business days.

H. The department shall rescind deemed status when the provider loses its accreditation.

I. A BHS provider approved for deemed status is subject to and shall comply with all provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1381 (July 2017).

§5619. Licensing Surveys

A. The department may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing behavioral health providers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. If deficiencies are cited, the department may require the provider to submit an acceptable plan of correction.

C. The department may conduct a follow-up survey following any survey in which deficiencies were cited to ensure correction of the deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015).

§5621. Complaint Investigations

A. Pursuant to R.S. 40:2009.13 et seq., the department may conduct unannounced complaint investigations on all behavioral health providers, including those with deemed status.

B. The department shall issue a statement of deficiencies to the provider if deficient practice is cited as a result of the complaint investigation.

C. Upon issuance of a statement of deficiencies, the department may require the provider to submit an acceptable plan of correction.

D. The department may conduct a follow-up survey following a complaint investigation in which deficiencies were cited to ensure correction of the deficient practices.

E. Informal Reconsiderations of Complaint Investigations

1. A provider that is cited with deficiencies found during a complaint investigation has the right to request an informal reconsideration of the deficiencies. The provider's written request for an informal reconsideration shall be received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies and shall identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

2. An informal reconsideration for a complaint investigation shall be conducted by HSS as a desk review.

3. Correction of the violation or deficiency shall not be the basis for the reconsideration.

4. The provider shall be notified in writing of the results of the informal reconsideration.

5. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the informal reconsideration shall constitute final action by the department regarding the complaint investigation, and there shall be no further right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1382 (July 2017).

§5623. Statement of Deficiencies

A. The BHS provider shall post the following statements of deficiencies issued by the department in a readily accessible place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. each of the complaint survey statements of deficiencies, including the plans of correction, issued after the most recent annual survey.

B. The BHS provider shall make its statements of deficiencies available to the public 30 days after the provider submits an acceptable plan of correction of the deficiencies or 90 days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Informal Dispute Resolution

1. Unless otherwise provided in statute or in this Chapter, a BHS provider has the right to an informal dispute resolution (IDR) of any deficiencies cited as a result of a survey.

2. Correction of the violation, noncompliance or deficiency shall not be the basis for the IDR.

3. The BHS provider's written request for IDR shall be received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies and shall identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

4. If a timely request for an IDR is received, the department shall schedule and conduct the IDR.

5. HSS shall notify the provider in writing of the results of the IDR.

6. Except as provided for complaint surveys and as provided in this Chapter:

a. the IDR decision is the final administrative decision regarding the deficiencies; and

b. there is no right to an administrative appeal of such deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1692 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1382 (July 2017).

§5625. Cessation of Business

A. Except as provided in §5677 and §5678 of these licensing regulations, a license shall be immediately null and void if a BHS provider ceases to operate.

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

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

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

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

1. give 30 days advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the client, legal guardian or legal representative, if applicable, of each client; and

2. provide for an orderly discharge and transition of all of the clients in accordance with the provisions of this Chapter.

F. In addition to the advance notice of voluntary closure, the BHS provider shall submit a written plan for the disposition of client medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

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

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

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

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

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

H. Once the BHS provider has ceased doing business, the BHS provider shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1693 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1382 (July 2017).

§5627. Sanctions

A. The department may issue sanctions for deficiencies and violations of law, rules and regulations that include:

1. civil fines;

2. license revocation or denial of license renewal; and

3. any sanctions allowed under state law or regulation.

B. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the Administrative Procedure Act.

C. The department may deny an initial license, revoke a license or deny a license renewal for any of the following reasons, including, but not limited to:

1. failure to be in compliance with the BHS licensing laws, rules and regulations;

2. failure to be in compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. cruelty or indifference to the welfare of the clients;

5. misappropriation or conversion of the property of the clients;

6. permitting, aiding or abetting the unlawful, illicit or unauthorized use of drugs or alcohol within the provider of a program;

7. documented information of past or present conduct or practices of BHS provider personnel which are detrimental to the welfare of the clients, including but not limited to illegal or criminal activities, or coercion;

8. failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. illegal or criminal activities;

9. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in Paragraph C.8 above;

10. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, client records or provider records;

d. matters under investigation by the department or authorized law enforcement agencies; or

e. information submitted for reimbursement from any payment source;

11. knowingly making a false statement or providing false, forged or altered information or documentation to LDH employees or to law enforcement agencies;

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

13. the BHS provider, an owner, officer, member, manager, administrator, medical director, clinical director, managing employee or clinical supervisor that has pled guilty or nolo contendere to a felony, or is convicted of a felony, as documented by a certified copy of the record of the court, related to:

a. violence, abuse or neglect against a person;

b. sexual misconduct and/or any crimes that require the person to register pursuant to the Sex Offenders Registration Act;

c. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

d. the misappropriation of property belonging to another person;

e. a crime of violence;

f. an alcohol or drug offense, unless the offender has:

i. completed his/her sentence, including the terms of probation or parole, at least five years prior to the ownership of or working relationship with the provider; and

ii. been sober per personal attestation for at least the last two years;

g. a firearm or deadly weapon;

h. Medicare or Medicaid fraud; or

i. fraud or misappropriation of federal or state funds;

14. failure to comply with all reporting requirements in a timely manner, as required by the department;

15. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview BHS provider staff or clients;

16. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

17. failure to allow or refusal to allow access to BHS provider or client records by authorized departmental personnel;

18. bribery, harassment, intimidation or solicitation of any client designed to cause that client to use or retain the services of any particular BHS provider;

19. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

20. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department;

21. failure to maintain accreditation, if accreditation is a federal or state requirement for participation in the program; or

22. failure to uphold client rights that may have resulted or may result in harm, injury or death of a client.

D. Any owner, officer, member, manager, director or administrator of such BHS provider is prohibited from owning, managing, directing or operating another BHS provider for a period of two years from the date of the final disposition of any of the following:

1. license revocation;

2. denial of license renewal; or

3. the license is surrendered in lieu of adverse action.

E. If the secretary of the department determines that the health and safety of a client or the community may be at risk, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. The department will provide written notification to the BHS provider if the imposition of the action will be immediate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1693 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1382 (July 2017).

§5629. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal

A. The department shall provide written notice to the provider of the following:

1. initial license denial;

2. license revocation; or

3. denial of license renewal.

B. The BHS provider has the right to an administrative reconsideration of the initial license denial, license revocation or denial of license renewal.

1. If the BHS provider chooses to request an administrative reconsideration, the request shall:

a. be in writing addressed to HSS;

b. be received by HSS within 15 calendar days of the BHS provider's receipt of the notice of the initial license denial, license revocation or denial of license renewal; and

c. include any documentation that demonstrates that the determination was made in error.

2. If a timely request for an administrative reconsideration is received, HSS shall provide the BHS provider with written notification of the date of the administrative reconsideration.

3. The HSS shall conduct the administrative reconsideration. The BHS provider may request to present an oral presentation and be represented by counsel.

4. The HSS shall not consider correction of a deficiency or violation as a basis for the reconsideration.

5. The BHS provider will be notified in writing of the results of the administrative reconsideration.

C. The administrative reconsideration process is not in lieu of the administrative appeals process.

D. The BHS provider has a right to an administrative appeal of the initial license denial, license revocation or denial of license renewal.

1. If the BHS provider chooses to request an administrative appeal, the request shall be received:

a. by the DAL or its successor, within 30 days of the BHS provider's receipt of the results of the administrative reconsideration; or

b. within 30 days of the BHS provider's receipt of the notice of the initial license denial, revocation or denial of license renewal if the BHS provider chooses to forego its rights to an administrative reconsideration;

2. The provider's request for administrative appeal shall:

a. be in writing;

b. include any documentation that demonstrates that the determination was made in error; and

c. include the basis and specific reasons for the appeal.

3. The DAL shall not consider correction of a violation or a deficiency as a basis for the administrative appeal.

4. If a timely request for an administrative appeal is received by the DAL, the BHS provider shall be allowed to continue to operate and provide services until the DAL issues a final administrative decision, unless the imposition of the revocation or denial of license renewal is immediate based on the secretary's determination that the health and safety of a client or the community may be at risk.

E. If a licensed BHS provider has been issued notice of license revocation by the department, and the license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

F. Administrative Hearings of Initial License Denials, Denial of License Renewals and License Revocations

1. If a timely administrative appeal is submitted by the BHS provider, the DAL or its successor, shall conduct the hearing in accordance with the APA.

2. If the final DAL decision is to reverse the initial license denial, denial of license renewal or license revocation, the BHS provider's license will be re-instated upon the payment of any outstanding fees or sanctions fees due to the department.

3. If the final DAL decision is to affirm the denial of license renewal or license revocation, the BHS provider shall:

a. discharge and transition any and all clients receiving services according to the provisions of this Chapter; and

b. notify HSS in writing of the secure and confidential location where the client records will be stored and the name, address and phone number of the contact person responsible for the records.

G. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new BHS provider, or the issuance of a provisional license to a licensed BHS provider.

H. Administrative Reconsiderations of Deficiencies Cited Resulting in the Expiration of a Provisional Initial License or Provisional License

1. A BHS provider with a provisional initial license or a provisional license that expires due to deficiencies cited at the follow-up survey has the right to request an administrative reconsideration of the validity of the deficiencies cited at the follow up survey.

2. The BHS provider's request for an administrative reconsideration shall:

a. be in writing;

b. be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

3. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative reconsideration.

4. A BHS provider with a provisional initial license or a provisional license that expires under the provisions of this Chapter, shall cease providing services and discharge or transition clients, unless the DAL or successor issues a stay of the expiration.

a. To request a stay, the BHS provider shall submit its written application to the DAL at the time the administrative appeal is filed.

b. The DAL shall hold a contradictory hearing on the stay application. If the BHS provider shows that there is no potential harm to its clients, then the DAL shall grant the stay.

I. Administrative Hearing of the Expiration of a Provisional Initial License or Provisional License

1. A BHS provider with a provisional initial license or a provisional license that expires due to deficiencies cited at the follow-up survey has the right to request an administrative appeal of the validity of the deficiencies cited at the follow up survey.

2. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative appeal.

3. The BHS provider's request for an administrative appeal shall:

a. be in writing;

b. be submitted to the DAL within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

4. If the BHS provider submits a timely request for an administrative hearing, the DAL shall conduct the hearing in accordance with the APA.

a. If the final DAL decision is to remove all disputed deficiencies, the department will reinstate the BHS provider's license upon the payment of any outstanding fees and settlement of any outstanding sanctions due to the department.

b. If the final DAL decision is to uphold the disputed deficiencies thereby affirming the expiration of the provisional license, the BHS provider shall discharge any and all clients receiving services and comply with the cessation of business requirements in accordance with this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1694 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1382 (July 2017).

Subchapter C. Organization and Administration

§5631. General Provisions

A. Purpose and Organizational Structure. The BHS provider shall develop and maintain a written statement that clearly defines the purpose and organization of the provider. The statement shall include:

1. the program philosophy;

2. the program goals and objectives;

3. the ages, sex and characteristics of clients accepted for care;

4. the geographical area served;

5. the types of services provided;

6. the admission criteria;

7. the needs, problems, situations or patterns addressed by the BHS provider's program; and

8. the BHS provider's organizational chart which clearly delineates the line of authority.

B. The BHS provider shall provide supervision and services that:

1. conform to the department's rules and regulations;

2. meet the needs of the client as identified and addressed in the client's treatment plan;

3. protect each client's rights; and

4. promote the social and physical well-being and behavioral health of clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1696 (September 2015).

§5633. Governing Body

A. A BHS provider shall have the following:

1. an identifiable governing body with responsibility for and authority over the policies and operations of the BHS provider;

2. documentation identifying the governing body's:

a. members;

b. contact information for each member;

c. terms of membership;

d. officers; and

e. terms of office for each officer.

B. The governing body of a BHS provider shall:

1. be comprised of one or more persons;

2. hold formal meetings at least twice a year;

3. maintain written minutes of all formal meetings of the governing body; and

4. maintain by-laws specifying frequency of meetings and quorum requirements.

C. The responsibilities of a BHS provider's governing body, include, but are not limited to:

1. ensuring the BHS provider's compliance with all federal, state, local and municipal laws and regulations as applicable;

2. maintaining funding and fiscal resources to ensure the provision of services and compliance with this Chapter;

3. reviewing and approving the BHS provider's annual budget;

4. designating a qualified person to act as administrator, and delegating this person the authority to manage the BHS provider;

5. at least once a year, formulating and reviewing, in consultation with the administrator, the clinical supervisor, clinical director and/or medical director, written policies concerning:

a. the BHS provider's philosophy and goals;

b. current services;

c. personnel practices and job descriptions; and

d. fiscal management;

6. evaluating the performance of the administrator at least once a year;

7. meeting with designated representatives of the department whenever required to do so;

8. informing the department, or its designee, prior to initiating any substantial changes in the services provided by the BHS provider; and

9. ensuring statewide criminal background checks are conducted as required in this Chapter and state law.

D. A governing body shall ensure that the BHS provider maintains the following documents:

1. minutes of formal meetings and by-laws of the governing body;

2. documentation of the BHS provider's authority to operate under state law;

3. all leases, contracts and purchases-of-service agreements to which the BHS provider is a party;

4. insurance policies;

5. annual operating budgets;

6. a master list of all the community resources used by the BHS provider;

7. documentation of ownership of the BHS provider;

8. documentation of all accidents, incidents, and abuse/neglect allegations; and

9. daily census log of clients receiving services.

E. Service Agreements. The governing body of a BHS provider shall ensure the following with regards to agreements to provide services for the provider:

1. the agreement for services is in writing;

2. the provider reviews all written agreements at least once a year;

3. the deliverables are being provided as per the agreement;

4. the BHS provider retains full responsibility for all services provided by the agreement;

5. all services provided by the agreement shall:

a. meet the requirements of all laws, rules and regulations applicable to a BHS provider; and

b. be provided only by qualified providers and personnel in accordance with this Chapter; and

6. if the agreement is for the provision of direct care services, the written agreement specifies the party responsible for screening, orientation, ongoing training and development of and supervision of the personnel providing services pursuant to the agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1696 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1383 (July 2017).

§5635. Policies and Procedures

A. Each BHS provider shall develop, implement and comply with provider-specific written policies and procedures related to compliance with this Chapter, including, but not limited to policies and procedures that address:

1. the protection of the health, safety, and well-being of each client;

2. the provision of treatment in order for clients to achieve recovery;

3. access to care that is medically necessary;

4. uniform screening for client placement and quality assessment, diagnosis, evaluation, and referral to appropriate level of care;

5. operational capability and compliance;

6. delivery of services that are cost-effective and in conformity with current standards of practice;

7. confidentiality and security of client records and files and any prohibitions related to social media;

8. client rights;

9. grievance procedures;

10. emergency preparedness;

11. abuse, neglect and exploitation of clients;

12. incidents and accidents, including medical emergencies and reporting requirements, if applicable;

13. universal precautions and infection control;

14. documentation of services;

15. admission, including screening procedures, emergency care, client orientation, walk-in services or other brief or short-term services provided.

16. transfer and discharge procedures;

17. behavior management;

18. transportation;

19. quality improvement;

20. medical and nursing services;

21. research or non-traditional treatment approaches and approval thereof, in accordance with federal and state guidelines;

22. access to and usage of laundry and kitchen facilities;

23. the BHS provider's exterior location where smoking, if allowed, may occur;

24. domestic animals, if permitted on premises that, at a minimum, include:

a. required animal vaccinations and updates, as indicated; and

b. management of the animals' care and presence consistent with the goals of the program and clients' needs, including those with allergies;

25. privacy and security of laboratory testing and screenings, if performed on-site;

26. what constitutes the authorized and necessary use of force and least restrictive measures by uniformed security as related to client behaviors and safety; and

27. compliance with applicable federal and state laws and regulations.

B. A BHS provider shall develop, implement and comply with written personnel policies that address the following:

1. recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of employees;

2. written job descriptions for each staff position, including volunteers;

3. an employee grievance procedure;

4. abuse reporting procedures that require staff to report:

a. any allegations of abuse or mistreatment of clients according to state and federal laws; and

b. any allegations of abuse, neglect, exploitation or misappropriation of a client to the HSS;

5. a nondiscrimination policy;

6. the requirement that all employees report any signs or symptoms of a communicable disease or contagious illness to their supervisor or the clinical supervisor as soon as possible;

7. procedures to ensure that only qualified personnel are providing care within the scope of the core functions of the provider's services;

8. the governing of staff conduct and procedures for reporting violations of laws, rules, and professional and ethical codes of conduct;

9. procedures to ensure that the staff's credentials are verified, legal and from accredited institutions;

10. procedure to obtain statewide criminal background checks, ensuring no staff is providing unsupervised direct care prior to obtaining the results of the statewide criminal background check and addressing the results of the background check, if applicable; and

11. a written policy to address prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media and include, at a minimum, ensuring confidentiality of client information and preservation of client dignity and respect, including protection of client privacy and personal and property rights.

C. A BHS provider shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1697 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1383 (July 2017).

Subchapter D. Provider Operations

§5637. Client Records

A. The BHS provider shall ensure that:

1. a client record is maintained for each client according to current professional standards;

2. policies and procedures regarding confidentiality, maintenance, safeguarding and storage of records are developed and implemented;

3. records are stored in a place or area where safeguards are in place to prevent unauthorized access, loss, and destruction of client records;

4. when electronic health records are used, the most current technologies and practices are used to prevent unauthorized access;

5. records are kept confidential according to federal and state law and regulations;

6. records are maintained at the provider where the client is currently active and for six months after discharge;

7. six months post-discharge, records may be transferred to a centralized location for maintenance;

8. client records are directly and readily accessible to the direct care staff caring for the client;

9. a system of identification and filing is maintained to facilitate the prompt location of the client's records;

10. all record entries are dated, legible and authenticated by the staff person providing the service or treatment, as appropriate to the media used;

11. records are disposed of in a manner that protects client confidentiality;

12. a procedure for modifying a client record in accordance with accepted standards of practice is developed, implemented and followed;

13. an employee is designated as responsible for the client records;

14. disclosures are made in accordance with applicable state and federal laws and regulations;

15. client records are maintained at least 6 years from discharge, and for minors, client records are maintained at least 10 years.

B. Contents. The provider shall ensure that a client record, at a minimum, contains the following:

1. the treatment provided to the client;

2. the client's response to the treatment;

3. all pertinent medical, psychological, social and other therapeutic information, including:

a. initial assessment;

b. admission diagnosis;

c. referral information;

d. client information/data such as name, race, sex, birth date, address, telephone number, social security number, school/employer, and authorized representative, if applicable;

e. screenings;

f. medical limitations such as major illnesses, allergies;

g. treatment plan that includes the initial treatment plan plus any updates or revisions;

h. lab work including diagnostic, laboratory and other pertinent information, when indicated;

i. legible written progress notes or equivalent documentation;

j. documentation of the services delivered for each client signed by the client or responsible person for services provided in the home or community;

k. documentation related to incidents;

l. consent forms;

m. physicians' orders;

n. a record of all medicines administered by the BHS provider or self-administered by the client, including medication name and type, dosage, frequency of administration, route and person who administered each dose;

o. discharge summary; and

p. other pertinent information related to client as appropriate;

4. progress notes that are documented in accordance with professional standards of practice and that:

a. document implementation of the treatment plan and results;

b. document the client's level of participation; and

c. are completed upon delivery of services by the direct care staff to document progress toward stated treatment plan goals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1697 (September 2015).

§5639. Quality Improvement Plan

A. A BHS provider shall develop, implement and maintain a quality improvement (QI) plan that:

1. assures that the provider is in compliance with federal, state, and local laws;

2. meets the needs of the provider's clients;

3. is attaining the goals and objectives established by the provider;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual outcomes and individual satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan;

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QI plan shall include:

1. a process for obtaining input from the client, or client's parents or legal guardian, as applicable, at least once a year that may include, but not be limited to:

a. satisfaction surveys conducted by a secure method that maintains the client's privacy;

b. focus groups; and

c. other processes for receiving input regarding the quality of services received;

2. a sample review of client case records on a quarterly basis to ensure that:

a. individual treatment plans are up to date;

b. records are accurate, complete and current;

c. the treatment plans have been developed and implemented as ordered; and

d. the program involves all services and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors;

3. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients of the BHS provider receiving services, that includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

4. a process to review and resolve individual client issues that are identified;

5. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above;

6. a process to correct problems that are identified through the program that actually or potentially affect the health and safety of the clients;

7. a process of evaluation to identify or trigger further opportunities for improvement, such as:

a. identification of individual care and service components;

b. application of performance measures; and

c. continuous use of a method of data collection and evaluation;

8. a methodology for determining the amount of client case records in the quarterly sample review that will involve all services and produce accurate data to guide the provider toward performance improvement.

C. The QI program shall establish and implement an internal evaluation procedure to:

1. collect necessary data to formulate a plan; and

2. hold quarterly committee meetings comprised of at least three individuals who:

a. assess and choose which QI plan activities are necessary and set goals for the quarter;

b. evaluate the activities of the previous quarter; and

c. implement any changes that protect the clients from potential harm or injury.

D. The QI plan committee shall:

1. be comprised of at least three persons, one of whom is a LMHP and the others are staff with the qualifying experience to contribute to the committee's purpose; and

2. develop and implement the QI plan.

E. The QI program outcomes shall be documented and reported to the administrator, clinical director and/or medical director for action, as necessary, for any identified systemic problems

F. The BHS provider shall maintain documentation of the most recent 12 months of the QI plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1698 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1383 (July 2017).

Subchapter E. Personnel

§5641. General Requirements

A. The BHS provider shall maintain an organized professional staff who is accountable to the governing body for the overall responsibility of:

1. the quality of all clinical care provided to clients;

2. the ethical conduct and professional practices of its members;

3. compliance with policies and procedures; and

4. the documented staff organization that pertains to the provider's setting and location.

B. The direct care staff of a BHS provider shall:

1. have the qualifying experience to provide the services required by its clients' treatment plans; and

2. not practice beyond the scope of his/her license, certification and/or training.

C. The provider shall ensure that:

1. Qualified direct care staff members are present with the clients as necessary to ensure the health, safety and well-being of clients;

2. Staff coverage is maintained in consideration of:

a. acuity of the clients being serviced;

b. the time of day;

c. the size, location, physical environment and nature of the provider;

d. the ages and needs of the clients;

e. ensuring the continual safety, protection, direct care and supervision of clients;

3. applicable staffing requirements in this Chapter are maintained;

4. mechanisms are developed for tracking staff attendance and hours worked during operational hours whether onsite or off-site;

5. there is adequate justification for the provider's assigned staffing patterns at any point in time.

D. Criminal Background Checks

1. For any provider that is treating children and/or adolescents, the provider shall either:

a. obtain a statewide criminal background check by an agency authorized by the Office of State Police to conduct criminal background checks on all staff that was conducted within 90 days prior to hire or employment; or

b. request a criminal background check on all staff prior to hire or employment in the manner required by R.S. 15:587.1 et seq.

2. For any provider that is treating adults, the provider shall obtain a statewide criminal background check on all unlicensed direct care staff within 90 days prior to hire or employment by an agency authorized by the Office of State Police to conduct criminal background checks. The background check shall be conducted within 90 days prior to hire or employment.

3. A provider that hires a contractor to perform work which does not involve any contact with clients is not required to conduct a criminal background check on the contractor if accompanied at all times by a staff person when clients are present in the provider.

E. Prior to hiring the unlicensed direct care staff member, and once employed, at least every six months thereafter or more often, the provider shall review the Louisiana state nurse aide registry and the Louisiana direct service worker registry to ensure that each unlicensed direct care staff member does not have a negative finding on either registry.

F. Prohibitions

1. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who:

a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of a felony involving:

i. abuse or neglect of a person;

ii. an alcohol or drug offense, unless the employee or contractor has:

(a). completed his/her court-ordered sentence, including community service, probation and/or parole; and

(b). been sober per personal attestation for at least the last 2 years;

iii. any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

iv. misappropriation of property belonging to another person when:

(a). the offense was within the last five years; or

(b). the employee/contractor has not completed his/her sentence, including, if applicable, probation or parole;

v. a crime of violence;

b. has a finding placed on the Louisiana state nurse aide registry or the Louisiana direct service worker registry.

G. Orientation and Training

1. All staff shall receive orientation. All direct care staff shall receive orientation prior to providing direct client care without supervision.

2. All staff shall receive in-service training:

a. at least once a year;

b. that complies with the provider's policies and procedures;

c. that is necessary depending on the needs of the clients; and

d. that is specific to the age of the provider's population.

3. The content of the orientation and in-service training shall include the following:

a. confidentiality in accordance with federal and state laws and regulations;

b. grievance process;

c. fire and disaster plans;

d. emergency medical procedures;

e. organizational structure and reporting relationships;

f. program philosophy;

g. policies and procedures;

h. detecting and mandatory reporting of client abuse, neglect or misappropriation;

i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

j. basic skills required to meet the health needs and challenges of the client;

k. crisis intervention and the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations;

l. telephone crisis mitigation for those staff members who provide such services;

m. client's rights;

n. duties and responsibilities of each employee;

o. standards of conduct required by the provider;

p. information on the disease process and expected behaviors of clients;

q. maintaining a clean, healthy and safe environment;

r. infectious diseases and universal precautions; and

s. basic emergency care for accidents and emergencies until emergency medical personnel can arrive at provider.

4. The orientation and in-service training shall:

a. be provided only by staff who are qualified by education, training, and qualifying experience; and

b. includes documentation of demonstrated competency of direct care staff, ongoing and prior to providing services to clients.

5. The in-service trainings shall serve as a refresher for subjects covered in orientation or training as indicated through the QI process.

I. The provider shall document an annual staff performance evaluation of all employees.

J. The provider shall report violations of laws, rules, and professional and ethical codes of conduct by provider staff and volunteers to the appropriate professional board or licensing authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1699 (September 2015).

§5643. Core Staffing Personnel Qualifications and Responsibilities

A. All BHS providers shall abide by the following minimum core staffing requirements and shall meet the additional requirements. All BHS providers shall also meet the additional requirements for each specialized program or module pursuant to the provisions of this Chapter as applicable to each BHS provider.

B. Professional Staffing Standards. All BHS providers shall, at a minimum, have the following staff:

1. a medical director who:

a. is a physician, or an advanced practice registered nurse, or a medical psychologist, with a current, unrestricted license to practice in the state of Louisiana with two years of qualifying experience in treating psychiatric disorders;

EXCEPTION: Mental health rehabilitation providers exclusively providing the evidence-based practice multi-systemic therapy (MST), functional family therapy (FFT), or Homebuilders® are excluded from the requirement of having a medical director. Such shall have a clinical director in accordance with §5643.B.2.

b. has the following assigned responsibilities:

i. ensures that the necessary medical services are provided to meet the needs of the clients;

ii. provides oversight for provider policy/procedure, client plans of care (POCs) and staff regarding the medical needs of the clients according to the current standards of medical practice;

iii. directs the specific course of medical treatment for all clients;

iv. reviews reports of all medically related accidents/incidents occurring on the premises and identify hazards to the administrator;

v. participates in the development and implementation of policies and procedures for the delivery of services;

vi. periodically reviews delivery of services to ensure care meets the current standards of practice; and

vii. participates in the development of new programs and modifications;

c. has the following responsibilities or designates the duties to a qualified practitioner:

i. writes the admission and discharge orders;

ii. writes and approves all prescription medication orders;

iii. develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;

iv. provides consultative and on-call coverage to ensure the health and safety of clients;

v. collaborates with the client's primary care physician and psychiatrists as needed for continuity of the client's care; and

d. may also fulfill the role of the clinical director, if the individual is qualified to perform the duties of both roles;

2. a clinical director who, for those mental health rehabilitation providers which exclusively provide the evidenced-based practice multi-systemic therapy (MST), functional family therapy (FFT) or Homebuilders®:

a. is a licensed psychiatrist, psychologist, clinical social worker, professional counselor (LPC) or marriage and family therapist (LMFT) with a minimum of two years qualifying experience in treating psychiatric disorders and

who maintains a current, unrestricted license to practice in the state of Louisiana;

b. has the following assigned responsibilities:

i. ensures that the necessary services are provided to meet the needs of the clients;

ii. provides oversight for provider policy/procedure, client plans of care (POCs) and staff regarding the clinical needs of the clients according the current standards of clinical practice;

iii. directs the specific course of clinical treatment for all clients;

iv. reviews reports of all accidents/incidents occurring on the premises and identifies hazards to the administrator;

v. participates in the development and implementation of policies and procedures for the delivery of services;

vi. periodically reviews delivery of services to ensure care meets the current standards of practice; and

vii. participates in the development of new programs and modifications; and

c. has the following responsibilities or designates the duties to a qualified practitioner:

i. provides consultative and on-call coverage to ensure the health and safety of clients; and

ii. collaborates with the client's primary care physician and psychiatrist as needed for continuity of the client's care;

3. an administrator who:

a. has either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates adequate knowledge, experience and expertise in business management;

b. is responsible for the on-site day to day operations of the BHS provider and supervision of the overall BHS provider's operation commensurate with the authority conferred by the governing body; and

c. shall not perform any programmatic duties and/or make clinical decisions unless licensed to do so;

4. a clinical supervisor who, with the exception of opioid treatment programs:

a. is an LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;

b. shall be on duty and on call as needed;

c. has two years of qualifying clinical experience as an LMHP in the provision of services provided by the provider;

d. shall have the following responsibilities:

i. provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling;

ii. serve as resource person for other professionals counseling persons with behavioral health disorders;

iii. attend and participate in care conferences, treatment planning activities, and discharge planning;

iv. provide oversight and supervision of such activities as recreation, art/music or vocational education;

v. function as client advocate in treatment decisions;

vi. ensure the provider adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload, and referrals;

vii. provide only those services that are within the person's scope of practice; and

viii. assist the clinical director and/or medical director and governing body with the development and implementation of policies and procedures;

5. nursing staff who, for those BHS providers whose services include medication management and/or addiction treatment services,:

a. provide the nursing care and services under the direction of a registered nurse necessary to meet the needs of the clients; and

b. have a valid current nursing license in the State of Louisiana.

i. A BHS provider with clients who are unable to self-administer medication shall have a sufficient number of nurses on staff to meet the medication needs of its clients.

ii. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement

C. Other Staffing Requirements. The provider shall abide by the following staffing requirements that are applicable to its provider:

1. Licensed Mental Health Professionals

a. The provider shall maintain a sufficient number of LMHPs, who are licensed to practice independently in the state of Louisiana to diagnose and treat mental illness and/or substance abuse, to meet the needs of the provider's clients.

b. The LMHP has the following responsibilities:

i. provide direct care to clients utilizing the core competencies of addiction counseling and/or mental health counseling and may serve as primary counselor to specified caseload;

ii. serve as resource person for other professionals in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities, and discharge planning;

iv. provide on-site and direct professional supervision of any unlicensed professional or inexperienced professional;

v. function as the client's advocate in all treatment decisions affecting the client; and

vi. prepare and write notes or other documents related to recovery (e.g. assessment, progress notes, treatment plans, discharge, etc.).

2. Unlicensed Professionals

a. The provider shall maintain a sufficient number of unlicensed professionals (UPs) to meet the needs of its clients.

b. The UP shall:

i. provide direct care to clients and may serve as primary counselor to specified caseload under clinical supervision;

ii. serve as resource person for other professionals and paraprofessionals in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities and discharge planning;

iv. function as the client's advocate in all treatment decisions affecting the client; and

v. prepare and write notes or other documents related to recovery (e.g. assessment, progress notes, treatment plans, etc.).

3. Direct Care Aides

a. A residential provider shall have a sufficient number of direct care aides to meet the needs of the clients.

b. A provider that provides outpatient services shall use direct care aides as needed.

c. Direct care aides shall meet the following minimum qualifications:

i. has obtained a high school diploma or equivalent;

ii. be at least 18 years old in an adult provider and 21 years old in a provider that treats children and/or adolescents.

d. Direct care aides shall have the following responsibilities:

i. ensure a safe environment for clients;

ii. exercise therapeutic communication skills;

iii. take steps to de-escalate distressed clients;

iv. observe and document client behavior;

v. assist with therapeutic and recreational activities;

vi. monitor clients' physical well-being;

vii. provide input regarding client progress to the interdisciplinary team;

viii. oversee the activities of the facility when there is no professional staff on duty;

ix. possess adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed; and

x. function as client advocate.

4. Volunteers

a. If a BHS provider utilizes volunteers, the provider shall ensure that each volunteer is:

i. supervised to protect clients and staff;

ii. oriented to the provider, job duties, and other pertinent information;

iii. trained to meet requirements of duties assigned;

iv. given a written job description or written agreement;

v. identified as a volunteer;

vi. trained in privacy measures;

vii. required to sign a written confidentiality agreement; and

viii. required to submit to a statewide criminal background check by an agency authorized by the Office of the State Police to conduct criminal background checks prior to providing direct care.

b. If a BHS provider utilizes student volunteers, it shall ensure that each student volunteer:

i. has current registration with the applicable Louisiana professional board, when required, and is in good standing at all times that is verified by the provider;

ii. is actively pursuing a degree in a human service field or professional level licensure or certification at all times;

iii. provides direct client care utilizing the standards developed by the professional board;

iv. provides care only under the direct supervision of the appropriate supervisor; and

v. provides only those services for which the student has been trained and deemed competent to perform.

c. A volunteer's duties may include:

i. direct care activities only when qualified provider personnel are present;

ii. errands, recreational activities; and

iii. individual assistance to support services.

d. The provider shall designate a volunteer coordinator who:

i. has the experience and training to supervise the volunteers and their activities; and

ii. is responsible for selecting, evaluating and supervising the volunteers and their activities.

5. Care Coordinator

a. The provider shall ensure that each care coordinator:

i. has a high school diploma or equivalent;

ii. is at least 18 years old in an adult provider and 21 years old in provider that treats children and/or adolescents; and

iii. has been trained to perform assigned job duties.

E. Multiple Positions. If a BHS provider employs a staff member in more than one position, the provider shall ensure that:

1. the person is qualified to function in both capacities; and

2. one person is able to perform the responsibilities of both jobs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1700 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1383 (July 2017).

§5645. Personnel Records

A. A BHS provider shall maintain a personnel file for each employee and direct care staff member. Each record shall contain:

1. the application for employment and/or resume, including contact information and employment history for the preceding five years, if applicable;

2. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

3. any required medical examinations or health screens;

4. evidence of current applicable credentials/certifications for the position;

5. annual performance evaluations;

6. personnel actions, other appropriate materials, reports and notes relating to allegations of abuse, neglect and misappropriation of clients' funds;

7. the employee's starting and termination dates;

8. proof of attendance of orientation, training and in-services;

9. results of statewide criminal background checks by an agency authorized by the Office of State Police to conduct criminal background checks on all direct care staff;

10. job descriptions and performance expectations;

11. prior to hiring the unlicensed direct care staff member, and once employed, at least every six months thereafter or more often, the provider shall have documentation of reviewing the Louisiana state nurse aide registry and the Louisiana direct service worker registry to ensure that each unlicensed direct care staff member does not have a negative finding on either registry; and

12. a written confidentiality agreement signed by the staff upon hire and subsequently per provider's policy.

B. A BHS provider shall retain personnel files for at least three years following termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1702 (September 2015).

Subchapter F. Admission, Transfer and Discharge

§5647. Admission Requirements

A. A BHS provider shall not refuse admission to any individual on the grounds of race, religion, national origin, sexual orientation, ethnicity or disability.

B. A BHS provider shall admit only those individuals whose behavioral health needs, pursuant to the Initial Admission Assessment, can be fully met by the provider.

C. Pre-Admission Requirements

1. Prior to admission, the provider shall either:

a. conduct an initial admission assessment; or

b. obtain a current assessment conducted within the past year that determines the individual's diagnosis and update the assessment to represent the client's current presentation.

2. If the client is disoriented due to psychological or physiological complications or conditions, the initial admission assessment shall be completed as soon as the client is capable of participating in the process.

3. The BHS provider shall include client participation in the assessment process to the extent appropriate.

4. The initial admission assessment shall contain the following:

a. a screening to determine eligibility and appropriateness for admission and referral;

b. a biopsycho-social evaluation that includes:

i. circumstances leading to admission;

ii. past and present behavioral health concerns;

iii. past and present psychiatric and addictive disorders treatment;

iv. significant medical history and current health status;

v. family and social history;

vi. current living situation;

vii. relationships with family of origin, nuclear family, and significant others;

viii. education and vocational training;

ix. employment history and current status;

x. military service history and current status;

xi. legal history and current legal status;

xii. emotional state and behavioral functioning, past and present; and

xiii. strengths, weaknesses, and needs;

c. physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process;

d. drug screening when history is inconclusive or unreliable;

e. appropriate assignment to level of care with referral to other appropriate services as indicated;

f. signature and date by the LMHP; and

g. for residential facilities, diagnostic laboratory tests or appropriate referral as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.

D. Admission Requirements

1. A provider shall establish admission requirements that include:

a. availability of appropriate physical accommodations;

b. legal authority or voluntary admission;

c. availability of professionals to provide services needed as indicated by the initial assessment and diagnosis; and

d. written documentation that client and family, if applicable, consents to treatment and understands the diagnosis and level of care.

2. Client/Family Orientation. Each provider shall ensure that a confidential and efficient orientation is provided to the client and the client's family, if applicable, concerning:

a. visitation in a residential facility, if applicable;

b. family involvement;

c. safety;

d. the rules governing individual conduct;

e. authorization to provide treatment;

f. adverse reactions to treatment;

g. the general nature and goals of the program;

h. proposed treatment to include treatment methodology, duration, goals and services;

i. risks and consequences of non-compliance;

j. treatment alternatives;

k. clients rights and responsibilities; and

l. all other pertinent information, including fees and consequences of non-payment of fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1702 (September 2015).

§5649. Transfer and Discharge Requirements

A. Each provider shall develop, implement and comply with policies and procedures that address:

1. discharge;

2. transition to another level of care; and

3. transfer to another licensed provider.

B. The BHS provider shall ensure that a client is discharged:

1. when the client's treatment goals are achieved, as documented in the client's treatment plan;

2. when the client's issues or treatment needs are not consistent with the services the provider is authorized or able to provide;

3. according to the provider's established written discharge criteria; or

4. when the voluntarily-admitted client, or client's parent or legal guardian, if applicable, requests discharge.

C. Discharge planning shall begin upon admission.

D. Discharge Plan. The provider shall submit a written discharge plan to each client upon discharge or, if unable to submit at discharge, within seven days after discharge. The discharge plan shall provide reasonable protection of continuity of services that includes:

1. the client's transfer or referral to outside resources, continuing care appointments, and crisis intervention assistance;

2. documented attempts to involve family or an alternate support system in the discharge planning process;

3. the client's goals or activities to sustain recovery;

4. signature of the client or, if applicable, the client's parent or guardian;

5. name, dosage, route and frequency of client's medications ordered at the time of discharge; and

6. the disposition of the client's possessions, funds and/or medications, if applicable.

E. Discharge Summary. The BHS provider shall ensure that each client record contains a written discharge summary that includes:

1. the client's presenting needs and issues identified at the time of admission;

2. the services provided to the client;

3. the provider's assessment of the client's progress towards goals;

4. the discharge disposition; and

5. the continuity of care recommended following discharge, supporting documentation and referral or transfer information.

F. When a request for discharge is received or when the client leaves the provider against the provider's advice, the provider shall:

1. have and comply with written procedures for handling discharges and discharge requests;

2. document the circumstances surrounding the leave; and

3. complete the discharge summary within 30 days of the client's leaving the program or sooner for continuity of care.

G. Transitions. When a client undergoes a transition to another level of care, the provider shall ensure that:

1. the transition to a different level of care is documented in the client's record by a member of the direct care staff;

2. the client is notified of the transition; and

3. if transitioning to a different provider, the staff coordinates transition to next level of care.

H. Transfer Process

1. If a residential provider decides to transfer a client, the provider shall ensure that there is an agreement with the receiving provider to provide continuity of care based on:

a. the compilation of client data; or

b. the medical history/examination/physician orders, psycho-social assessment, treatment plan, discharge summary and other pertinent information provided upon admission to inpatient or outpatient care.

2. The residential provider responsible for the transfer and discharge of the client shall:

a. request and receive approval from the receiving provider prior to the transfer;

b. notify the receiving provider prior to the arrival of the client of any significant medical and/or psychiatric conditions and complications or any other pertinent information that will be needed to care for the client prior to arrival;

c. transfer all requested client information and documents upon request; and

d. ensure that the client has consented to the transfer.

I. If a client is involuntarily committed to a provider, the provider shall:

1. maintain the care of the client until an appropriate level of care becomes available; and

2. comply with the transfer and discharge requirements in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1703 (September 2015).

Subchapter G. Services

§5651. Treatment Protocols

A. A BHS provider shall deliver all services according to a written plan that:

1. is age and culturally appropriate for the population served;

2. demonstrates effective communication and coordination;

3. provides utilization of services at the appropriate level of care;

4. is an environment that promotes positive well-being and preserves the client's human dignity; and

5. utilizes evidence-based counseling techniques and practices.

B. The provider shall make available a variety of services, including group and/or individual treatment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1704 (September 2015).

§5653. Treatment Plan

A. Each client of the BHS provider shall have a treatment plan linked to the assessment that contains:

1. documented input from the counselor and client within 72 hours after admission to a residential facility, with information from other disciplines added as the client is evaluated and treated;

2. client-specific, measurable goals that are clearly stated in behavioral terms;

3. the treatment modalities to be utilized;

4. realistic and specific expected achievement dates;

5. the strategies and activities to be used to help the client achieve the goals;

6. information specifically related to the mental, physical, and social needs of the client; and

7. the identification of staff assigned to carry out the treatment.

B. The BHS provider shall ensure that the treatment plan is in writing and is:

1. developed in collaboration with the client and when appropriate, the client's family and is signed by the client or the client's family, when appropriate;

2. reviewed and revised as required by this Chapter or more frequently as indicated by the client's needs;

3. consistently implemented by all staff members;

4. signed by the LMHP or physician responsible for developing the treatment plan; and

5. is in language easily understandable to the client and to the client's family, when applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1704 (September 2015).

§5655. Core Services

A. A BHS provider shall provide the following services to its clients when needed:

1. assessment;

2. orientation;

3. treatment;

4. client education;

5. consultation with professionals;

6. counseling services;

7. referral;

8. rehabilitation services;

9. crisis mitigation; and

10. medication management.

EXCEPTION: Mental health rehabilitation providers exclusively providing the evidence-based practice multi-systemic therapy (MST), functional family therapy (FFT) or Homebuilders® are excluded from the requirement of §5655.A.10.

B. A BHS provider that is a mental health rehabilitation provider exclusively providing the evidence-based practice multi-systemic therapy (MST), functional family therapy (FFT) or Homebuilders® shall:

1. provide services in accordance with §5655.A.1-9; and

2. develop policies and procedures to ensure:

a. screening of clients for medication management needs;

b. referral to appropriate community providers for medication management including assistance to the client/family to secure services; and

c. collaboration with the client's medication management provider as needed for coordination of the client's care.

C. Crisis Mitigation Services

1. The BHS provider's crisis mitigation plan shall:

a. identify steps to take when a client suffers from a medical, psychiatric, medication or relapse crisis; and

b. specify names and telephone numbers of staff or organizations to assist clients in crisis.

2. If the provider contracts with another entity to provide crisis mitigation services, the BHS provider shall have a written contract with the entity providing the crisis mitigation services.

3. The qualified individual, whether contracted or employed by the BHS provider, shall call the client within 30 minutes of receiving notice of the client's call.

D. Referral

1. The provider shall provide:

a. appropriate resource information regarding local agencies to client and family, if applicable, upon need or request; and

b. procedures to access vocational services, community services, transitional living services and transportation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1704 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1384 (July 2017).

§5657. Laboratory Services

A. Each BHS provider that provides medication management and/or addiction treatment services shall:

1. have a written agreement for laboratory services off-site or provide laboratory services on-site;

2. ensure that the laboratory providing the services has current clinical laboratories improvement amendments (CLIA) certification when necessary;

3. ensure diagnostic laboratory services are available to meet the behavioral health needs of the clients; and

4. maintain responsibility for all laboratory services provided on-site or off-site via contractual agreement.

B. If collection is performed on-site, the provider shall develop, implement and comply with written policies and procedures for the collection of specimens in accordance with current standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1705 (September 2015).

§5659. Medications

A. A BHS provider that stores stock medications of scheduled controlled dangerous substances shall maintain:

1. a site-specific Louisiana controlled dangerous substance license in accordance with the Louisiana Uniform Controlled Dangerous Substance Act; and

2. a United States Drug Enforcement Administration controlled substance registration for the provider in accordance with title 21 of the *United States Code*.

B. The provider, when applicable, shall develop, implement and comply with written policies and procedures that govern:

1. the safe administration and handling of all prescription and nonprescription medications;

2. identification of medications being brought into the premises when the provider is responsible for administering medications;

3. the storage, dispensing, if applicable, and recording and control of all medications;

4. The self-administration of all medications, that includes:

a. age limitations for self-administration;

b. order from the authorized licensed prescriber;

c. parental consent, if applicable; and

d. the manner in which the client is monitored by staff to ensure medication is taken as prescribed in the treatment plan;

5. the disposal of all discontinued and/or expired medications and containers with worn, illegible or missing labels in accordance with state and federal law and regulations;

6. the use of prescription medications including:

a. when medication is administered and monitoring of the effectiveness of the medication administered;

b. a procedure to inform clients, staff, and where appropriate, client's parent(s) or legal guardian(s) of each medication's anticipated results, the potential benefits and side-effects as well as the potential adverse reaction that could result from not taking the medication as prescribed;

c. involving clients and, when appropriate, their parent(s) or legal guardian(s) in decisions concerning medication; and

d. staff training to ensure the recognition of the potential side effects of the medication;

7. recording of medication errors and adverse drug reactions and reporting them to the client's physician or authorized prescriber;

8. the reporting of and steps to be taken to resolve discrepancies in inventory, misuse and abuse of controlled dangerous substances in accordance with federal and state law; and

9. reconciliation of all controlled dangerous substances to guard against diversion.

C. The provider shall ensure that:

1. any medication administered to a client is administered as prescribed;

2. all medications are kept in a locked cabinet, closet or room and under recommended temperature controls;

3. all controlled dangerous substances shall be kept separately from other medications in a locked cabinet or compartment accessible only to individuals authorized to administer medications;

4. current and accurate records are maintained on the receipt and disposition of all scheduled drugs;

5. schedule II, III and IV of the provider's controlled dangerous substances are reconciled at least twice a day by different shifts of staff authorized to administer controlled dangerous substances;

6. medications are administered only upon receipt of written orders by paper, facsimile, or electronic transmission, or verbal orders from an authorized licensed prescriber;

7. all verbal orders are signed by the authorized licensed prescriber within 10 calendar days;

8. medications that require refrigeration are stored in a refrigerator or refrigeration unit separate from food, beverages, blood, and laboratory specimens;

9. all prescription medications are labeled to identify:

a. the client's full name;

b. the name of the medication;

c. dosage;

d. quantity and date dispensed;

e. directions for taking the medication;

f. required accessory and cautionary statements;

g. prescriber's name; and

h. the expiration date, if applicable;

10. medication errors, adverse drug reactions, and interactions with other medications, food or beverages taken by the client are immediately reported to the medical director with an entry in the client's record; and

11. discrepancies in inventory of controlled dangerous substances are reported to the pharmacist.

D. BHS Providers that Dispense Medications

1. If the BHS provider dispenses medications to its clients, the provider shall:

a. provide pharmaceutical services on-site at the center; or

b. have a written agreement with a pharmaceutical provider to dispense the medications.

2. The provider shall ensure that all compounding, packaging, and dispensing of medications is:

a. accomplished in accordance with Louisiana law and Board of Pharmacy regulations; and

b. performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1705 (September 2015).

Subchapter H. Client Rights

§5661. Client Rights

A. The BHS provider shall develop, implement and comply with policies and procedures that:

1. protect its client's rights;

2. respond to questions and grievances pertaining to these rights;

3. ensure compliance with client's rights enumerated in R.S. 28:171; and

4. ensure compliance with minor's rights enumerated in the *Louisiana Children's Code* article 1409.

B. A BHS provider's client and, if applicable, the client's parent(s) or legal guardian, have the following rights:

1. to be informed of the client's rights and responsibilities at the time of admission or within 24 hours of admission;

2. to have a family member, chosen representative and/or his or her own physician notified of admission to the BHS provider at the request of the client;

3. to receive treatment and medical services without discrimination based on race, age, religion, national origin, gender, sexual orientation, or disability;

4. to maintain the personal dignity of each client;

5. to be free from abuse, neglect, exploitation and harassment;

6. to receive care in a safe setting;

7. to receive the services of a translator or interpreter, if applicable, to facilitate communication between the client and the staff;

8. to be informed of the client's own health status and to participate in the development, implementation and updating of the client's treatment plan;

9. to make informed decisions regarding the client's care by the client or the client's parent or guardian, if applicable, in accordance with federal and state laws and regulations;

10. to participate or refuse to participate in experimental research when the client gives informed, written consent to such participation, or when a client's parent or legal guardian provides such consent, when applicable, in accordance with federal and state laws and regulations;

11. for clients in residential facilities, to consult freely and privately with the client's legal counsel or to contact an attorney at any reasonable time;

12. to be informed, in writing, of the policies and procedures for filing a grievance and their review and resolution;

13. to submit complaints or grievances without fear of reprisal;

14. for clients in residential facilities, to possess and use personal money and belongings, including personal clothing, subject to rules and restrictions imposed by the BHS provider;

15. for clients in residential facilities, to visit or be visited by family and friends subject to rules imposed by the provider and to any specific restrictions documented in the client's treatment plan;

16. to have the client's information and medical records, including all computerized medical information, kept confidential in accordance with federal and state statutes and rules/regulations;

17. for clients in residential facilities, access to indoor and outdoor recreational and leisure opportunities;

18. for clients in residential facilities, to attend or refuse to attend religious services in accordance with his/her faith;

19. to be given a copy of the program's rules and regulations upon admission;

20. to receive treatment in the least restrictive environment that meets the client's needs;

21. to not be restrained or secluded in violation of federal and state laws, rules and regulations;

22. to be informed in advance of all estimated charges and any limitations on the length of services at the time of admission or within 72 hours;

23. to receive an explanation of treatment or rights while in treatment;

24. to be informed of the:

a. nature and purpose of any services rendered;

b. the title of personnel providing that service;

c. the risks, benefits, and side effects of all proposed treatment and medications;

d. the probable health and mental health consequences of refusing treatment; and

e. other available treatments which may be appropriate;

25. to accept or refuse all or part of treatment, unless prohibited by court order or a physician deems the client to be a danger to self or others or gravely disabled;

26. for children and adolescents in residential BH facilities, to access educational services consistent with the client's abilities and needs, relative to the client's age and level of functioning; and

27. to have a copy of these rights, which includes the information to contact HSS during routine business hours.

C. The residential or outpatient clinic provider shall

1. post a copy of the clients' rights on the premises that is accessible to all clients; and

2. give a copy of the clients' rights to each client upon admission and upon revision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1706 (September 2015).

§5663. Grievances

A. The provider shall develop, implement and comply with a written grievance procedure for clients designed to allow clients to submit a grievance without fear of retaliation. The procedure shall include, but not be limited to:

1. a procedure for filing a grievance;

2. a time line for responding to the grievance;

3. a method for responding to a grievance; and

4. the staff's responsibilities for addressing grievances.

B. The provider shall ensure that:

1. the client and, if applicable, the client's parent(s) or legal guardian(s), is informed of the grievance procedure; and

2. all grievances are addressed and resolved to the best of the provider's ability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

Subchapter I. Physical Environment

§5665. Exterior Space Requirements

A. The provider shall maintain its exterior areas that are accessible to the clients, including the grounds and structures on the grounds, in good repair and free from potential hazards to health or safety.

B. The provider shall ensure the following:

1. garbage stored outside is secured in noncombustible, covered containers and removed on a regular basis;

2. trash collection receptacles and incinerators are separate from recreation areas;

3. unsafe areas have safeguards to protect clients from potential hazards;

4. fences are in good repair;

5. exterior areas are well lit; and

6. the provider has signage that indicates the provider's:

a. legal or trade name;

b. address;

c. hours of operation; and

d. telephone number(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

§5667. Interior Space for Residential Facilities and Outpatient Clinics

A. The BHS provider that provides services on-site shall:

1. have a physical environment that ensures the health, safety and security of the clients;

2. have routine maintenance and cleaning services;

3. be well-lit, clean, safe and ventilated;

4. maintain its physical environment, including, but not limited to, all equipment, fixtures, plumbing, electrical, furnishings, doors and windows, in good order and safe condition and in accordance with manufacturer's recommendations; and

5. maintain heating, ventilation and cooling systems in good order and safe condition to ensure a temperature controlled environment.

B. The provider shall have designated space for the secure storage of the staff's personal belongings.

C. Furnishings. The BHS provider shall ensure that the provider's furnishings for all living and treatment areas are designed to meet the needs of the clients.

D. Medication Storage and Preparation. The provider shall have an area for medication preparation, administration and storage that meets one of the following:

1. a secured medication room that contains sufficient space for a work counter, sink, refrigerator, locked storage for controlled dangerous substances; or

2. a secured self-contained medication distribution unit located in a clean workroom, alcove or other staff work area with an easily accessible hand washing station.

E. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from the client living and/or treatment areas that serves as an administrative office.

2. The provider shall have a designated space(s) to allow for private and group discussions and counseling sessions.

F. Smoking. The provider shall prohibit smoking in the interior of its licensed space.

G. Bathrooms

1. There shall be at least one bathroom for use by clients and staff and meets the requirements of the Louisiana *Sanitary Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015).

§5669. Interior Space for Residential Facilities

A. The provider shall evaluate each client's physical, emotional and medical needs and the physical environment of the facility in order to ensure the safety and well-being of all admitted clients.

B. Common Area. The facility's physical environment shall have a designated space accessible to the clients:

1. to be used for group meetings, dining, visitation, leisure and recreational activities;

2. that is at least 25 square feet per client and no less than 150 square feet, exclusive of bedrooms or sleeping areas, bathrooms, areas restricted to staff, laundry rooms and office areas; and

3. that contains a sufficient number of tables and chairs for eating meals.

C. The facility's physical environment shall have a designated room(s) or area(s) to allow for private and group discussions and counseling sessions that:

1. safely accommodates the clients being served;

2. has adequate space to meet the client's needs in the therapeutic process; and

3. is exclusive of bedrooms, bathrooms and common areas.

D. Client Bedrooms. The provider shall ensure that each client bedroom in the facility:

1. contains at least 80 square feet for single bedrooms, exclusive of fixed cabinets, fixtures, furniture and equipment;

2. contains at least 60 square feet per bed for multi-bedrooms, exclusive of fixed cabinets, fixtures, and equipment;

3. has at least a 7 1/2 foot ceiling height over the required area except in a room with varying ceiling height, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space;

4. has at least 2 foot minimum clearance at the foot of each bed; and

5. contains no more than four beds;

EXCEPTION: Providers licensed as substance abuse/addiction treatment residential facilities at the time this Rule is promulgated that have more than four clients per bedroom, may maintain the existing bedroom space that allows more than four clients per bedroom provided that the bedroom space has been previously approved by a LDH waiver. This exception applies only to the currently licensed physical location.

6. has at least three feet between beds;

7. has designated storage space for the client's:

a. clothes;

b. toiletries; and

c. personal belongings;

8. has a screened window that opens to the outside;

9. has sheets, pillow, bedspread and blankets for each client that are clean and in good repair and discarded when no longer usable;

10. has sufficient headroom to allow the occupant to sit up; and

11. contains a bed(s) that:

a. is longer than the client is tall;

b. is no less than 30 inches wide;

c. is of solid construction;

d. has a clean, comfortable, nontoxic fire retardant mattress; and

e. is appropriate to the size and age of the client.

E. The provider shall:

1. prohibit any client over the age of five years to occupy a bedroom with a member of the opposite sex who is not in the client's immediate family;

2. require separate bedrooms and bathrooms for adults, and children/adolescents, except in the Mothers with Dependent Children Program, and for males and females;

3. prohibit adults and children/adolescents from sharing the same space, except in the Mothers with Dependent Children Program;

4. require sight and sound barriers between adult area/wing and the adolescent area/wing;

5. for facilities with child/adolescent clients, ensure that the age of clients sharing bedroom space is not greater than four years in difference unless contraindicated based on diagnosis, the treatment plan or the behavioral health assessment of the client;

6. ensure that each client has his/her own bed;

7. prohibit mobile homes from being used as client sleeping areas; and

8. prohibit bunk beds in the following programs:

a. clinically managed residential detoxification (ASAM level III.2D);

b. Clinically Managed High Intensity Residential Program (ASAM level III.5);

c. medically monitored intensive residential treatment (ASAM level III.7); and

d. medically monitored residential detoxification (ASAM level III.7D).

F. Bathrooms

1. In accordance with the Louisiana state *Sanitary Code*, a provider shall have bathrooms equipped with lavatories, toilets, tubs and/or showers for use by the clients located within the provider and the following:

a. shatterproof mirrors secured to the walls at convenient heights; and

b. other furnishings necessary to meet the clients' basic hygienic needs.

2. The provider shall have the ratio of lavatories, toilets, tubs and/or showers to clients required by the Louisiana state *Sanitary Code*.

3. A provider shall have at least one separate toilet, lavatory, and bathing facility for the staff located within the provider.

4. In a multi-level facility, there shall be at least one a full bathroom with bathing facility reserved for client use on each client floor.

5. Each bathroom shall be located so that it opens into a hallway, common area or directly into the bedroom. If the bathroom only opens directly into a bedroom, it shall be for the use of the occupants of that bedroom only.

6. The provider shall ensure that each client has personal hygiene items, such as a toothbrush, toothpaste, shampoo, and soap as needed.

H. Kitchen

1. If a BHS provider prepares meals on-site, the BHS provider shall have a full service kitchen that meets the requirements of the Louisiana state *Sanitary Code* and:

a. includes a cooktop, oven, refrigerator, freezer, hand washing station, storage and space for meal preparation;

b. is inspected and approved annually by OPH;

c. has the equipment necessary for the preparation, serving, storage and clean-up of all meals regularly served to all of the clients and staff; and

d. contains trash containers covered and made of metal or United Laboratories-approved plastic;

2. A BHS provider that does not prepare meals on-site shall have a nourishment station or a kitchenette, that includes:

a. a sink;

b. a work counter;

c. a refrigerator;

d. storage cabinets;

e. equipment for preparing hot and cold nourishments between scheduled meals; and

f. space for trays and dishes used for nonscheduled meal service.

I. Laundry. The provider shall have a laundry space complete with a ratio of 1:20 washers and dryers to meet the needs of the clients.

J. Staff Quarters. The provider utilizing live-in staff shall provide adequate, separate living space with a private bathroom for staff usage only.

K. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

L. The provider shall ensure that outside doors and windows prohibit an outsider from gaining unauthorized ingress.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1707 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1385 (July 2017).

Subchapter J. Safety and Emergency Preparedness

§5671. Safety Provisions for Outpatient Clinics and Residential Facilities

A. The provider shall provide additional supervision when necessary to provide for the safety of all individuals.

B. The provider shall:

1. prohibit weapons of any kind on-site unless possessed by security or law enforcement official or hired security while in uniform and on official business;

2. ensure that its equipment, furnishings, accessories and any other items that are in a state of disrepair or defects are removed and inaccessible until replaced or repaired;

3. ensure that all poisonous, toxic and flammable materials are:

a. maintained in appropriate containers and labeled as to the contents;

b. securely stored in a separate and locked storage area that is inaccessible to clients;

c. maintained only as necessary; and

d. are used in such a manner as to ensure the safety of clients, staff and visitors;

4. ensure that supervision and training is provided to any staff member or client exposed to or that may come in contact with potentially harmful materials such as cleaning solvents and/or detergents;

5. ensure that a first aid kit is readily available in the provider and in all vehicles used to transport clients.

C. Required Inspections. The provider shall be in compliance with all required inspections and shall have documentation to demonstrate compliance with applicable laws and regulations.

D. The provider shall have an on-going safety program in any facility where clients, staff and others may be, that includes:

1. continuous inspection of the provider for possible hazards;

2. continuous monitoring of safety equipment and maintenance or repair when needed;

3. investigation and documentation of all accidents or emergencies; and

4. fire control and evacuation planning with documentation of all emergency drills.

E. Required BHS Provider Reporting. The provider shall report the following incidents in writing to HSS on the HSS approved form within 24 hours of discovery:

1. any disaster or emergency or other unexpected event that causes significant disruption to program operations and an inability to provide services for greater than 24 hours;

2. any death or serious injury of a client that:

a. may potentially be related to program activities; or

b. at the time of his/her death or serious injury, was on-site at the BHS provider's premises or a resident of the provider's facility; and

3. allegations of client abuse, neglect and/or exploitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1709 (September 2015).

§5673. Infection Control

A. The provider shall provide a sanitary environment to avoid source(s) and transmission of infections and communicable diseases.

B. The provider shall have an active Infection Control Program that requires:

1. reporting of infectious disease in accordance with CDC and state OPH guidelines;

2. monitoring of:

a. the spread of infectious disease;

b. hand washing;

c. staff and client education; and

d. incidents of specific infections in accordance with OPH guidelines;

3. corrective actions; and

4. a designated infection control coordinator who:

a. develops and implements policies and procedures related to infection control; and

b. has training and/or experience in infection control;

5. universal precautions; and

6. strict adherence to all sanitation requirements.

C. The provider shall maintain a clean and sanitary environment and shall ensure that:

1. supplies and equipment are available to staff;

2. consistent ongoing monitoring and cleaning of all areas of the provider;

3. methods used for cleaning, sanitizing, handling and storing of all supplies and equipment prevent the transmission of infection;

4. procedures are posted for sanitizing kitchen, kitchen, bathroom and laundry areas in accordance with the *Louisiana Sanitary Code*; and

5. storage, handling, and removal of food and waste will not spread disease, cause noxious odor, or provide a breeding place for pests.

D. The provider may enter into a written contract for housekeeping services necessary to maintain a clean and neat environment.

E. The provider shall have an effective pest control plan.

F. After discharge of a client, the residential provider shall:

1. clean the bed, mattress, cover, bedside furniture and equipment;

2. ensure that mattresses, blankets and pillows assigned to clients are in sanitary condition; and

3. ensure that the mattress, blankets and pillows used for a client with an infection is sanitized before assigned to another client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1709 (September 2015).

§5675. Emergency Preparedness

A. The BHS provider shall have written disaster and emergency preparedness plans which are based on a risk assessment using an all hazards approach for both internal and external occurrences, developed and approved by the governing body and updated annually:

1. to maintain continuity of the provider's operations in preparation for, during and after an emergency or disaster;

2. to manage the consequences of all disasters or emergencies that disrupt the provider's ability to render care and treatment, or threaten the lives or safety of the clients; and

3. that are prepared in coordination with the provider's local and/or parish Office of Homeland Security and Emergency Preparedness (OHSEP) and include provisions for persons with disabilities.

B. The BHS provider shall develop and implement policies and procedures based on the emergency plan, risk assessment and communication plan which shall be reviewed and updated at least annually. Such policies shall include a system to track on duty staff and sheltered clients, if any, during the disaster or emergency.

C. The BHS provider shall develop and maintain a disaster and emergency preparedness plan that complies with both federal and state laws. Client care shall be well-coordinated within the BHS provider, across health care providers and with state and local public health departments and emergency systems.

D. The BHS provider shall develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of disaster and emergency procedures. Such training shall be provided at least annually.

E. Additional Requirements. The residential facility or outpatient clinic shall:

1. post floor plans with diagrams giving clear directions on how to exit the building safely and in a timely manner at all times;

2. post emergency numbers by all telephones;

3. have a separate floor plan or diagram with designated safe zones or sheltering areas for non-fire emergencies;

4. train its employees in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for each employee and on each shift; and

5. ensure that emergency equipment and supplies are:

a. immediately available for use during emergency situations;

b. appropriate for the BHS provider's client population;

c. maintained by appropriate personnel; and

d. are specified by the medical staff and approved by the governing body for treatment of all age groups serviced by the BHS provider.

F. The residential BHS provider's disaster and emergency preparedness plans shall include, at a minimum:

1. in the event of a disaster or an emergency, an assessment of all clients to determine the clients:

a. who continue to require services and should remain in the care of the provider; or

b. who may be discharged to receive services from another provider;

2. the determination as to when the provider will shelter in place and when the provider will evacuate for a disaster or emergency and the conditions that guide these determinations in accordance with local or parish OHSEP;

3. provisions for when the provider shelters-in-place that include:

a. the decision to take this action is made after reviewing all available and required information on the emergency/disaster, the provider, the provider's surroundings, and consultation with the local or parish OHSEP;

b. provisions for seven days of necessary supplies to be provided by the provider prior to the emergency, including drinking water or fluids and non-perishable food; and

c. the delivery of essential services to each client;

4. provisions for when the provider evacuates with clients:

a. the delivery of essential provisions and services to each client, whether the client is in a shelter or other location;

b. the provider's method of notifying the client's family or caregiver, including:

i. the date and approximate time that the provider or client is evacuating;

ii. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

iii. a telephone number that the family or responsible representative may call for information regarding the client's evacuation;

c. provisions for ensuring that supplies, medications, clothing and a copy of the treatment plan are sent with the client, if the client is evacuated;

d. the procedure or methods that will be used to ensure that identification accompanies the client. The identification shall include the following information:

i. current and active diagnosis;

ii. all medication, including dosage and times administered;

iii. allergies;

iv. special dietary needs or restrictions; and

v. legal representative, if applicable, including contact information;

e. transportation or arrangements for transportation for an evacuation that is adequate for the current census;

5. provisions for staff to maintain continuity of care during an emergency; and

6. staff distribution and assignment of responsibilities and functions during an emergency.

G. The outpatient clinic's disaster and emergency preparedness plan shall include, at a minimum:

1. in the event of an emergency or disaster, an assessment of all clients to determine the clients:

a. who continue to require services; or

b. who may be discharged to receive services from another provider;

2. a plan for each client to continue to receive needed services during a disaster or emergency either by the provider or referral to another program; and

3. measures to be taken to locate clients after an emergency or disaster and determine the need for continued services and/or referral to other programs.

H. The provider shall:

1. follow and execute its disaster and emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency;

2. if the state, parish or local OHSEP orders a mandatory evacuation of the parish or the area in which the agency is serving, ensure that all clients are evacuated according to the provider's disaster and emergency preparedness plan;

3. review and update its disaster and emergency preparedness plan at least once a year;

4. cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and provide information as requested;

5. monitor weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials;

6. upon request by the department, submit a copy of its emergency preparedness plan for review; and

7. upon request by the department, submit a written summary attesting how the emergency plan was followed and executed. The summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1710 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1385 (July 2017).

§5677. Inactivation of License due to a Declared Disaster or Emergency

A. A licensed BHS provider located in a parish which is the subject of an executive order or proclamation of emergency or disaster issued, may seek to inactivate its license for a period not to exceed one year, provided that the provider:

1. submits written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the BHS provider has experienced an interruption in the provisions of services and an inability to resume services as a result of events that are the subject of such executive order or proclamation of emergency or;

b. the BHS provider intends to resume operation as a BHS provider in the same service area;

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

d. includes an attestation that all clients have been properly discharged or transferred to another provider; and

e. lists the clients and the location of the discharged or transferred clients;

2. submits documentation of the provider's interruption in services and inability to resume services as a result of the emergency or disaster;

3. resumes operating as a BHS provider in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state statute;

4. continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil fines; and

5. continues to submit required documentation and information to the department.

B. Upon receiving a completed request to inactivate a BHS provider license, the department may issue a notice of inactivation of license to the BHS provider.

C. In order to obtain license reinstatement, a BHS provider with a department-issued notice of inactivation of license shall:

1. submit a written license reinstatement request to HSS 60 days prior to the anticipated date of reopening that includes:

a. the anticipated date of opening, which is within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state statute;

b. a request to schedule a licensing survey; and

c. a completed licensing application with appropriate licensing fees and other required documents, if applicable;

2. submit written approvals for occupancy from OSFM and OPH.

D. Upon receiving a completed written request to reinstate a BHS provider license, the department shall conduct a licensing survey.

E. If the BHS provider meets the requirements for licensure and the requirements under this subsection, the department shall issue a notice of reinstatement of the BHS provider license.

F. During the period of inactivation, the department prohibits change of ownership of the provider.

G. The provisions of this Section shall not apply to a BHS provider which has voluntarily surrendered its license.

H. Failure to request inactive status when the license becomes nonoperational due to a disaster or emergency and/or failure to comply with any of the provisions of this subsection shall be deemed a voluntary surrender of the BHS provider license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1711 (September 2015).

§5678. Inactivation of License due to a Non-Declared Emergency or Disaster

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

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

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

b. the licensed BHS provider intends to resume operation as a BHS provider in the same service area;

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

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

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

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

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

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

C. Upon the provider's receipt of the department's approval of request to inactivate the provider's license, the provider shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to the OSFM and the OPH as required.

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

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

E. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a BHS provider which has received a notice of inactivation of its license from the

department shall be allowed to reinstate its license upon the following conditions being met:

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

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

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

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

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

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

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the BHS provider license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1386 (July 2017).

Subchapter K. Additional Requirements for Children/Adolescent Programs

NOTE: In addition to the requirements applicable to all Behavioral Health Service providers, programs that treat children and/or adolescents shall meet the applicable requirements below.

§5679. General Provisions

A. The BHS provider that provides services to children and/or adolescents shall:

1. provide program lectures and written materials to the clients that are age-appropriate and commensurate with their education and skill-level;

2. involve the client's family or an alternate support system in the process or document why this is not appropriate;

3. prohibit staff from:

a. providing, distributing or facilitating access to tobacco products, alcohol or illegal drugs; and

b. using tobacco products in the presence of adolescent clients;

4. prohibit clients from using tobacco products on the program site or during structured program activities;

5. address the special needs of its clients and comply with all applicable standards, laws and protocols to protect their rights;

6. develop and implement policies and procedures for obtaining consent in accordance with state statutes; and

7. prohibit adults and children/adolescents from attending the same group counseling sessions and activities unless it is therapeutically indicated.

B. Staffing

1. All direct care employees shall have training in adolescent development, family systems, adolescent psychopathology and mental health, substance use in adolescents, and adolescent socialization issues.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1711 (September 2015).

§5681. Residential Programs for Children and/or Adolescents

A. Staffing

1. While the clients are on-site, the staff shall:

a. directly supervise and be readily available within hearing distance of the clients at all times; and

b. conduct visual checks, including bed checks, at least once every hour, or more frequently as indicated in the treatment plan.

2. The clients who are off-site but under the responsibility of the provider shall be within eyesight of the staff at all times. While off-site, there shall be a ratio of one staff member to five clients.

B. Educational Resources. The provider shall provide a Department of Education-approved opportunity for clients to maintain grade level and continuity of education during any treatment lasting longer than 14 days unless the treatment occurs during school vacation.

C. Family Communications. The provider shall allow regular communication between a client and the client's family and shall not arbitrarily restrict any communications without clear, written, individualized clinical justification documented in the client record.

D. Recreational Space. Clients shall have access to safe, suitable outdoor recreational space and age appropriate equipment that is located, installed and maintained to ensure the safety of the clients.

E. The provider shall provide a tobacco cessation program to assist client's with nicotine dependency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

Subchapter L. Additional Requirements for Mental Health Programs

NOTE: In addition to the requirements applicable to all BHS providers, a provider that provides mental health services shall meet the requirements of Subchapter L.

§5683. Staffing Requirements

A. Medical Director. The provider with a mental health program shall ensure that its medical director, when the provider is required to have a medical director, holds a current, unrestricted license to practice in the state of Louisiana in accordance with the practitioner's state licensing board, and meets the requirements of §5643.B.1.a Exception.

NOTE: The medical director may fulfill the role of the clinical director if the individual is qualified to perform the duties of the clinical director.

B. Clinical Director. The provider with a mental health program shall ensure that its clinical director holds a current, unrestricted license to practice in the state of Louisiana in accordance with the practitioner's state licensing board and meets the requirements of §5643.B.2.a.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1387 (July 2017).

§5685. Psychosocial Rehabilitation Services

A. The provider that provides psychosocial rehabilitation services (PSR) shall:

1. provide PSR either individually or in a group setting;

2. provide services in community locations where the client lives, works, attends school and/or socializes in addition to or instead of at the licensed entity;

3. assist the client in developing social and interpersonal skills to:

a. increase community tenure;

b. enhance personal relationships;

c. establish support networks;

d. increase community awareness; and

e. develop coping strategies and effective functioning in the individual's social environment;

4. assist the client with developing daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living;

5. implement learned skills so the client can remain in a natural community location and achieve developmentally appropriate functioning; and

6. assist the client with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

B. Staffing. The provider shall ensure that:

1. the unlicensed professionals providing PSR receive regularly scheduled clinical supervision from an LMHP;

2. the size of group therapy does not exceed 15 adults or 8 adolescents or children;

3. its staff providing PSR services:

a. is at least 18 years old;

b. has a high school diploma or equivalent; and

c. is at least three years older than any individual served under the age of 18.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

§5687. Crisis Intervention

A. Crisis intervention services may occur in a variety of locations including a health care provider or the community.

B. The provider shall ensure that:

1. a preliminary screening of risk, mental status and stability and the need for further evaluation or other mental health services is conducted by an UP that:

a. includes contact with the client, family members or other collateral sources with pertinent information; and

b. includes a referral to other alternative mental health services at an appropriate level if necessary;

2. an assessment of risk, mental status and psychiatric stability is conducted by a LMHP.

C. Staffing

1. Unlicensed Professionals

a. Unlicensed professionals (UPs) shall:

i. be at least 20 years old and be at least three years older than a client under the age of 18; and

ii. have either:

(a). an associate's degree in social work, counseling, psychology or a related human services field;

(b). two years of course work in a human services field; or

(c). two years of qualifying experience working with clients who have behavioral health disorders.

b. The responsibilities of the UP include:

i. performing the preliminary screening;

ii. assisting the program's LMHP in conducting the assessment;

iii. developing and implementing an individualized written crisis plan from the assessment that provides procedures to reduce the risks of harm to the client and others as well as follow-up procedures;

iv. consulting with physician or the program's LMHP when necessary;

v. providing short term crisis intervention, including crisis resolution and debriefing with the client;

vi. contacting family members when necessary; and

vii. following up with the client and as necessary, with family members and/or caretaker.

2. Licensed Mental Health Professionals

a. The licensed mental health professional (LMHP) shall have experience in administering crisis intervention techniques that work to minimize the risk of harm to self or others.

b. The responsibilities of the LMHP are:

i. to conduct the assessment of risk, mental status and medical stability;

ii. to be available for consultation and support; and

iii. to supervise the development and implementation of each crisis plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1712 (September 2015).

§5689. Community Psychiatric Support and Treatment

A. The provider that provides community psychiatric support and treatment (CPST) services shall:

1. provide services in community locations where the client lives, works, attends school and/or socializes in addition to or instead of at the licensed entity;

2. provide CPST services with the client present;

3. provide services to minimize the negative effects of the symptoms, emotional disturbances or associated environmental stressors which interfere with the client's daily living;

4. provide individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the client;

5. participates in and utilizes strengths-based planning and treatments, that includes identifying strengths and needs, resources, natural supports and developing goals and objectives to address functional deficits associated with the client's mental illness; and

6. provides restoration, rehabilitation and support to develop skills to locate, rent and keep a home.

B. Staffing Requirements

1. Unlicensed Professionals Providing CPST Services

a. The program's UPs that provide CPST, except counseling, shall have one of the following:

i. a bachelor's degree in social work, counseling, psychology or a related human services field;

ii. four years of equivalent education in a human service field; or

iii. four years of qualifying experience working with clients who have behavioral health disorders.

b. The program's UPs that provide counseling services shall have a master's degree in social work, counseling, psychology or a related human services field.

c. The responsibilities of the UPs, when providing CPST services include:

i. assisting the client with effectively responding to or avoiding identified precursors or triggers that would risk the client remaining in a natural community location;

ii. assisting in the development of daily living skills specific to managing a home; and

iii. assisting the client and family members to identify strategies or treatment options associated with the client's mental illness.

2. Licensed Mental Health Professionals

a. The LMHP shall have experience in CPST services.

b. The LMHP is responsible for providing clinical supervision of the CPST staff.

3. The provider shall ensure that the direct care staff's caseload size:

a. is based on the needs of the clients and their families with emphasis on successful outcomes and individual satisfaction; and

b. meets the needs identified in the individual treatment plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1713 (September 2015).

§5691. Behavioral Health Service Providers with a Mental Health Program that Provide Services Only in the Home and Community

A. The BHS provider with only a home and community-based mental health program shall notify HSS of the

parishes in the state of Louisiana in which it will provide services. The parishes shall be contiguous.

B. Business Office. The provider offering behavioral health services only in the home or community shall have a business location that:

1. is part of the licensed location of the BHS provider;

2. is located in a parish where the provider offers services;

3. has at least one employee on duty in the business office during hours of operation listed on the approved license application;

4. stores the administrative files, including governing body documents, contracts to which the provider is a party, insurance policies, budgets and audit reports, personnel files, client records, policies and procedures, and other files or documents the BHS provider is required to maintain; and

5. is not located in an occupied personal residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1713 (September 2015).

Subchapter M. Additional Requirements for Substance Abuse/Addiction Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, a provider that provides substance abuse/addiction treatment services shall meet the requirements of Subchapter M.

§5693. General Requirements

A. The BHS provider shall provide, either directly or through referral:

1. access to HIV counseling and testing services;

2. access to testing for pregnancy, tuberculosis and sexually transmitted diseases; and

3. appropriate follow-up referral and care.

B. Staffing

1. Medical Director

a. The provider shall ensure that its medical director is a licensed physician who:

i. is an addictionologist; or

ii. meets all of the following:

(a). is board-eligible or board-certified;

(b). has two years of qualifying experience in treating addictive disorders; and

(c). maintains a consulting relationship with an addictionologist.

b. A PA may perform duties as designated by the supervising physician in accordance with the Louisiana State Board of Medical Examiners.

c. The APRN shall have a collaborative practice agreement with a physician in accordance with the Louisiana State Board of Nursing.

2. LMHPs. The LMHP providing addiction treatment services shall have documented credentials, experience and/or training in working with clients who have addictive disorders.

3. UPs. A UP providing addiction treatment services shall meet one of the following qualifications:

a. a master's-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in addiction treatment settings, the master's prepared UP shall be supervised by a LMHP who meets the requirements of this Section;

b. be a registered addiction counselor;

c. be a certified addiction counselor; or

d. be a counselor in training (CIT) that is registered with ADRA and is currently participating in a supervisory relationship with a ADRA-registered certified clinical supervisor (CCS).

C. Policies and Procedures. The BHS provider shall have a policy and procedure that addresses drug screen tests and collections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1714 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1387 (July 2017).

§5695. Addiction Outpatient Treatment Program (ASAM Level I)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level I into this program;

2. provide fewer than nine contact hours per week for adults and fewer than six hours per week for children/adolescents; and

3. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 90 days.

B. Staffing. The provider shall ensure that:

1. there are physician services available as needed for the management of psychiatric and medical needs of the clients;

a. physician services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The

BHS provider shall maintain documentation of such arrangement;

2. there is a clinical supervisor available on site for supervision as needed, and available on call at all times;

3. there is at least one LMHP or UP on-site when clinical services are being provided;

4. each LMHP/UP's caseload does not exceed 1:50 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1714 (September 2015).

§5697. Intensive Outpatient Treatment Programs (ASAM Level II.1)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level II.1 into this program;

2. maintain a minimum of 9 contact hours per week for adults, at a minimum of three days per week, with a maximum of 19 hours per week;

3. maintain a minimum of 6 hours per week for children/adolescents, at a minimum of three days per week, with a maximum of 19 hours per week; and

4. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days.

B. Staffing. The provider shall ensure that:

1. a physician is on site as needed for the management of psychiatric and medical needs and on call 24 hours per day, seven days per week;

2. there is a clinical supervisor on-site 10 hours a week and on call 24 hours per day, seven days per week;

3. there is at least one LMHP or UP on site when clinical services are being provided;

4. each LMHP/UP caseload does not exceed 1:25 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1714 (September 2015).

§5698. Partial Hospitalization Services (substance abuse only) (ASAM Level II.5)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level II.5 into this program;

a. services may be offered during the day or evening hours, before or after work or on weekends, while also allowing the patient to apply their new skills and strategies in the community;

2. maintain a minimum of 20 contact hours per week for adults, at a minimum of three days per week;

3. maintain a minimum of 20 hours per week for children/adolescents, daily or as specified in the patient's treatment plan and may occur during school hours;

a. adolescents shall have access to educational services; or

b. the provider shall be able to coordinate with the school system to ensure that the adolescent's educational needs are met; and

4. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days.

B. Staffing. The provider shall ensure that:

1. a licensed physician is on site as needed for the management of psychiatric and medical needs and on call 24 hours per day, seven days per week;

2. there is a clinical supervisor on-site 10 hours a week and on call 24 hours per day, seven days per week;

3. there is at least one LMHP or UP on site when clinical services are being provided;

4. each LMHP/UP caseload does not exceed 1:25 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:1387 (July 2017).

§5699. Ambulatory Detoxification with Extended On-Site Monitoring (ASAM Level II-D) (Adults Only)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level II-D into this program;

2. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days; and

3. ensure that level II-D services are offered in conjunction with intensive outpatient treatment services (ASAM level II.1);

B. Staffing. The provider shall ensure that:

1. a physician is on-site at least 10 hours per week during operational hours and on-call 24 hours per day, seven days per week;

2. there is a LMHP or UP on site 40 hours per week;

3. each LMHP/UP caseload does not exceed 1:25 active clients;

4. there is a licensed nurse on call 24 hours per day, seven days per week and on site no less than 40 hours a week; and

5. there is a RN on-site as needed to perform nursing assessments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1715 (September 2015).

§5701. Clinically Managed Low-Intensity Residential Treatment Program (ASAM Level III.1)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level III.1 into its Clinically Managed Low-Intensity Residential Treatment Program;

2. offer at least five hours per week of a combination of low-intensity clinical and recovery focused services, including:

a. individual therapy;

b. group and family therapy;

c. medication management; and

d. medication education;

3. ensure that the treatment plan is reviewed in collaboration with the client at least every 90 days;

4. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing

1. The provider shall have a clinical supervisor available for clinical supervision and by telephone for consultation.

2. There shall be at least one LMHP or UP on duty at least 40 hours a week.

3. Adult Staffing Patterns

a. The LMHP/UP caseload shall not exceed 1:25 active clients.

b. There shall be at least one direct care aide on duty during each shift.

4. Children/Adolescent Staffing Patterns

a. The UP caseload shall not exceed 1:8 active clients.

b. The provider shall have at least two direct care aides on duty during each shift.

c. There shall be a ratio of 1:8 direct care aides during all shifts and a ratio of 1:5 direct care aides on therapy outings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1715 (September 2015).

§5703. Clinically Managed Residential Detoxification (Social Detoxification) (ASAM Level III.2D)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level III.2D into its Clinically Managed Residential Detoxification Program;

2. screen each client upon arrival for at least the following to ensure proper placement:

a. withdrawal potential;

b. biomedical conditions; and

c. cognitive/emotional complications;

3. have at least one staff member on each shift trained in cardiopulmonary resuscitation (CPR);

4. develop and implement an individualized stabilization/treatment plan in collaboration with the client that:

a. shall be reviewed and signed by the UP and the client; and

b. shall be filed in the client's record within 24 hours of admission;

5. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Emergency Admissions

1. If a client is admitted under emergency circumstances, the admission process may be delayed until the client can be interviewed, but no longer than 24 hours unless assessed and evaluated by a physician.

2. The provider shall orient the direct care staff to monitor, observe and recognize early symptoms of serious illness associated with detoxification and to access emergency services promptly.

C. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week and on duty as needed for management of psychiatric and medical needs of the clients;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is at least one LMHP or UP available on site at least 40 hours per week; and

4. for adults:

a. each LMHP/UP's caseload shall not exceed 1:25;

b. there is at least one direct care aide per shift with additional as needed;

5. for children/adolescents:

a. each LMHP/UP's caseload shall not exceed 1:16;

b. there are at least two direct care aides per shift with additional as needed; and

c. the ratio of aides to clients shall not exceed 1:10.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1715 (September 2015).

§5705. Clinically Managed Medium-Intensity Residential Treatment (ASAM Level III.3) (Adult Only)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level III.3 into its Clinically Managed Medium-Intensity Residential Program;

2. offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services;

3. ensure that the treatment plan is reviewed in collaboration with the client as needed or at a minimum of every 90 days and documented accordingly; and

4. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day and on duty as needed for management of psychiatric and medical needs;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is 24 hour on-call availability by an RN plus a licensed nurse on duty whenever needed to meet the professional nursing requirements;

4. there is a LMHP or UP on site 40 hours a week to provide direct client care;

5. each LMHP/UP caseload shall not exceed 1:12; and

6. there is at least one direct care aide on duty for each shift plus additional aides as needed.

C. Mothers with Dependent Children Program (Dependent Care Program)

1. A provider's Mothers with Dependent Children Program shall:

a. meet the requirements of ASAM level III.3;

b. provide weekly parenting classes where attendance is required;

c. address the specialized needs of the parent;

d. provide education, counseling, and rehabilitation services for the parent that further addresses:

i. the effects of chemical dependency on a woman's health and pregnancy;

ii. parenting skills; and

iii. health and nutrition;

e. regularly assess parent-child interactions and address any identified needs in treatment; and

f. provide access to family planning services.

2. Child Supervision

a. The provider shall ensure that it provides child supervision appropriate to the age of each child when the mother is not available to supervise her child.

b. The provider shall ensure that its child supervision is provided by either:

i. the provider's on-site program with all staff members who:

(a). are at least 18 years old;

(b). have infant CPR certification; and

(c). have at least eight hours of training in the following areas prior to supervising children independently:

(i). chemical dependency and its impact on the family;

(ii). child development and age-appropriate activities;

(iii). child health and safety;

(iv). universal precautions;

(v). appropriate child supervision techniques; and

(vi). signs of child abuse; or

ii. a licensed day care provider pursuant to a written agreement with the provider.

c. The provider shall maintain a staff-to-child ratio that does not exceed 1:3 for infants (18 months and younger) and 1:6 for toddlers and children.

d. Child Specialist. The provider shall have a child specialist who:

i. is available to provide staff training, evaluate effectiveness of direct care staff, and plan activities, for at least one hour per week per child;

ii. has 90 clock hours of education and training in child development and/or early childhood education; and

iii. has one year of documented experience providing services to children.

e. Clients shall not supervise another parent's child or children without written consent from the legal guardian and staff approval.

f. Staff shall check all diapers frequently and change as needed, dispose of the diapers in a sealed container and sanitize the changing area.

3. Clinical Care for Children. The provider shall:

a. address the specialized and therapeutic needs and care for the dependent children and develop an individualized plan of care to address those needs, to include goals, objectives and target dates;

b. provide age-appropriate education, counseling, and rehabilitation services for children that address or include:

i. the emotional and social effects of living with a chemically dependent care-giver;

ii. early screening and intervention of high risk behavior and when indicated provide or make appropriate referrals for services;

iii. screening for developmental delays; and

iv. health and nutrition;

c. ensure that all children have access to medical care when needed;

d. ensure that children are administered medication according to the label by the parent or licensed staff qualified to administer medications; and

e. ensure that if licensed staff will be administering medications, the provider:

i. obtains written consent from the parent to administer the prescribed and over the counter medications, including identifying information relative to dosage, route, etc.;

ii. assumes full responsibility for the proper administration and documentation of the medications; and

iii. ensures original labeled medication containers with name, dosage, route, etc. are obtained prior to medication administration.

f. maintain current immunization records and allergy records for each child at the program site; and

g. obtain consent for emergency medical care for each child at admission.

4. Child Services

a. The daily activity schedule for the children shall include a variety of structured and unstructured age-appropriate activities.

b. School age children shall have access to school.

c. The health, safety, and welfare of the children shall be protected at all times.

d. Behavior management shall be fair, reasonable, consistent, and related to the child's behavior. Physical discipline is prohibited.

e. The children shall be well-groomed and dressed weather-appropriate.

f. An adequate diet for childhood growth and development, including two snacks per day, shall be provided to each child.

5. The program shall develop, implement and comply with written policies and procedures that:

a. address abuse and/or neglect of a child;

b. prohibit children under the age of 18 months from sleeping in bed with their mothers;

c. require a current schedule showing who is responsible for the children at all times;

d. address isolating parents and children who have communicable diseases and providing them with appropriate care and supervision; and

e. identify those persons authorized to remove a child from the facility other than legal guardian or parent.

6. Safety and Emergency Preparedness

a. The program shall develop and implement an emergency preparedness plan that includes provisions and services for the clients and children.

b. The program shall ensure that all toys and equipment are age appropriate, in good order and safe condition, and in accordance with manufacturer's recommendations.

c. Staff, volunteers, and parents shall use universal precautions at all times.

d. The provider shall ensure that only the legal guardian or a person authorized by the legal guardian may remove a child from the provider.

e. If an individual shows documentation of legal custody, staff shall record the person's identification before releasing the child.

7. Physical Environment

a. The program shall provide potty chairs for small children and sanitize them after each use.

b. The program shall provide age-appropriate bathing facilities. Infants shall not be bathed in sinks.

c. Each child shall be provided with his/her own bed.

d. Infants up to 18 months shall sleep in either a bassinet or cribs appropriate to the size of the child.

e. The provider shall provide a variety of age-appropriate equipment, toys, and learning materials for the children/adolescents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1716 (September 2015).

§5707. Clinically Managed High-Intensity Residential (ASAM Level III.5)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.5 into its Clinically Managed High Intensity Residential Treatment Program;

2. the treatment plan is reviewed in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly;

3. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. the provider shall have one licensed RN on call 24/7 to perform nursing duties for the provider; and

4. there shall be at least one LMHP or UP on duty at least 40 hours per week;

5. for adult staffing patterns:

a. each LMHP/UP's caseload shall not exceed 1:12;

b. there shall be at least one direct care aide on duty on all shifts with additional as needed; and

c. there shall be at least one licensed nurse on duty during the day and evening shifts to meet the nursing needs of the clients. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement;

6. for children/adolescent staffing patterns:

a. each LMHP/UP's caseload shall not exceed 1:8; and

b. there shall be at least two direct care aides on duty during all shifts with additional as needed. The ratio of aides to clients shall not exceed 1:8. On therapy outings, the ratio shall be at least 1:5;

c. there shall be a psychologist available when needed; and

d. there shall be a licensed nurse on duty to meet the nursing needs of the clients.

i. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1717 (September 2015).

§5709. Medically Monitored Intensive Residential (ASAM Level III.7) (Adults Only)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.7 into its Medically Monitored Intensive Residential Treatment Program; and

2. the treatment plan is reviewed and updated in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly;

3. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is at least one LMHP or UP on duty at least 40 hours/week;

4. there is at least one RN on call 24 hours per day, seven days per week to perform nursing duties and at least one licensed nurse is on duty during all shifts with additional licensed nursing staff to meet the nursing needs of the clients;

5. its on-site nursing staff is solely responsible for III.7 program and does not provide services for other levels of care at the same time;

6. each LMHP/UP caseload shall not exceed 1:10;

7. there is at least one direct care aide on duty on all shifts with additional as needed;

8. there is an activity or recreational therapist on duty at least 15 hours per week.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1718 (September 2015).

§5711. Medically Managed Residential Detoxification (Medical Detoxification) (ASAM Level III.7D) (Adults Only)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.7D into its Medically Managed Residential Detoxification Program;

2. ensure that:

a. a physical examination is conducted by a physician, PA or APRN within 24 hours of admission; or

b. the provider's admitting physician reviews and approves a physical examination conducted by a physician, PA or APRN within 24 hours prior to admission;

3. ensure that each client's progress is assessed at least daily;

4. ensure that each client's physical condition, including vital signs, is assessed at least daily, or more frequently as indicated by physician's order or change in the client's status;

5. have a reliable, adequately sized emergency power system to provide power during an interruption of normal electrical service;

6. provide case management that is conducted:

a. by a care coordinator who is on duty as needed; or

b. by the clinical staff.

B. Emergency Admissions

1. If a client is admitted under emergency circumstances, the admission process may be delayed until the client can be interviewed, but no longer than 24 hours unless seen by a physician.

2. The provider shall orient the direct care staff to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

C. Staffing

1. The provider shall have a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients.

2. Nursing

a. The provider shall have at least one RN on call 24 hours per day, seven days per week to perform nursing duties.

b. There shall be at least one licensed nurse on duty during all shifts with additional as needed based upon the provider's census and the clients' acuity levels.

c. There shall be a RN on-site no less than 40 hours per week who is responsible for conducting nursing assessments upon admission and delegating staffing assignments to the nursing staff based on the assessments and the acuity levels of the clients.

d. The provider shall ensure that its on-site nursing staff is solely responsible for III.7D program and does not provide services for other levels of care at the same time.

e. The nursing staff is responsible for:

i. monitoring client's progress; and

ii. administering medications in accordance with physician orders.

3. Clinical Supervisor and Unlicensed Professionals

a. The provider shall have a clinical supervisor available for clinical supervision when needed and by telephone for consultation.

b. The LMHP/UP caseload shall not exceed 1:10.

4. There shall be at least one direct care aide on all shifts with additional as needed based upon the provider's census and the clients' acuity levels.

5. The provider shall have at least one employee on duty certified in CPR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1718 (September 2015).

Subchapter N. Additional Requirement for Substance Abuse/Addictive Residential Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, residential programs that treat substance abuse/addiction shall meet the applicable requirements below.

§5713. Client Funds and Assets

A. If a BHS provider manages clients' personal funds accounts, the BHS provider shall develop and implement written policies and procedures governing the maintenance and protection of the client fund accounts that include, but are not limited to:

1. the maximum amount each client may entrust with the provider;

2. the criteria by which clients can access money;

3. the disbursement procedure, including the maximum amount that may be disbursed to the client;

4. staff members who may access such funds; and

5. the method for protecting and maintaining the funds.

B. The BHS provider that manages a client's personal funds shall:

1. furnish a copy of the provider's policy and procedures governing the maintenance and protection of client funds to the client or the client's parents or legal guardian, if applicable;

2. obtain written authorization from the client or the client's parent or legal guardian, if applicable, for the safekeeping and management of the funds;

3. provide each client with an account statement upon request with a receipt listing the amount of money the provider is holding in trust for the client;

4. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;

5. provide a list or account statement regarding personal funds upon request of the client; and

6. be prohibited from commingling the clients' funds with the provider's operating account.

C. If the BHS provider manages funds for a client, the provider shall ensure that:

1. any remaining funds shall be refunded to the client or his/her legal guardian within five business days of notification of discharge; and

2. in the event of the death of a client, any remaining funds are refunded to the client's legal representative within five business days of the client's death.

D. The BHS provider shall develop, implement and comply with a policies and procedures that address:

1. the maintenance and safeguard of client possessions, including money, brought to the provider by its clients;

2. maintaining an inventory of each client's possessions from the date of admission;

3. returning all possessions to the client upon the client's discharge; and

4. requiring the client and one staff member to sign documentation indicating that the client's possessions have been placed with the provider and the return of possessions to the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1719 (September 2015).

§5715. Dietary Services

A. The residential BHS provider shall ensure that:

1. all dietary services are provided under the direction of a Louisiana licensed dietician;

2. menus are approved by a licensed dietician;

3. meals are of sufficient quantity and quality to meet the nutritional needs of clients, including religious and dietary restrictions;

4. meals are in accordance with FDA dietary guidelines and the orders of the authorized licensed prescriber;

5. at least three meals plus an evening snack are provided daily with no more than 14 hours between any two meals;

6. all food is stored, prepared, distributed, and served under safe and sanitary conditions in accordance with the Louisiana state *Sanitary Code*;

7. all equipment and utensils used in the preparation and serving of food are properly cleaned, sanitized and stored in accordance with the LAC 51, *Public Health—Sanitary Code*; and

8. if meals are prepared on-site, they are prepared in an OPH approved kitchen.

B. The BHS provider may provide meal service and preparation pursuant to a written agreement with an outside food management company. If provided pursuant to a written agreement, the provider shall:

1. maintain responsibility for ensuring compliance with this Chapter;

2. ensure that the outside food management company possesses a valid OPH retail food permit; and

3. ensure that, if the provider does not employ or directly contract with a licensed dietician, the food

management company employs or contracts with a licensed dietician who serves the provider as needed to ensure that the nutritional needs of the clients are met in accordance with the authorized licensed prescriber's orders and acceptable standards of practice.

C. The licensed dietician shall:

1. approve therapeutic menus; and

2. be available for consultation when necessary.

D. If the BHS provider has a program that allows menu planning and preparation by clients, the provider shall develop and implement a policy with guidelines for the participating clients that:

1. ensures that meal preparation/service, with client participation, meets all requirements listed above; and

2. defines client's participation in writing and has written instructions posted or easily accessible to clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1719 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1388 (July 2017).

§5717. Transportation

A. A residential BHS provider shall assist in arranging for or provide transportation necessary for implementing the client's treatment plan, including but not limited to, court-ordered hearings and medically necessary appointments with a health care provider.

B. The BHS provider may provide transportation pursuant to a written agreement with an outside transportation service. If provided pursuant to a written agreement, the provider shall maintain responsibility for ensuring compliance with this Chapter.

C. Any vehicle used to transport a BHS provider's client shall be:

1. properly licensed and inspected in accordance with state law;

2. maintained in a safe condition;

3. operated at a climate controlled temperature that does not compromise the health, safety or needs of the client; and

4. operated in conformity with all of the applicable motor vehicle laws, including but not limited to, utilization of seat belts and vehicular child restraint systems.

D. The provider shall ensure that it or its contracted transportation service:

1. has documentation of current liability insurance coverage for all owned and non-owned vehicles used to transport clients. The personal liability insurance of a provider's employee shall not be substituted for the required coverage;

2. utilizes only drivers who are properly licensed and insured to operate that class of vehicle in accordance with state laws, rules and regulations;

3. obtains a driving history record from the state Office of Motor Vehicles for each employee upon hire and annually thereafter;

4. prohibits the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the vehicle; and

5. determines the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff responsible for transporting clients.

E. The provider shall comply with the following when transporting disabled non-ambulatory clients in a wheelchair:

1. a ramp to permit entry and exit of a client from the vehicle;

2. wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners; and

3. the client is securely fastened in the wheelchair.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1719 (September 2015).

§5719. Staffing

A. The provider shall ensure that there are at least two staff persons on site at all times when a client is present.

B. House Manager

1. A residential provider shall have a house manager.

2. The house manager shall:

a. be at least 21 years old;

b. have at least two years qualifying experience working for a provider that treats clients with mental illness and/or addiction disorders;

c. supervise the activities of the facility when the professional staff is not on duty;

d. perform clinical duties only if licensed to do so;

e. report incidents of abuse, neglect and misappropriation to the medical director;

f. identify and respond to and report any crisis situation to the clinical supervisor when it occurs; and

g. coordinate and consult with the clinical staff as needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 41:1720 (September 2015).

§5721. Policies and Procedures

A. House Rules and Regulations. A residential provider shall:

1. have a clearly written list of house rules and regulations governing client conduct and behavior management;

2. provide a copy of the house rules and regulations to all clients and, where appropriate, the client's parent(s) or legal guardian(s) upon admission;

3. post the rules and regulations in an easily accessible location in the provider and make them available when requested; and

4. have a policy and procedure that pertains to the bedroom assignment of its clients, with consideration given to age, client's diagnosis and severity of client's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1720 (September 2015).

Subchapter O. Additional Requirements for Opioid Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, opioid treatment programs shall also meet the requirements of Subchapter O.

§5723. General Provisions

A. A provider with an opioid treatment program shall:

1. meet the requirements of the protocols established by OBH/state opioid authority;

2. update the Louisiana methadone central registry daily and as needed;

3. upon the death of a client:

a. report the death of a client enrolled in their clinic to the SOA within 24 hours of the discovery of the client's death;

b. report the death of a client to HSS within 24 hours of discovery if the death is related to program activity;

c. submit documentation on the cause and/or circumstances to SOA and to HSS, if applicable, within 24 hours of the provider's receipt of the documentation; and

d. adhere to all protocols established by LDH on the death of a client; and

4. conduct at least eight random monthly drug screen tests on each client per year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1720 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1388 (July 2017).

§5725. Treatment

A. Client Admission Criteria. The program shall only admit clients that:

1. are at least 18 years old, unless the client has consent from a parent, or legal guardian, if applicable;

2. meet the federal requirements regarding the determination that the client is currently addicted to opiates and has been addicted to opiates for at least one year prior to admission or the exceptions;

3. are verified by a physician that treatment is medically necessary;

4. have had a complete physical evaluation by the client's or program's physician before admission to the opioid treatment program;

5. have had a full medical exam, including results of serology and other tests, completed within 14 days of admission; and

6. have a documented history of opiate addiction.

B. Treatment Phases

1. Initial Treatment. During the initial treatment phase that lasts from three to seven days in duration, the provider shall:

a. conduct client orientation;

b. provide individual counseling; and

c. develop the initial treatment plan including initial dose of medication and plan for treatment of critical health or social issues.

2. Early Stabilization. In the early stabilization period that begins on the third to seventh day following initial treatment through 90 days duration, the provider shall:

a. conduct weekly monitoring by a nurse of the client's response to medication;

b. provide at least four individual counseling sessions;

c. revise the treatment plan within 30 days to include input by all disciplines, the client and significant others; and

d. conduct random monthly drug screen tests.

3. Maintenance Treatment. In the maintenance treatment phase that follows the end of early stabilization and lasts for an indefinite period of time, the provider shall provide:

a. random monthly drug screen tests until the client has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated;

b. thereafter, monthly testing to clients who are allowed six days of take-home doses, as well as random testing for alcohol when indicated;

c. continuous evaluation by the nurse of the client's use of medication and treatment from the program and from other sources;

d. documented reviews of the treatment plan every 90 days in the first 2 years of treatment by the treatment team; and

e. documentation of response to treatment in a progress note at least every 30 days.

4. Medically Supervised Withdrawal from Synthetic Narcotic with Continuing Care. Medically supervised withdrawal is provided if and when appropriate. If provided, the provider shall:

a. decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by the client;

b. provide counseling of the type and quantity determined by the indicators and the reason for the medically supervised withdrawal from the synthetic narcotic; and

c. conduct discharge planning with continuity of care to assist client to function without support of the medication and treatment activities.

5. Required Withdrawal. The provider shall provide medically-approved and medically-supervised assistance to withdrawal from the synthetic narcotic when:

a. the client requests withdrawal;

b. quality indicators predict successful withdrawal; or

c. client or payer source suspends payment of fees.

C. Counseling. The provider shall ensure that:

1. counseling is provided when requested by the client or client's family;

2. written criteria are used to determine when a client will receive additional counseling;

3. the type and quantity of counseling is based on the assessment and recommendations of the treatment team;

4. written documentation supports the decisions of the treatment team, including indicators such as positive drug screens, maladjustment to new situations, inappropriate behavior, criminal activity, and detoxification procedure; and

5. all counseling is provided individually or in homogenous groups, not to exceed 12 clients.

D. Physical Evaluations/Examinations. The provider shall ensure that each client has a documented physical evaluation and examination by a physician or advanced practice registered nurse as follows:

1. upon admission;

2. every other week until the client becomes physically stable;

3. as warranted by client's response to medication during the initial stabilization period or any other subsequent stabilization period;

4. after the first year and annually thereafter; and

5. any time that the client is medically unstable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1721 (September 2015).

§5727. Additional Staffing Requirements

A. The provider's opioid treatment program shall have the following staff in addition to the general staffing requirements.

1. Pharmacist or Dispensing Physician

a. An opioid treatment program that dispenses prescription medication on-site shall employ or contract with a pharmacist or dispensing physician to assure that any prescription medication dispensed on-site meets the requirements of applicable state statutes and regulations.

b. The pharmacist or dispensing physician shall have a current, valid unrestricted license to practice in the state of Louisiana.

c. The provider's pharmacist or dispensing physician shall:

i. provide on-site services;

ii. dispense all medications;

iii. consult with the provider as needed;

iv. evaluate medication policy and procedure of provider to dispense medications;

v. reconcile inventories of medications that were dispensed and/or administered at least every 30 days;

vi. maintain medication records for at least three years in accordance with state laws, rules and regulations; and

vii. approve all transport devices for take-home medications in accordance with the program's diversion control policy.

2. Nursing

a. The provider shall maintain a nursing staff sufficient to meet the needs of the clients.

b. Each nurse shall have a current unrestricted license to practice nursing in the state of Louisiana.

c. The responsibilities of the nurse(s) include but are not limited to:

i. administering medications; and

ii. monitoring the client's response to medications.

3. Licensed Mental Health Professionals

a. The provider shall maintain a sufficient number of LMHPs to meet the needs of its clients and there is at least one LMHP or UP on site when clinical services are being provided.

b. The provider shall ensure that:

i. the caseload of the LMHP shall not exceed 75 active clients; and

ii. there is an LMHP on site at least five hours/week.

4. Unlicensed Professionals

a. The provider shall have UPs sufficient to meet the needs of the clients.

b. The caseload of the UP shall not exceed 75 active clients.

5. Physician or APRN. There shall be a physician or APRN who is on-site as needed or on-call as needed during hours of operation.

B. Training. All direct care employees shall receive orientation and training for and demonstrate knowledge of the following, including, but not limited to:

1. symptoms of opiate withdrawal;

2. drug screen testing and collections;

3. current standards of practice regarding opiate addiction treatment;

4. poly-drug addiction; and

5. information necessary to ensure care is provided within accepted standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1721 (September 2015).

§5729. Medications

A. The provider shall ensure that all medications are administered by a nurse, pharmacist or other practitioner licensed under state law and authorized by federal and state law to administer or dispense opioid drugs.

B. Take-Home Dose(s)

1. The provider shall ensure that:

a. determinations for take-home dose(s) and the factors considered are made by the client's treatment team and are documented in the client's record when each take-home dose is authorized;

b. date and recommended dosage are documented in the client's record; and

c. take-home dose(s) are ordered by the medical director.

2. The provider shall ensure that the following factors are considered by the medical director and treatment team before a take-home dose is authorized by the treatment team:

a. a negative drug/alcohol screen for at least 30 days;

b. documented regularity of clinic attendance relative to treatment plan;

c. absence of serious behavioral problems;

d. absence of known criminal activity;

e. absence of known drug related criminal activity during treatment;

f. stability of home environment and social relationships;

g. assurance that take-home medication can be safely stored; and

h. whether the benefit to the client outweighs the risk of diversion.

3. Standard Schedule. The provider shall abide by the following schedule of take-home, therapeutic doses when a take-home dose is authorized:

a. after the first 30 days of treatment, and during the remainder of the first 90 days of treatment, one take-home, therapeutic dose per week;

b. in the second 90 days of treatment, two doses, consisting of take-home, therapeutic doses, may be allowed per week;

c. in the third 90 days of treatment, three doses consisting of take-home, therapeutic doses may be allowed per week;

d. in the final 90 days of treatment during the first year, four doses consisting of take-home, therapeutic doses may be allowed per week;

e. after one year in treatment, a six-day dose supply consisting of take-home, therapeutic doses may be allowed once a week;

f. after two years in treatment, a 13-day dose supply consisting of take-home, therapeutic doses may be allowed once every two weeks.

4. Loss of Privilege. Positive drug screens at any time for any drug other than those prescribed shall require a new determination to be made by the treatment team regarding take-home doses.

5. Exceptions to the Standard Schedule. The provider shall request and obtain approval for an exception to the standard schedule from the state opioid authority. Any

exception shall be for an emergency or severe travel hardship.

C. Temporary Transfers or Guest Dosing. The providers involved in a temporary transfer or guest dosing shall ensure the following:

1. the receiving provider shall verify dosage prior to dispensing and administering medication;

2. the sending provider shall verify dosage and obtain approval and acceptance from receiving provider prior to client's transfer; and

3. that documentation to support all temporary transfers and guest dosing is maintained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1722 (September 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1388 (July 2017).

§5731. Client Records

A. In addition to the general requirements for client records, each client record shall contain:

1. recording of medication administration and dispensing in accordance with federal and state requirements;

2. results of five most recent drug screen tests with action taken for positive results;

3. physical status and use of additional prescription medication;

4. monthly or more frequently, as indicated by needs of client, contact notes and progress notes which include employment/vocational needs, legal and social status, and overall individual stability;

5. documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate;

6. documentation of approval of any exception to the standard schedule of take-home doses and the physician's justification for such exception; and

7. any other pertinent information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1723 (September 2015).

Chapter 60. Emergency Medical Transportation Services

Subchapter A. General Provisions

§6001. Definitions

Advanced Life Support (ALS)—emergency medical care administered to at least the level of an emergency medical technician-paramedic's scope of practice.

Air Ambulance—any aircraft, either fixed-winged or rotary-winged, designed and operated as a part of a regular course of conduct or business to transport a sick or injured individual, or which is advertised or otherwise held out to the public as such.

Air Ambulance Service—any person, firm, association, or government entity owning, controlling, or operating any business or service which furnishes, operates, conducts, maintains, advertises, engages in, proposes to engage in, or professes to engage in the business or service of transporting, in air ambulances, individuals who may need medical attention during transport.

Ambulance—any authorized emergency vehicle, equipped with warning devices, designed and operated as a part of a regular course of conduct or business to transport a sick or injured individual or which is advertised or otherwise held out to the public as such.

1. For purposes of these provisions, ambulance shall not mean a hearse or other funeral home vehicle utilized for the transportation of the dead.

Ambulance Service or Ambulance Provider—any person, firm, association, or government entity owning, controlling, or operating any business or service which furnishes, operates, conducts, maintains, advertises, engages in, proposes to engage in, or professes to engage in the business or service of transporting, in ambulances, individuals who may need medical attention during transport.

1. Ambulance services/providers shall not include any of the following:

a. an agency of the federal government;

b. a volunteer nonprofit organization or municipal nonprofit organization operating an invalid coach or coaches;

c. an entity rendering assistance to a licensed ambulance or ambulances in the case of a major disaster;

d. a licensed hospital providing nonemergency, noncritical, inter-hospital transfer and patient transportation for diagnostic and therapeutic purposes when such transportation originates at a licensed hospital;

e. an entity operating an ambulance(s) from a location outside of the state to transport patients from a location outside of the state to a location inside the state or to transport a patient(s)from a medical facility inside of the state to a location outside of the state; or

f. an entity providing transportation to employees, who become sick or injured during the course of their employment, from a job site to the nearest appropriate medical facility.

Appropriate Facility—an institution generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition.

Auto-Injector—a spring-loaded needle and syringe with a single dose of epinephrine that will automatically release and inject the medicine.

Basic Life Support (BLS)—emergency medical care administered to the EMT-basic scope of practice.

Bureau—the Department of Health and Hospitals, Office of Public Health, Bureau of Emergency Medical Services.

Certified Emergency Medical Technician—an individual who is certified as any one of the following:

1. a certified emergency medical technician-basic;

2. a certified emergency medical technician-intermediate; or

3. a certified emergency medical technician-paramedic.

Certified Emergency Medical Technician-Basic—an individual who has successfully completed the emergency medical technician-basic training program adopted by the bureau, who is nationally registered and who is certified by the bureau.

Certified Emergency Medical Technician-Intermediate—an individual who has successfully completed the emergency medical technician-intermediate training program adopted by the bureau, who is nationally registered and who is certified by the bureau.

Certified Emergency Medical Technician-Paramedic—an individual who has successfully completed the emergency medical technician-paramedic training program adopted by the bureau, who is nationally registered and who is certified by the bureau.

Certified First Responder—an individual who has successfully completed a training course adopted by the bureau for first responders and who is certified by the bureau.

Change of Ownership (CHOW)—the sale or transfer (whether by purchase, lease, gift or otherwise) of an ambulance service by a person/entity with controlling interest that results in a change of ownership, or control of 30 percent or greater of either the voting rights or assets of a provider, or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the provider.

Commission—the Louisiana Emergency Medical Services Certification Commission.

Department—the Louisiana Department of Health and Hospitals (DHH).

Emergency Medical Personnel or Emergency Service Person—an individual who is a certified first responder or a certified emergency medical technician.

Emergency Medical Response Vehicle—a marked emergency vehicle with fully visual and/or audible warning signals, operated by a certified ambulance service, whose primary purpose is to respond to the scene of a medical emergency to provide emergency medical stabilization or support, command, control, and communications, but which is not an ambulance designed or intended for the purpose of transporting a victim from the scene to a medical facility, regardless of its designation.

1. Included are such vehicles referred to, but not limited to, the designation as "sprint car", "quick response vehicle", "special response vehicle", "triage trucks", "staff cars", "supervisor units", and other similar designations.

2. Emergency medical response vehicles shall not include fire apparatus and law enforcement patrol vehicles which carry first aid or emergency medical supplies, and which respond to medical emergencies as part of their routine duties.

Emergency Medical Services (*EMS)*—a system that represents the combined efforts of several professionals and agencies to provide pre-hospital emergency care to the sick and injured.

EMS Professional—an individual who is a certified first responder or certified emergency medical technician.

EMS Task Force—individuals appointed by the assistant secretary of the Office of Public Health who advise and make recommendations to the office and the department on matters related to emergency medical services.

Emergency Vehicle—a vehicle that meets the definition of emergency vehicle in the Louisiana Highway Regulatory Act (R.S. 32:1).

First Aid Certificate—a certificate in the emergency response course issued by the American Red Cross or other certificate in a first aid course approved by the bureau and issued to any individual who has successfully completed the required training and met the established standards of such organizations.

Headquarters—an ambulance service's center of operation and control.

Industrial Ambulance—any vehicle owned and operated by an industrial facility and used for transporting any employee who becomes sick, injured or otherwise incapacitated in the course and scope of his employment from a job site to an appropriate medical facility.

Intermediate Life Support (ILS)—emergency medical care administered to the EMT-Intermediate scope of practice.

Moral Turpitude—an act of baseness, vileness, or depravity in the duties which one person owes another, or to

society in general, which is contrary to the usual, accepted and customary rule of right and duty which a person should follow.

Municipal Nonprofit Organization—an organization owned by a parish, municipality or entity of a parish or municipality which in its regular course of business responds to a call for help and renders medical treatment and whose attendants are emergency medical personnel, a registered nurse or a physician.

Operational—for an ambulance service to be considered operational, it must have a functional communications center (either owned and operated, or contracted) on duty 24 hours a day, 365 days a year. There must also be at least one staffed ambulance at the service's level of care on duty and able to respond to requests for service 24 hours a day, 365 days a year within the provider's service area unless excepted under other provisions of this Chapter.

Physician—a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners.

V-MED 28—the National Emergency Medical Services Mutual Aid (radio) frequency of 155.340 MHZ in the VHF broad band frequency spectrum.

Volunteer Nonprofit Organization—an organization which in its regular course of business responds to a call for help and renders medical treatment, whose attendants are emergency medical personnel, a registered nurse, or a physician and which is chartered as a nonprofit organization under Section 501c of the United States Internal Revenue Code, as a volunteer fire department by the Louisiana State Fire Marshal's Office, or as a nonprofit organization by the Louisiana Secretary of State.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1231.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:466 (March 2009), amended LR 41:2153 (October 2015).

§6003. Licensing Requirements and Types of Licenses

A. All ambulance services shall be licensed by the Department of Health and Hospitals (DHH). It shall be unlawful to operate or maintain an ambulance service in the state of Louisiana without possessing a license from the department. The Department of Health and Hospitals is the only licensing agency for ambulance services in the state of Louisiana.

B. No person, firm, corporation, association or government entity shall conduct, manage, operate, or maintain an ambulance service in Louisiana without a valid current license from the department.

1. Exception. No license shall be required for any hospital that operates a vehicle solely for the purpose of moving its own patients between parts of its own campus, provided that all of the following conditions are met:

a. the parts of the hospital's campus are not more than 10 miles apart;

b. at the time of transport, the patient is attended by at least two individuals who are an emergency medical technician, a licensed practical or registered nurse, or a physician; and

c. the vehicle utilized by the hospital for transport contains the same equipment as is required for a licensed ambulance.

C. Ground ambulance services shall be licensed separately from air ambulance services. In those air ambulance services that are joint ventures, the license shall be issued to the provider of medical care and services.

D. A separately licensed ambulance service shall not use a name which is substantially the same as the name of another ambulance service licensed by the department unless the applicant is part of the same corporation or is chain affiliated.

E. A license issued to an ambulance service shall:

1. be issued to the person or entity named in the license application;

2. be valid only for one service's headquarters and its substations to which it is issued, and only for the specific geographic address of that headquarters;

3. be valid for one year from the date of issuance, unless revoked, suspended, modified or terminated prior to that date or unless a provisional license is issued;

4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the service;

5. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place in the ambulance service's headquarters at all times.

F. The department has the authority to issue the following types of licenses.

1. A full license is issued only to those applicants that are in substantial compliance with all applicable federal, state, and local laws, regulations, and policies. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

2. A provisional license may be issued to those providers or applicants that do not meet the criteria for full licensure. The license shall be valid for a period not to exceed six months.

a. The department may conduct a follow-up inspection prior to the expiration of the provisional license. If at the follow-up inspection, the provider or applicant has corrected all non-compliance or violations, the department may issue a full license. The full license will be valid until the ambulance service's license anniversary date.

b. For an applicant applying for initial licensure, if the follow-up inspection reveals that the ambulance service failed to correct all violations, the service shall be required

to begin the initial licensing process again by submitting a new initial licensing packet and fee in order to become licensed.

c. For an existing ambulance provider, if the follow-up inspection reveals that the provider has failed to correct all violations, the department may re-issue a provisional license or allow the provisional license to expire.

d. A provisional license may be issued by the department for the following nonexclusive reasons:

i. the applicant or service has more than five violations of ambulance service regulations during one inspection;

ii. the applicant or service has more than three valid complaints in a one-year period;

iii. the department, medical director, or the quality improvement program have identified medical care that places patient(s) at risk;

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

v. the applicant fails to submit assessed fees after notification by the department; or

vi. there is documented evidence that the applicant has bribed, intimidated or harassed someone to use the services of any particular ambulance service.

3. If an existing licensed ambulance provider has been issued a notice of license revocation, suspension, modification or termination and the provider's license is due for annual renewal, the department shall issue a renewal license subject to the pending license revocation, suspension, modification or termination if a timely administrative appeal has been filed. The license renewal letter and the renewal license shall state that the license is being renewed subject to the pending license revocation, suspension, modification or termination. The renewal of such a license does not affect in any manner the license revocation, suspension, modification or termination; the renewal of such a license does not render any such license revocation, suspension, modification or termination moot. This type of license is valid for the pendency of the administrative appeal, provided that the renewal fees are timely paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:467 (March 2009).

§6005. Initial Licensing

A. All requirements of the application process for licensing shall be completed by the applicant before the application will be processed by the department. No application will be reviewed until the application fee is paid.

B. An application packet shall be obtained from the Department of Health and Hospitals. A completed application packet for an ambulance service shall be submitted to, and approved by, the department prior to an applicant providing ambulance services.

C. The license application shall be submitted to the department on forms provided for that purpose. The application shall provide documentation that the applicant meets the appropriate requirements for an ambulance provider as specified by regulations established by the department. An incomplete application shall be returned to the applicant.

D. An applicant seeking a license as an ambulance provider shall:

1. apply to provide the level of care consistent with its equipment and personnel and in accordance with the United States Department of Transportation National Highway Traffic Safety Administration's National Standard Emergency Medical Services (EMS) Curriculum and the Louisiana EMS Certification Commission's rules; this is the highest level of care that the service may function:

a. applicants must be able to provide at least one unit at the level of care for which they apply for 24 hours a day, 365 days a year;

b. ambulance services that serve more than one parish, must be able to provide at least one unit at the highest level of care for 24 hours a day, 365 days a year in each parish served;

c. the minimum level of care for an air ambulance service shall be at least at the EMT paramedic level. The department may require the submission of work schedules and individual credentials to verify this;

2. in the initial application only, petition the department for hours of operation other than 24 hours a day, 365 days a year;

3. submit a completed application to the department on the designated forms with the required information and the following supporting documentation:

a. a notarized certificate of insurance verifying that the provider has the legally mandated insurance coverage;

b. proof that the provider has a medical director and that such director is a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners;

c. all medical protocols signed by the physician/medical director with their prescribed approvals by the parish or component medical society, and/or the Louisiana Emergency Response Network (LERN) as applicable;

d. copies of personnel certifications:

i. the department may inspect and review these certifications at an applicant’s office(s) by prior agreement between the applicant and the department;

e. for those providers providing advanced life support, verification that the provider possesses a Louisiana Controlled Substance License and a United States Drug

Enforcement Administration Controlled Substance Registration;

f. proof that the service holds a Clinical Laboratory Improvement Act waiver;

g. a Federal Aviation Administration (FAA) Part 135 Commercial Air Taxi Certificate (where applicable); and

h. documentation that the provider is in compliance with the criminal history check requirements of R.S. 40:1300.51-1300.56;

4. submit to a background investigation which includes, but is not limited to, fingerprinting and a criminal history check; and

5. be a United States citizen or a legal alien with appropriate documentation from the U.S. Department of Homeland Security.

E. The applicant must be prepared to be fully operational for an initial inspection within 90 days after payment of the application fee. If the applicant is unable to do so, the application will be closed.

1. If the application is closed and the applicant is still interested in becoming an ambulance service provider, he/she shall submit a new initial application packet, including a new initial fee to start the licensing process.

F. Prior to the initial license being issued to the provider, an initial licensing inspection shall be conducted on-site at the ambulance provider to assure compliance with licensing standards and appropriate federal, state or local statues, laws, ordinances, rules and regulations.

G. Until the initial license is issued to the provider by the department, no patient shall be provided ambulance services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:468 (March 2009).

§6007. Service Areas

A. An ambulance provider's service area is that territory which the ambulance provider renders services, has vehicles posted or domiciled, and is legally authorized by the local governing body(ies) to provide services.

B. Upon initial application, an applicant for an EMS license shall declare his service area in writing. The department may require the applicant to provide a map of the service area. The applicant shall also provide copies of all necessary local licenses and permits to operate within the service area, or other legal clearances.

C. If an ambulance provider wishes to expand into additional service areas, he must notify the department at least 72 hours in advance.

1. This notification must include:

a. a description of the territory added;

b. the unit numbers and vehicle identification numbers of vehicles assigned to the area; and

c. the address and telephone number of any substations within the designated service area.

2. The provider shall also provide a copy of all necessary local permits and licenses or other legal clearances.

D. Within 90 days of moving into a new territory, the ambulance service shall furnish the department with a copy of the necessary protocol approvals by the appropriate parish or component medical society in accordance with RS 40:1234.E.1.

E. If an ambulance service withdraws from a territory, it must notify the department at least 30 days in advance. It must provide the department with evidence that it has notified the appropriate local authorities that it will no longer be providing ambulance service in the area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:469 (March 2009).

§6009. Fees

A. Any remittance submitted to the department in payment of a required fee must be in the form of a company or certified check or money order made payable to the Department of Health and Hospitals.

B. Fee amounts shall be determined by the department.

C. Fees paid to the department are not refundable.

D. A fee is required to be submitted with:

1. an initial application;

2. a renewal application;

3. a change of controlling ownership; and

4. a change of name or physical address.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.3.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:469 (March 2009).

§6011. Inspections

A. Initial Inspections. An applicant must successfully complete an initial inspection by the department which includes:

1. an inspection of all vehicles to determine that they are safe and in working order and that they are equipped with all of the prescribed medical equipment as required by these provisions and R.S. 40:1235, 40:1235.1 or 40:1236.2:

a. what is safe and working order shall be determined pursuant to the provisions of R.S. 32 and the Louisiana Motor Vehicle Inspection Manual, in addition to the provisions of this Chapter and R.S. 40:1235 and 1235.1;

b. for aircraft, the safe and working order shall be determined by the rules of the FAA;

c. each vehicle successfully completing the inspection shall receive a permit authorizing it to be operated as part of the applicant's service;

2. an inspection of all personnel credentials to verify that they meet the requirements of law;

3. an inspection, and when deemed necessary by the department, verification of the information required in this Chapter and that such information remains current;

4. verification that the provider has complied with all applicable federal, state, and local statutes, and rules, and that the provider has obtained all necessary and applicable licenses, permits, and certifications, including certificates of need or certificates of public convenience and necessity; and

5. for those providers rendering advanced life support, verification that the provider possesses a Louisiana controlled substance license and a U.S. Drug Enforcement Administration controlled substance registration.

B. Other Inspections. The department may conduct the following types of inspections.

1. Licensing Inspection. Licensing inspection is a periodic onsite visit conducted as necessary to assure compliance with ambulance licensing standards.

2. Follow-Up Inspection. An onsite follow-up may be conducted whenever necessary to assure correction of violations. When applicable, the department may clear violations at an exit interview and/or by mail.

3. Complaint Inspection. A complaint inspection shall be conducted to investigate allegations of noncompliance. Complaint inspections are unannounced.

C. Vehicle Inspections

1. Fleet Addition Inspections

a. Any ambulance service adding an ambulance, air ambulance or sprint vehicle to their fleet must provide written notification to the department in advance of the addition. The notification must include:

i. the vehicle identification number;

ii. a copy of the certificate of registration from the Office of Motor Vehicles or the Federal Aviation Administration;

iii. proof of commercial automobile or aircraft liability insurance; and

iv. the vehicle certification fee.

b. All ambulances, air ambulances, and emergency medical response vehicles must be inspected as soon as possible after they are placed in service. They will be inspected for the requirements of the Louisiana Motor Vehicle Inspection Act, FAA Part 135 rules, and this Chapter.

c. Any vehicle borrowed, leased or rented by the service for less than 90 days shall not be subject to a vehicle inspection fee. However, all vehicles shall be subject to compliance with this Chapter.

2. Spot Check Inspections

a. A vehicle compliance inspection may be performed at any time that the vehicle is not in route to a call or transporting a patient. This may include verification of staff credentials.

D. The department may issue appropriate sanctions including, but not limited to, civil fine(s) and license revocation for violations or findings of non-compliance found during an inspection.

E. DHH surveyors and staff shall be given access to all areas of the provider and all relevant files during any inspection. DHH surveyors and staff shall be allowed to interview any person with ownership interest, staff or patient, as necessary or required to conduct the inspection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:469 (March 2009).

§6013. Changes

A. The Department of Health and Hospitals shall be notified, in writing, within five working days of the occurrence of any changes in:

1. physical address of the headquarters;

2. agency name;

3. phone number;

4. 24-hour contact procedure;

5. ownership;

6. address or phone number of any substation or the addition of any substation;

7. administrators (a completed key personnel change form obtained from department is required);

8. director of operations (a completed key personnel change form is required);

9. medical directors;

10. insurance coverage;

11. cessation of business; or

12. change in the service area.

B. Change of Ownership (CHOW)

1. Actions which constitute a change of ownership include, but are not limited to the following.

a. Unincorporated Sole Proprietorship. Transfer of title and property to another party constitutes a change of ownership.

b. Corporation/Limited Liability Corporation (LLC). The merger of the provider corporation into another corporation, or the consolidation of two or more

corporations, resulting in the creation of a new corporation constitutes a change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.

c. Partnership. In the case of a partnership, the removal, addition or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law, constitutes a change of ownership.

d. Leasing. The lease of all or part of a provider facility constitutes a change of ownership of the leased portion.

2. Change of Ownership packets may be obtained from the department. Only an agency with a full license shall be approved to undergo a change of ownership. An ambulance service license is not transferable from one entity or owner to another.

3. The following information must be submitted within five working days after the act of sale:

a. a new license application and the current licensing fee:

i. the purchaser of the agency must meet all criteria required for initial licensure as an ambulance services provider;

b. any changes in the name and/or address of the ambulance service;

c. any changes in administrative personnel (administrator, medical director, director of operations);

d. disclosure of ownership forms; and

e. a copy of the Bill of Sale and Articles of Incorporation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:470 (March 2009).

§6015. License Renewal

A. An ambulance service license must be renewed annually.

B. An ambulance service seeking a renewal of its license shall:

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

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

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

C. The department may issue a full renewal license to an existing licensed provider that is in substantial compliance with all applicable federal, state departmental and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is revoked, suspended, denied, or modified.

D. Failure to submit to the department a completed license renewal application packet prior to the expiration of the current license or prior to the expiration of deadlines established by the department shall result in the voluntary non-renewal of the license.

E. The renewal of a license does not in any manner affect any sanction, civil monetary penalty or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.E.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:471 (March 2009).

§6017. Denial, Revocation or Suspension of a License

A. Denial of a License. An applicant may be denied a license for one of the following nonexclusive reasons:

1. the background investigation indicates that the applicant has a felony conviction;

2. has had any license pertaining to the provision of emergency medical services revoked in any jurisdiction;

3. failure to comply with applicable federal, state, and local laws, statutes, rules or regulations;

4. intentional falsification of material information provided pursuant to this Chapter; or

5. conviction, guilty plea or plea of nolo contendre of a felony by the following, as shown by a certified copy of the record of the court of the conviction:

a. administrator;

b. director of operations;

c. members or officers; or

d. the person(s) designated to manage or supervise the ambulance service if the applicant is a firm or corporation.

B. Revocation or Denial of License Renewal. An ambulance service's license may be revoked or may be denied renewal for any one of the following:

1. failure to be in substantial compliance with the ambulance service licensing standards;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms of a settlement agreement or education letter;

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

5. failure of the agency to protect patients/persons in the community from harmful actions of the agency employees; including, but not limited to:

a. health and safety;

b. coercion;

c. threat;

d. intimidation; and

e. harassment;

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

7. failure to employ qualified personnel and maintain an adequate quality insurance program that identifies poorly performing staff and remediates or terminates them for deficiencies;

8. failure to remain fully operational at any time for any reason other than a disaster, unless specifically excepted by the department;

9. failure to submit fees including, but not limited to:

a. renewal fee;

b. change of agency address or name; or

c. any fines assessed by the department;

10. failure to allow the department to conduct an investigation, inspection or survey, or to interview staff or participants, or to allow access to any relevant records during any inspection;

11. failure to remedy a situation where patients were not protected from unsafe, skilled and/or unskilled care by any person employed by the ambulance service;

12. failure to correct violations after being issued a provisional license;

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

a. application for licensing;

b. data forms;

c. clinical records;

d. matters under investigation by the department;

e. information submitted for reimbursement from any payment source;

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

g. ambulance service staff being misrepresented or was fraudulent in conducting ambulance service business; or

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

14. failure to comply with all reporting requirements in a timely manner; or

15. cessation of operations for any reason other than a man-made or natural disaster.

C. If an ambulance provider's license is revoked or denied renewal by the department, other than for cessation of business or non-operational status, any owner, officer, member, manager or administrator of such service is prohibited from owning, managing, directing or operating another service for a period of two years from the date of the final disposition of the revocation or denial action.

D. The secretary of the department may immediately suspend the license of an ambulance provider in accordance with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:471 (March 2009).

§6019. Sanctions

A. Any person or provider violating the provisions of this Chapter when such violation poses a threat to the health, safety, rights, or welfare of a patient or client may be liable to civil fines and other penalties, to be assessed by the department, in addition to any criminal action which may be brought under other applicable laws.

B. Class A Violations. If an ambulance or emergency medical response vehicle is found to have been operated in violation of any of the requirements of this Chapter concerning the number of personnel, the qualifications of personnel or failure to provide a qualified attendant to the patient, the ambulance, emergency medical response vehicle, or air ambulance shall be immediately taken out of service until it meets those requirements. The ambulance service shall be subject to a civil fine of not more than $500 for the first violation and not more than $1,000 per day for each repeat violation.

C. Class B Violations. If an ambulance service is found to have been operating in violation of any of the requirements of this Chapter concerning insurance coverage, its license shall be immediately suspended until it meets those requirements. The ambulance service shall be subject to a civil fine of not more than $500 for the first violation and not more than $1,000 per day for each repeat violation.

D. Class C Violations. If an ambulance, emergency medical response vehicle or air ambulance is found to have been operated without undergoing any inspection required under the provisions of this Chapter, the ambulance or emergency medical response vehicle shall be immediately taken out of service until it meets those requirements. The ambulance service shall be subject to a civil fine of not more

than $500 for the first violation and not more than $1,000 per day for each repeat violation.

E. Class D Violations. If an ambulance or emergency medical response vehicle is found to have been operated in violation of any of the requirements of this Chapter concerning medical and safety equipment, the ambulance, emergency medical response vehicle or air ambulance shall be immediately taken out of service until it meets those requirements. The ambulance service shall be subject to a civil fine of not more than $100 for the first violation and not more than $500 per day for each repeat violation.

F. Class E Violations. If an ambulance or emergency medical response vehicle is found to have been operated in violation of any of the requirements of Chapter 7 of Title 32 of the Louisiana Revised Statutes, the ambulance, emergency response vehicle or air ambulance shall be immediately taken out of service until it meets those requirements. The ambulance service shall be subject to a civil fine of not more than $100 for the first violation and not more than $500 per day for each repeat violation.

G. Repeat and Egregious Violations. Those providers who commit multiple or egregious violations may be subject to suspension of their license to operate an ambulance service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:472 (March 2009).

§6021. Notices, Informal Reconsideration and Appeals

A. Following an inspection, the department will issue a notice of violations if any violations are found. The notice of violations will list the department's findings at the inspection and the statutes, laws, and/or regulations that were violated.

B. If the department decides to impose a civil fine upon a provider, the department shall issue written notice of the civil fine to the provider detailing the amount of the fine and the violation(s) which is the basis of the fine. This notice may be issued subsequent to the notice of violations.

C. Informal Reconsideration. Upon notice of a violation of any of the rules in this Chapter or any applicable statute, notice of a denial, suspension, revocation of a license or license non-renewal, notice of the expiration of a provisional license due to non-compliance or of the imposition of a civil fine, or other sanction, the ambulance service provider may request an informal reconsideration.

1. A request for an informal reconsideration must be submitted in writing to the department within 15 days of receipt of the notification.

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

3. The provider shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

4. Reconsideration shall be made based on the documents before the official(s). The provider may present documents at the informal reconsideration.

5. Correction of a violation shall not be the basis for reconsideration.

6. There is no right to an informal reconsideration of the department's decision to issue a provisional license or for a license that has been voluntarily surrendered.

D. Administrative Appeal of a Decision to Deny, Suspend, Revoke or Deny Renewal of a License. Any ambulance service provider whose license has been revoked, suspended, denied or denied renewal by the department shall have the right to have the proceedings of the department reviewed by an administrative law judge, provided that such appeal is made within 30 days after the notice of the decision of the department.

1. An appeal of a decision to deny, revoke or deny renewal of a license is suspensive, and the decision will not be implemented until a decision affirming the department's decision is rendered on judicial review, or there is no request for judicial review within the applicable time limits.

2. An appeal of a suspension of a license is devolutive. The provider must cease providing services upon receipt of notification of the suspension of its license.

3. An ambulance provider has the right to a judicial review of an administrative appeal affirming a denial, suspension, revocation or non-renewal of a license in accordance with the Administrative Procedures Act. Judicial review shall be by trial de novo.

F. Administrative Appeal of a civil fine or other sanction. An ambulance service provider has the right to submit an administrative appeal of a notice of a civil fine(s). Such appeal is suspensive and must be submitted within 30 days of the notice of the results of the informal reconsideration contesting the civil fine(s). If the administrative appeal decision is adverse to the provider, the provider may request a judicial review of the decision in accordance with the Administrative Procedures Act.

G. Administrative appeal of an expired provisional license due to non-compliance at the follow-up inspection. A provider with a provisional license that expires due to non-compliance or deficiencies cited at the follow-up inspection may request an administrative appeal of the expiration.

1. The appeal is limited to whether the violations or findings of non-compliance were properly cited at the follow-up inspection.

2. The provider has 15 days from the notice of the results of the follow-up inspection to request an administrative appeal.

3. The provider's appeal is devolutive; the provider must cease providing services unless an administrative tribunal issues a stay of the expiration. To request a stay, an application for a stay must be filed by the provider at the time the administrative appeal is filed. The stay may be granted by the administrative tribunal; only after a contradictory hearing and only upon a showing that there is no potential harm to the patient(s) being served by the provider.

H. If an ambulance provider fails to submit an administrative appeal within 30 days of receiving the notification of which the provider may appeal, the department's decision becomes final and enforceable against the provider.

I. There is no right to an administrative appeal of the department's decision to issue a provisional license or for a license that has been voluntarily surrendered.

J. Correction of a violation or finding of non-compliance after the applicable inspection shall not be the basis for an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:472 (March 2009).

Subchapter B. Provider Responsibilities

§6031. General Provisions

A. Insurance Coverage

1. Each ambulance provider shall continuously have in effect the following minimum amounts of insurance:

a. general liability insurance in the amount of $500,000 per occurrence and $500,000 in the aggregate;

b. automobile or aircraft liability insurance in the amount of $500,000; and

c. medical malpractice liability insurance in the amount of $500,000.

2. Participation in the Louisiana Patients' Compensation Fund will be accepted as medical malpractice insurance.

3. An ambulance service shall provide an original notarized certificate of insurance as proof that it has sufficient insurance coverage.

B. Infection Control and Laboratory Testing

1. An ambulance service must have and comply with a written infection control plan in accordance with 29 CFR 1910.120.

2. Ambulance services conducting blood glucose or other laboratory testing in the field must have the appropriate Clinical Laboratory Improvement Act (CLIA) permits or waivers.

C. Communications

1. All ambulance services shall have a dispatch facility. They may either own and operate their own facility or contract their dispatching to an appropriate emergency communications agency. All dispatch facilities must have 24 hour emergency power.

2. In addition to 911, the ambulance service will provide the department with a conventional seven digit telephone number for their dispatch facility that may be reached 24 hours a day, 365 days a year.

3. All ambulance services shall have a Federal Communications Commission (FCC) type accepted two-way dispatching communications system. They may either own or lease the system.

a. All dispatch center(s) and/or point(s) of dispatch shall have a proper FCC licensed radio system or an agreement with an FCC licensed communication provider that does not allow for transmission by unauthorized users, but will provide the capability for the dispatcher, with one transmission, to be heard simultaneously by all of its ambulances/emergency medical response units within that defined geographic service area.

b. Services that utilize multiple transmitters/tower sites shall have simultaneous communications capabilities with all units utilizing a specific transmitter/tower site.

4. Ambulance services may not dispatch their day-to-day ambulance operations over a commercial wireless telephone, pager system, FMRS, or GMRS radio system, or Voice over Internet Protocol radio system.

5. All ambulance services must be compliant with the Louisiana EMS Communications Plan.

6. All ambulance services shall be compliant with any applicable mandates of the FCC, the U.S. Department of Homeland Security, the Governor's Office of Homeland Security and Emergency Preparedness, and other applicable governmental agencies.

7. Any ambulance encountering a patient outside of its service area must make radio or telephone with the local 911 communications center.

D. Scanner Usage

1. No commercial ambulance shall make any emergency run based solely on information intercepted by use of a radio communication scanner or similar device except in cases where human life is threatened, unless that commercial ambulance has been specifically requested to respond to such an emergency. Nothing in this Section shall be construed to prohibit service to a subscriber of a commercial ambulance service.

a. No person certified under this Chapter or certified or licensed pursuant to any provision of Louisiana law shall operate a commercial ambulance in violation of this provision.

b. An ambulance service that violates this provision shall have its license to operate an ambulance service in Louisiana suspended for a period of six months.

E. Cessation of Business

1. If at any time the ambulance service is no longer operational, for any reason other than man-made or natural disaster, the license shall be deemed to be invalid and shall be returned to the department within five working days.

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

3. All emergency vehicles no longer in use shall have all audible and visible warning signals and markings indicating their emergency status removed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:473 (March 2009).

§6033. Personnel

A. Director of Operations

1. The director of operations (DOO), or equivalent job title, shall be designated, in writing, to supervise:

a. all aspects of patient care;

b. all activities of professional staff and allied health personnel; and

c. responsible for compliance with regulatory requirements.

2. The DOO, or alternate, shall be on site or immediately available to be on site at all times during operating hours, and additionally as needed. If the DOO is unavailable he/she shall designate a certified EMT or paramedic to be responsible during his/her absence.

3. The director of operations shall be at least a nationally registered EMT, or above, and must be currently certified to practice in the state of Louisiana:

a. with at least three years experience as an EMT; and

b. be a full-time employee of only one ambulance service facility. The director of operations is prohibited from simultaneous/concurrent employment.

4. The department may exempt the director of operations from the requirements of this §6133.A.3.a-b if services are primarily staffed and operated by volunteers.

5. The director of operations shall supervise all patient care activities to assure compliance with current standards of accepted EMS practice including, but not limited to, the following:

a. supervise the employee health program and implement policies and procedures that establish and support quality patient care;

b. assure compliance with local, state, and federal laws, and promote health and safety of employees, patients and the community, using the following nonexclusive methods:

i. resolve problems;

ii. perform complaint investigations;

iii. provide orientation and in-service training to employees to promote effective ambulance services and safety of the patient, and to familiarize staff with regulatory issues, and agency policy and procedures;

iv. orient new direct health care personnel;

v. perform timely annual performance evaluations of health care personnel;

vi. assure participation in regularly scheduled appropriate continuing education for all health professionals;

viii. assure that the care provided by the health care personnel promotes effective emergency medical care and the safety of the patient; and

ix. assure that the ambulance service polices are enforced.

6. The director of operations shall be responsible for compliance with all regulations, laws, policies and procedures applicable to the ambulance service facility specifically and to Medicare/Medicaid issues when applicable.

7. The director of operations shall also perform the following duties:

a. implement personnel and employment policies to assure that only qualified personnel are hired:

i. licensing and/or certification (as required by law) shall be verified prior to employment and annually thereafter and records shall be maintained to support competency of all allied health personnel;

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

c. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the ambulance service and be available after hours as needed;

d. be responsible for and direct the day-to-day operations of the ambulance service facility;

e. act as liaison among staff, patients and the community;

f. designate, in writing, an individual who meets the qualifications of director of operations to assume the authority and the control of the ambulance service if the director of operations is unavailable; and

g. designate in advance a committee he/she chooses to establish policies governing the day-to-day provisions of the ambulance service.

8. The Director of Operations shall refer to the Louisiana Emergency Medical Services Commission, or other authority of competent jurisdiction, any certified or licensed employee who has been proven to have committed any of the following:

a. the selling, attempting to sell, falsely obtaining, or furnishing any professional certification document;

b. conviction of a crime or offense which reflects the inability of that person to provide care with due regard of the health and safety of the patient. This includes a plea of *nolo contendre* regardless of the final outcome; or

c. is guilty in the aiding and abetting of someone in violation of these regulations or the regulations of the Louisiana EMS Certification Commission.

B. Medical Director

1. The medical director must be a licensed physician, authorized to practice medicine in Louisiana and knowledgeable about emergency medical care and the emergency medical services system. The medical director is the clinical supervisor of the ambulance service. The medical director reviews, coordinates, and is responsible for the management of clinical and medical care for all patients. The medical director may be an employee or a volunteer of the agency. The agency may also contract for the services of the medical director.

2. The medical director or his designee shall assume overall responsibility for the medical component of the patient care program including, but not limited to:

a. responsibility for all controlled dangerous substances utilized by the ambulance service;

b. developing and coordinating procedures for the provision of emergency medical care;

c. participating in the development of the protocols or procedures for providing care; and

d. acting as a liaison between the ambulance service provider and the local health care community.

3. The medical director must maintain a current list of all certified emergency medical services personnel that function under the Medical Director's supervision.

C. Certified Emergency Medical Services Personnel

1. A certified first responder must be certified by the Louisiana Bureau of Emergency Medical Services. A certified first responder may only drive the ambulance and assist the EMT. He may not attend the patient in the back of the ambulance by himself.

2. A certified emergency medical technician-basic may drive the ambulance, assist another medic and may attend the patient by himself provided the patient does not require advanced life support (ALS) services, and the assessment and interventions fall within the scope of practice of the EMT-basic.

3. A certified emergency medical technician-intermediate may drive the ambulance, assist another medic or attend the patient by himself as long as the assessment and interventions fall within the scope of the EMT-intermediate.

4. An emergency medical technician-paramedic may drive the ambulance, assist another medic or attend the patient by himself provided the medical procedures being performed are within his established scope of practice.

5. The highest ranking EMT in the ambulance is responsible for the patient's care.

D. Other Medical Personnel. Other medical personnel such as physicians, registered nurses, etc., may function in an ambulance in accordance with R.S. 40:1235 and the scopes of practice established by the appropriate boards of competent jurisdiction.

E. All medical personnel working in an ambulance shall have either a current Health Care Provider or a Professional Rescuer CPR certification from the American Heart Association or the American Red Cross.

F. All drivers must successfully complete and hold a valid current defensive driving certificate issued by the National Safety council or its equivalent as determined by the Department of Health and Hospitals. The course must be equivalent to at least the National Safety Council's DDC-6 program or emergency vehicle operation program. Pre-licensing driving courses shall not be acceptable.

G. Pilots

1. Pilots shall not participate in patient care activities, except for loading and unloading the patient, and incidental duties.

2. Pilots shall:

a. hold a valid appropriate commercial pilot's license from the Federal Aviation Administration;

b. have a valid physical examination certificate from an FAA flight surgeon. Copies of these credentials shall be made available to the department;

c. be qualified to operate the specific aircraft; and

d. have an appropriate instrument flight rating as necessary.

H. The ambulance service shall have a person (employee or contractor) charged with the following financial responsibilities:

1. ensuring that all services are correctly billed to the proper payer source; and

2. reviewing patient eligibility for Medicare and Medicaid reimbursement.

I. Identification and Credentials

1. All personnel working on an ambulance and/or sprint vehicle shall carry with them at all times while on

duty a copy of their pertinent medical certifications (state license or certification) and driver's license.

2. All medical personnel working on an ambulance, air ambulance, or emergency medical response vehicle, shall have their level of certification readily identifiable to the public. This may include, but is not limited to, a badge, embroidered patch or emblem, lapel pin, photo ID card, or distinguishable shirt.

3. All ambulance services must provide their personnel with photo identification cards. All personnel working on ambulance service vehicles must carry these cards while working on duty.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:474 (March 2009).

§6035. Medications

A. All medications, including IV fluids, shall be current in accordance with the manufacturer's expiration date.

B. All ambulance services shall have a system in place to identify and remove recalled pharmaceuticals from the service's inventory.

C. Controlled Dangerous Substances

1. All paramedic ambulance services must have both a Louisiana Controlled Dangerous Substance (CDS) license and a U.S. Drug Enforcement Administration (DEA) controlled substance registration. This license and registration shall be for the services, headquarters or central location.

a. If the ambulance service is owned by a hospital that holds a CDS license and DEA registration it is exempt from this requirement.

2. All controlled dangerous substances carried on ambulances must be under the personal control of a paramedic or kept in a substantially constructed, securely locked cabinet on the vehicle. Controlled substances may not be left unattended in unlocked medication kits.

3. All controlled substances kept at the ambulance service's central location must be stored in a substantially constructed securely locked cabinet or a safe.

4. Ambulance services must maintain both a dispenser's log and a perpetual inventory of their controlled substances unless they are part of a hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2 and R.S. 40:973.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:475 (March 2009).

§6037. Medical Protocol

A. In those parishes where the parish or component medical society has established a written pre-hospital EMS protocol for use in the parish, the ambulance service must follow that protocol, and/or the protocols of the Louisiana Emergency Response Network as applicable.

B. In those parishes where the parish or component medical society have not established a written pre hospital EMS protocol for use in the parish, the EMS service must develop a protocol to be used by its personnel. The appropriate portions of this protocol must be approved by the parish or component medical society.

C. These protocols shall include protocols for the care of:

1. cardiac arrest;

2. ventricular tachycardia;

3. supraventricular tachycardia;

4. suspected cardiogenic chest pain or suspected myocardial infarction;

5. stroke or suspected stroke;

6. bradydysrhythmias;

7. hypoglycemia;

8. anaphylactic reactions;

9. hypovolemic shock;

10. unconsciousness or altered mental status;

11. suspected drug overdose;

12. treatment induced unconsciousness, altered mental status, hypotension, or respiratory depression from physician ordered or protocol appropriate paramedic administered narcotics;

13. respiratory failure or respiratory arrest;

14. active seizure;

15. hospital patient destination;

16. pre-hospital diversion;

17. patient with advanced directives;

18. mass casualty incidents;

19. injuries from weapons of mass destruction;

20. pediatric specific care; and

21. traumatic injuries.

D. The EMS service shall adopt the protocols established by the Louisiana Emergency Response Network (LERN) or develop an agency specific protocol with specific language related to the transportation of the following patients:

1. Acute stroke patients shall be transported to the closest appropriate primary stroke center, acute stroke ready hospital, or closest appropriate hospital if the patient exhibits a compromise of airway, breathing or circulatory function, or other potential life threatening emergency as defined by the protocols implemented by the ambulance service's medical director. Acute stroke patients may also be diverted to the closest appropriate hospital by order of LERN or

online medical control from the local facility, potential receiving facility or medical director.

2. Patients suffering an acute ST elevation myocardial infarction (STEMI) shall be transported to the closest appropriate STEMI receiving center or, when appropriate, a STEMI referring center.

3. In any case where the treating emergency medical technician's evaluation, according to protocol, indicates a potentially unstable condition or potential medical emergency that, if traveling the extra distance to the recommended appropriate facility could put the patient at higher risk, the emergency medical technician in his/her discretion may divert to the nearest appropriate facility.

E. All protocols shall:

1. meet or exceed the requirements of these licensing standards and all applicable federal, state, and local laws;

2. be consistent with the January 2009 National EMS Education Standards scope of practice and the rulings of the Louisiana EMS Certification Commission;

3. be reviewed annually by the licensed agency's medical director, or the parish medical society; and

4. be submitted to the department no more than 30 days after the implementation of the protocol.

F. Ambulance services are accountable for assuring compliance with applicable protocols by their personnel. Exceptions to these protocols must be reviewed on a case-by-case basis by the physician medical director.

1. Treatment decisions shall be considered given the current health status of the patient in conjunction with all of the associated risks factors including, but not limited to, distance to the nearest stroke facility.

G. Ambulance services must produce, and provide to all personnel, a policy and procedures manual governing the service's operation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1133.14 and 40:1135.3.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:476 (March 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2153 (October 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1090 (July 2016).

§6039. Records

A. There shall be a permanent record of each patient encounter made by the ambulance service. These records may be maintained as hard copy and/or electronically. The record shall be maintained to assure that the medical treatment of each patient is completely and accurately documented. Records shall be readily available and systematically organized to facilitate the compilation and copying of such information.

B. The record of each patient encounter shall include at a minimum:

1. pertinent demographic information about the patient;

2. location of the response;

3. date and time of response;

4. situation;

5. patient's chief complaint;

6. patient's signs and symptoms;

7. a synopsis of the assessment of the patient to include both the initial and complete assessment of the patient;

8. vital signs;

9. pertinent past medical history;

10. any interventions or treatments conducted;

11. transport destination and arrival time if applicable; and

12. any other significant information that pertains to the patient or to the response.

C. Safeguards shall be established and implemented to maintain confidentiality and protection of the medical record from fire, water, or other sources of damage.

D. Safeguards shall be established and implemented to maintain the confidentiality and protection of all medical records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

E. The department shall have access to all business records, patient records or other documents maintained by, or on behalf of the provider, to the extent necessary to insure compliance with this Chapter. Ensuring compliance includes, but is not limited to:

1. permitting photocopying of records by the department; and

2. providing photocopies to the department of any record or other information the department may deem necessary to determine or verify compliance with this Chapter.

F. The provider shall keep patient records for a period of six years after the patient encounter. The patient records shall:

1. remain in the custody of the provider;

2. remain in the headquarters for at least one year from the date of the last patient encounter; and

3. not be disclosed or removed unless authorized by law or regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:476 (March 2009).

§6041. Emergency Preparedness

A. All ambulance services shall have an all hazards disaster plan on file that has been approved by their local Office of Emergency Preparedness and/or Homeland Security.

B. This plan shall include terrorist incidents and Weapons of Mass Destruction events.

C. This plan shall include an incident command system that is compliant with the National Incident Management System as established by the U.S. Department of Homeland Security.

D. All ambulance services shall have disaster mutual aid agreements with all ambulance services that are located in the same DHH established region(s) that the ambulance service operates in.

E. All ambulance services shall have appropriate medical protocols as a part of their disaster plan.

F. All ambulance services shall have an emergency communications plan. This plan should be triple redundant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:477 (March 2009).

§6043. Quality Assurance

A. The ambulance service shall have an on-going comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care is provided at all times in compliance with accepted standards of professional practice.

B. The ambulance service shall have written plans, policies and procedures addressing quality assurance.

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

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

1. goals and objectives;

2. the identity of the person responsible for the program;

3. a system to ensure systematic, objective regular reports are prepared and distributed to the governing body and any other committees as directed by the governing body;

4. the method for evaluating the quality and the appropriateness of care;

5. a method for resolving identified problems; and

6. a method for implementing practices to improve the quality of patient care.

E. The plan shall be reviewed at least annually and revised as appropriate by the medical director and director of operations.

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

1. services provided by professional and volunteer staff;

2. audits of patient charts;

3. reports from staff, volunteers and clients about services;

4. concerns or suggestions for improvement in services;

5. organizational review of the ambulance service program;

6. patient/family evaluations of care; and

7. high-risk, high volume and problem-prone activities.

G. When problems are identified in the provision of ambulance care, there shall be:

1. evidence of corrective actions, including ongoing monitoring;

2. revisions of policies and procedures; and

3. educational intervention and changes in the provision of services.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:477 (March 2009).

Subchapter C. Emergency Vehicles—Ground Transportation

§6053. General Provisions

A. All emergency vehicles utilized by ambulance services must be in compliance with the Louisiana Motor Vehicle Regulatory Act.

B. All emergency vehicles must be insured in accordance with R.S. 40:1236.4.

C. An ambulance service may rent or borrow a vehicle for up to 90 days without having it inspected or pay certification fees. However, the vehicle will be subject to spot check inspection if necessary. The vehicle must be in compliance with R.S. 32:1 et seq., and this Chapter.

D. Unless an ambulance or a sprint vehicle is obtained for less than 90 days, it must be registered in the ambulance service's name.

E. All emergency vehicles must have permanent signage indicating the name of the provider and the unit number. All numbering and lettering shall be reflective and be at least 3 inches high or greater. If a logo is used it must be 6 inches or greater in size. This shall appear on the rear and on both sides of the vehicle.

1. Vehicles borrowed or rented for less than 90 days are exempt from this permanent signage requirement.

F. Any equipment provided to ambulance services for their vehicles with grants from the U.S. Department of Health and Human Services must be stocked on the vehicle in accordance with the provisions of the grant.

G. Emergency Warning Lights. These lights shall be mounted as high and as widely spaced laterally apart as practicable. There must be two alternating flashing red lights on the front of the vehicle mounted at the same level. There must be two alternating flashing red lights on the rear of the vehicle mounted at the same level. These front and rear lights shall have sufficient intensity to be visible at 500 feet in normal sunlight. The following exceptions apply:

1. Any authorized emergency vehicle may be equipped with a large revolving red light on the roof instead of alternating flashing red lights on the front. This light must be discernible in all directions and have sufficient intensity to be visible at 500 feet in normal sunlight.

2. Authorized emergency medical response vehicles of organized fire companies may be equipped with a large red and white light on the roof encased in a clear dome, instead of the large red light on the roof. This light must be discernible in all directions and have sufficient intensity to be visible at 500 feet in normal sunlight.

H. Audible Warning Signals. Each emergency medical response vehicle must have a siren, exhaust whistle, or bell capable of giving an audible signal sufficient to warn motorists of its approach (audible up to 500 feet).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:477 (March 2009).

§6055. Emergency Medical Response Vehicles (Sprint Vehicles)

A. Emergency Medical Response Vehicle Qualifications. The vehicle may be on either an automobile or truck chassis, have four or more wheels and must have the following external markings:

1. all numbering and lettering shall be reflective;

2. the unit number shall be displayed in numerals 3 inches high or greater on the rear and both sides of the vehicle;

3. the agency's name shall appear on both sides of the vehicle in lettering 3 inches high or greater, or with a logo that is 6 inches or greater in size;

4. the agency's name or logo shall appear on the trunk or rear door in lettering 3 inches high. Agency logos must be specific to the agency and on file with the department; and

5. the vehicle's markings shall indicate its designation as an emergency medical response vehicle such as sprint car, supervisor, chief, special services, etc. No markings on the vehicle may imply that it is an ambulance.

B. Equipment and Supplies

1. All vehicle units must have a FCC type accepted two-way radio communication system for day-to-day communications. The emergency medical response vehicle's dispatch center(s) and/or point(s) of dispatch must be capable of interactive two-way radio communications within all of the service's defined area.

2. In addition to the day-to-day communication system, all emergency medical response vehicles must have a two-way radio with disaster communications capability on the very high frequency (VHF) broadband frequency designated by the FCC to be V-MED 28 or the national EMS mutual aid frequency, also known as the Hospital Emergency Activation Radio (HEAR) system (155.340) MHz with carrier squelch, ENCODER optional.

a. Direct communication with a physician and hospital must be conducted through:

i. HEAR;

ii. wireless telephone;

iii. Radio Telephone Switch Station (RTSS); or

iv. Med. 10 System, etc.

3. All emergency medical response vehicles must be equipped with at least the following:

a. one fire extinguisher, 10 B:C (secured and identified);

b. one set of three triangle reflectors (or cyalume light sticks or traffic cones);

c. one flashlight, two "C" minimum;

d. one current USDOT Hazardous Materials Guidebook;

e. per each crew member, one hard hat and safety goggles (ANZI spec) or fire fighter's helmet with face shield; and

f. per each crew member, one pair of leather or nomex gauntlet gloves.

4. All emergency medical response vehicles must have the following basic life support medical supplies:

a. one portable suction unit;

b. one suction tubing, wide bore (if required);

c. one rigid pharyngeal/tonsillar wide bore suction;

d. one suction catheter 5 or 6 or 5/6;

e. one suction catheter, 14 or larger;

f. one portable oxygen cylinder, D, Jumbo D, or E, appropriate color:

i. maximum of 2000 to 2200 psi, minimum of 500 psi;

g. one variable flow regulator for portable oxygen cylinder with wrench;

h. one oxygen nonrebreather mask with tubing, adult;

i. one oxygen nonrebreather mask with tubing, pediatric;

j. one oxygen nasal prongs with tubing;

k. one bag valve mask, adult;

l. one bag valve mask, pediatric;

m. one oral airway, adult;

n. one oral airway, child;

o. one oral airway, infant;

p. one extremity splint device, long;

q. one extremity splint device, short;

r. one long spine immobilization device with at least 3 points of confinement:

i. a clamshell device may be used;

s. one cervical immobilization device;

t. one extrication-type cervical collar, pediatric, small;

u. one extrication-type cervical collar, pediatric, medium;

v. one extrication-type cervical collar, pediatric, large;

w. one extrication-type cervical collar, adult, small;

x. one extrication-type cervical collar, adult, medium;

y. one extrication-type cervical collar, adult, large;

z. one burn sheet, sterile;

aa. ten small sterile dressings 4" x 4", at least 2 per packet;

bb. four large sterile dressings at least 5" x 9";

cc. one multi-trauma dressing (at least 10" x 30") or 1" x 24" military ABD dressing;

dd. two triangular bandages, manufactured;

ee. four complete rolls of roller bandage, soft gauze, at least 2 inches wide;

ff. one roll each of Hypoallergenic medical adhesive tape, 1" and 2";

gg. two occlusive dressings, 3" x 8" or larger or commercial chest seal;

hh. one liter normal saline for irrigation in plastic container;

ii. one supra glottis airway approved by Louisiana EMS Certification Commission;

jj. one tube of oral glucose gel or paste, 12.5 grams, cake icing will suffice;

kk. one epinephrine auto-injector, adult, .30 mg;

ll. one epinephrine auto-injector, pediatric, .15 mg;

mm. one 5 grain (325 mg) aspirin tablet or four 81 grain pediatric aspirin tablets;

nn. one Albuterol, 2.5 mg with appropriate delivery device;

oo. one two-way radio communication device, EMS Disaster (VMED 28);

pp. one two-way radio communications device, EMT to physician;

qq. one two-way radio communication device, EMT to dispatch;

rr. one disposable OB kit;

ss. one roll of aluminum foil or a silver swaddler;

tt. one stethoscope;

uu. one blood pressure cuff, adult;

vv. one blood pressure cuff, pediatric;

ww. one pair EMT shears, either issued to vehicle or individual;

xx. one blanket;

yy. twenty-five triage tags;

zz. one sharps container, 1 quart; and

aaa. one Supraglottic airway, approved by the Louisiana EMS Certification Commission.

5. All emergency medical response vehicles that are not staffed and equipped to the EMT-paramedic level must carry an automated external defibrillator (either automatic or semi-automatic) with the appropriate lead cables and at least two sets of the appropriate disposable electrodes. If the automated defibrillator is also capable of manual defibrillation, then an appropriate lock out mechanism (such as an access code, computer chip, or lock and key) to prevent unauthorized use of the device by those persons not authorized to manually defibrillate must be an integral part of the device.

6. All emergency medical response vehicles must carry infection control equipment as follows:

a. one box of gloves, non sterile exam;

b. one box of gloves, non latex;

c. one pair per crew member, full peripheral glasses with surgical face mask or fluid shields;

d. one per crew member, N-95 mask;

e. one per crew member, disposable, impervious coveralls, gown, jumpsuit;

f. one pair per crew member, disposable, impervious shoe covers;

g. one bottle or 12 towelettes, commercial, anti-microbial hand cleaner;

h. one readily identifiable bio hazard disposal bag;

i. one per crew member, chemical resistant, full coverage, hooded coverall;

j. one pair per crew member, chemical resistant footwear;

k. one roll of chemical resistant sealant tape (not duct tape);

l. one pair per crew member, chemical resistant goggles with a minimum of N-95 mask;

m. one per crew member, incident command vest with florescent trim and appropriate logos; and

n. one per crew member Mark I kits (.7 mg atropine and 2 PAM-V).

7. The following must be carried by intermediate level and paramedic level emergency medical response vehicles:

a. two bags of IV fluid for KVO lines, D5W or isotonic 0.9% NaCl in at least 250 cc bags:

i. all IV fluids must be in plastic bags or jugs, not glass bottles, unless medically indicated otherwise;

b. 1000 cc of Lactated ringers or isotonic 0.9% NaCl in at least 2 approved containers;

c. one macrodrip IV administration set

d two minidrip IV administration sets;

e. one three way stopcock extension tubing;

f. one each, over-the-needle IV catheters, 1.5" long, 14, 16, 18, 20, and 22 gauge;

g. one intraosseous needle of choice;

h. one venous tourniquet;

i. one 1 cc syringe with .1 cc graduations;

j. one 3 to 6 cc syringe;

k. one 30 cc or larger syringe;

l. one 21 to 23 gauge hypodermic needle;

m. one 24 to 26 gauge hypodermic needle; and

n. six antiseptic prep pads.

8. The following must be carried by all paramedic level emergency medical response vehicles:

a. one pair of McGill forceps, adult;

b. one pair of McGill forceps, pediatric;

c. one tube or five packets of water soluble lubricating jelly (non cellulose);

d. one endotracheal tube, uncuffed (3.0 to 3.5);

e. one endotracheal tube, uncuffed, 4.0 to 4.5;

f. one endotracheal tube, uncuffed, 5.0 to 5.5;

g. one endotracheal tube, cuffed, 6.0 to 6.5;

h. one endotracheal tube, cuffed, 7.0 to 7.5;

i. one endotracheal tube, cuffed, 8.0 to 8.5;

j. one stylette, adult;

k. one stylette, pediatric;

l. one laryngoscope handle with batteries and bulb;

m. one set of spare batteries and bulb;

n. one laryngoscope blade, straight, size 0;

o. one laryngoscope blade, straight, size 1;

p. one laryngoscope blade, straight, size 2;

q. one laryngoscope handle, straight or curved, size 4;

r. one monitor defibrillator with electrodes, lead cables, defib pads or jel;

s. one glucometer, CLIA approved;

t. one pediatric dosing chart;

u. one end title CO2 detection or monitoring device;

v. analgesics:

i. one aspirin 5 grain or four 81 mg; and

ii. morphine *, 10 mg/ml;

w. anti-arrhythmics:

i. three Adenosine, 6 mg;

ii. four Atropine, pf, 1 mg;

iii. one Calcium Chloride, 10 percent, 1 gram;

iv. three Amiodorone (pre-filled), 150 mg or four Lidocaine, 100 mg pf bolus; and

v. one Lidocaine, pm, 1 gram;

x. anti-convulsive:

i. one Valium *, 10 mg/2 ml; and

ii. one Mag Sulfate, 2 grams;

y. anti-histamine:

i. Benadryl,50 mg;

z. bronchodilators:

i. one Albuterol , 2.5 mg*, inhalation;

aa. cardio-vascular:

i. one Dopamine, pm, 200 mg; and

ii. three NTG, .4 mg Tablet or spray;

bb. diabetic control:

i. one D50W, 50 cc; and

ii. one Glucagon, 1 mg;

cc. loop diuretic:

i. one Bumex, 2 mg; or

ii. one Lasix; 80 mg;

dd. narcotic antagonist:

i. one Naloxone, 2 mg;

ee. vasopressors, 4 mg total:

i. two Epinephrine, 1 mg 1:1,000;

ii. two Epinephrine, 1 mg 1:10,000; and

iii. Vasopressin (optional), 1 mg

NOTE: Laryngoscopes may be reusable or disposable.

*-or alternative drug approved by parish or component medical society.

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 35:478 (March 2009).

§6057. Ambulances

A. Any vehicle used as an ambulance must be designed and constructed by the manufacturer as such.

B. The following medical and safety equipment are requirements for certification of all ground ambulances operating within the state of Louisiana.

1. All ambulances must have a national standard public safety two-way radio communication (day-to-day communications). The ambulance dispatch center(s) and/or point(s) of dispatch must be capable of interactive two-way communications within all of the service's defined area.

2. Two-way radio with disaster communications must be VHF-National EMS Mutual Aid Frequency, V-MED 28, also known as the Hospital Emergency Activation Radio (HEAR) system 155.34 0 Mhz with carrier squelch, ENCODER optional.

3. Direct communication with a physician and hospital must be conducted through:

a. HEAR; or

b. wireless telephone;

c. Radio Telephone Switch Station (RTSS); or

d. Med. 10 System, etc.

4. All ambulances must carry the following basic medical supplies and equipment:

a. one suction unit capable of providing a suction of at least 300 mm Hg;

b. two wide bore tubing;

c. two rigid pharygeal tonsilar wide bore tip;

d. a second suction unit that is portable;

e. two each suction liners or refills, if required;

f. two suction catheters, 5 fr, or 6 fr, or 5/6 fr;

g. two suction catheters, 14 fr or larger;

h. one portable oxygen cylinder, at least 500 psi, 2000 psi full, appropriate color;

i. one portable oxygen regulator/ flowmeter, variable flow;

j. one fixed oxygen cylinder, "M" or "O" cylinder, at least 500 psi, 2000 psi full, appropriate color or equivalent;

k. one fixed oxygen regulator, variable flow;

l. one oxygen wrench;

m. one fixed oxygen flowmeter;

n. one humidifier;

o. four adult non-rebreather masks;

p. four pediatric non-rebreather masks;

q. four adult nasal prongs with supply tubing;

r. two adult BVM with reservoir and supply tubing;

s. two pediatric BVM with reservoir and supply tubing;

t. two oral airways, adult;

u. two oral airways, child;

v. two oral airways, pediatric;

w. one traction splint with ratchet, straps, and ankle hitch, adult;

x. two extremity splints, upper;

y. two extremity splints, lower;

z. three extrication-type cervical collars, adult;

aa. three extrication-type cervical collars–pediatric;

bb. three cervical immobilization devices;

cc. three long spine immobilization device with at least 3 points of confinement (one must be a clamshell device);

dd. one short spine immobilization device with appropriate straps and pillows;

ee. two burn sheets, sterile;

ff. fifty small sterile dressings, 4" x 4" (at least 25 packs of 2);

gg. ten large combine dressings, sterile, 5" x 9" or larger;

hh. two multi-trauma dressings, 10" x 30" or larger or 18" x 24" military abdominal dressings;

ii. eight triangle bandages, commercial;

jj. ten soft roller bandages, 2" wide, unused rolls;

kk. six rolls of hypoallergenic adhesive tape, 1" and 2" or wider (no paper tape);

ll. two occlusive dressings, 3" x 8" petroleum gauze or commercial chest seal;

mm. four chemical cold packs;

nn. two liters normal saline for irrigation in plastic containers;

oo. sterile water, 500 cc or larger in plastic container;

pp. oral glucose, 12.5 mg (cake icing may be substituted);

qq. one aspirin, 325 mg (5 grain) or four aspirin, 81 grain pediatric;

rr. one albuterol inhalation solution, 2.5 mg with appropriate delivery device;

ss. three per crew member Mark I kits (.7 mg atropine and 2 PAM-V0;

tt. radio communication , two-way disaster;

uu. radio communication, two way EMT to physician;

vv. radio communication, two way EMT to dispatch;

ww. one OB kit;

xx. one roll of aluminum or a silver swaddler;

yy. one blood pressure cuff, adult;

zz. one blood pressure cuff, pediatric;

aaa. one stethoscope;

bbb. one pair trauma shears;

ccc. one set of three triangle reflectors (or cyalume light sticks, or traffic; cones), set;

ddd. two flashlights, minimum of 2 "C" cell size with spare batteries and bulbs;

eee. twenty-five triage tags; and

fff. one supra glottis airway approved by the Louisiana EMS Certification Commission.

5. All ambulances must carry the following infection control supplies and equipment:

a. one box of non-sterile exam gloves;

b. one box of gloves, non latex;

c. two pair of full peripheral glasses with face masks, or fluid shields;

d. one per crew member jumpsuit/gown, impervious to liquid, disposable;

e. two readily identifiable trash bags, labeled for contaminated wastes;

f. one pair per crew member shoe covers;

g. one sharps container, 1 quart;

h. one bottle or 12 towelettes of commercial antimicrobial hand cleaner;

i. two biohazard trash bags;

j. four N-95 masks;

k. one set per crew member, chemical resistant, full body coverage coverall with hood;

l. one pair per crew member, chemical resistant footwear;

m. one roll per crew member, chemical sealant tape (not duct tape); and

n. one pair per crew member, chemical resistant goggle with a minimum of a N-95 mask.

6. All ambulances must be equipped with the following:

a. two fire extinguishers, 2:-10:B:C;

b. two blankets;

c. one current US DOT Hazardous Materials Guidebook;

d. one set per crew member, hard hat and safety goggles (ANZ! 37.1 or NFPA approved fire fighter turn out gear);

e. one pair per crew member, leather or nomex gauntlet gloves;

f. one per crew member, incident command vest with florescent trim and appropriate logos;

g. one stretcher, wheeled, multi-level;

h. one set of stretcher straps with at least three points of confinement, including shoulder harness; and

i. all ambulances that are not staffed and equipped to the EMT Paramedic level must carry:

i. one automated external defibrillator with electrodes and leads;

ii. one epinephrine auto injector adult, .30 mg; and

iii. one epinephrine auto injector, pediatric, .15 mg.

7. The following must be carried by all ambulances that are not staffed and equipped to the EMT Paramedic level:

a. an automated external defibrillator (either automatic or semi-automatic) with the appropriate lead cables and at least two sets of the appropriate disposable electrodes. If the automated defibrillator is also capable of manual defibrillation, then an appropriate lock-out mechanism (such as an access code, computer chip, or lock and key) to prevent unauthorized use of the device by those persons not authorized to manually defibrillate must be an integral part of the device;

b. two bags of IV fluids for KVO lines, D5W or isotonic 0.9 percent NaCl, 250 cc bag minimum:

i. all IV fluids must be in plastic bags or bottles, not glass bottles, unless medically indicated otherwise;

c. 4,000 cc IV fluids for volume expansion, Ringers' Lactate or 0.9% isotonic NaCl (these bags of saline do not include the bags or bottles of saline above for irrigation purposes):

i. all IV fluids must be in plastic bags or bottles, not glass bottles, unless medically indicated otherwise;

d. four sets of minidrip tubing;

e. four sets of macrodrip tubing;

f. one set of Y-type blood tubing;

g. two extension tubings;

h. one three-way stop cock;

i. four over-the-needle IV catheters, 14 gauge;

j. four over-the-needle IV catheters, 16 gauge;

k. four over-the-needle IV catheters, 18 gauge;

l. four over-the-needle IV catheters, 20 gauge;

m. four over-the-needle IV catheters, 22 gauge;

n. two venous tourniquets;

o. two syringes, 1 cc w/ .1cc graduations;

p. two syringes, 3cc to 6 cc;

q. two syringes, 10 cc to 12 cc;

r. two syringes, 30 cc w/ leur lock

s. two hypodermic needles, 21 to 23 gauge;

t. two hypodermic needles, 25 to 27 gauge;

u. one EPA or OSHA approved sharps container for use at the patient's side;

v. ten antiseptic solution wipes;

w. one IV pole or roof hook;

x. three arm boards of various sizes; and

y. one supra glotic airway device as approved by the Louisiana EMS Certification Commission.

8. The following must be carried by all paramedic level ambulances:

a. two intra osseus needles of preference;

b. one McGill forceps, adult;

c. one McGill forceps, pediatric;

d. one tube or five packets of water soluble lubricant not containing cellulose;

e. two endotracheal tubes, uncuffed, 3.0 to 3.5;

f. two endotracheal tubes, uncuffed, 4.0 to 4.5;

g. two endotracheal tubes, uncuffed, 5.0 to 5.5;

h. two endotracheal tubes, cuffed, 6.0 to 6.5;

i. two endotracheal tubes, cuffed, 7.0 to 7.5;

j. two endotracheal tubes, cuffed, 8.0 to 8.5;

k. two stylettes, adult;

l. two stylettes, pediatric;

m one laryngoscope handle w/ 1 set of spare batteries and bulbs, or two disposable handle units;

n. one laryngoscope blade, Size 0, straight, or two disposable blades, Size 0, straight;

o. one laryngoscope blade, Size 1, straight, or two disposable blades, Size 1, straight;

p. one laryngoscope blade, Size 2, straight, or two disposable blades, Size 2, straight;

q. one laryngoscope blade, Size 3, straight or curved, or two disposable blades, Size 3, straight or curved;

r. one laryngoscope blade, Size 4, straight or curved, or two disposable, Size 4, straight or curved;

s. one cardiac monitor defibrillator with paper strip recorder;

t. two sets defib pads or gel;

u. one set of lead cables;

v. two sets of disposable monitoring electrodes;

w. one glucometer, CLIA approved;

x. two end tidal CO_2 detection or monitoring devices;

y. analgesic:

i. one aspirin 5 grain or four 81 mg;

ii. morphine *, 10 mg/ml;

z. anti-arrhythmic:

i. five Adenosine, 6 mg;

ii. four Atropine, pf, 1 mg;

iii. one Calcium Chloride, 10 percent, 1 gram;

iv. three Amiodorone (pre-filled), 150 mg or four Lidocaine,100 mg pf bolus;

v. one Lidocaine, pm, 1 gram;

aa. anti-convulsive:

i. one Valium *, 10 mg/2 ml;

ii. two Mag Sulfate, 2 grams;

bb. anti-histamine:

i. one Benadryl, 50 mg;

cc. bronco-dilators:

i. one Albuterol , 2.5 mg*;

dd. cardio-vascular:

i. two Dopamine, pm, 200 mg;

ii. three NTG, .4mg Tablet or spray;

ee. diabetic control:

i. two D50W, 50 cc;

ii. two Glucagon, 1 mg;

ff. loop diuretic:

i. two Bumex, 2 mg or two Lasix, 80 mg;

gg. narcotic antagonist:

i. Naloxone, 2mg;

hh. vasopressors, 12 mg total;

i. at least two Epinephrine, 1 mg 1:1000;

ii. at least two Epinephrine, 1 mg 1:10000; and

iii. Vasopressin, 1 mg (optional).

NOTE: *or alternative medication approved by the appropriate parish or component medical society.

C. All ambulances must have a functional air conditioner and heater in the patient compartment. They must function within the vehicle manufacturer's recommended guidelines or specifications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:480 (March 2009), amended LR 41:2154 (October 2015).

Subchapter D. Emergency Vehicles—Aircraft Transportation

§6065. General Provisions

A. All aircraft utilized as air ambulances must provide the department with a copy of their FAA Certificate of Registrations and Certificate of Air Worthiness. Upon request, they shall make their maintenance logs available to the department.

B. All air ambulances shall be equipped with the safety equipment required by the FAA.

C. All air ambulances shall be equipped with the medical and patient care equipment as recommended by the Air Ambulance Standards Committee and promulgated into the Administrative Rules of the Department of Health and Hospitals.

D. Until a specific list of medical equipment has been prepared and required by the department, air ambulances will carry the equipment that is mandated to them in protocol by the service's medical director.

E. An air ambulance provider must indicate to the department whether his air ambulances are fixed-winged or rotary winged.

F. All air ambulances shall be staffed to at least the advanced life support (EMT-paramedic) level.

G. Any equipment provided to ambulance services for their vehicles with grants from the U.S. Department of Health and Human Services, must be stocked on the vehicle in accordance with the provisions of the grant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1235.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:482 (March 2009).

§6067. Emergency Aircraft—Rotary-Winged (Reserved)

§6069. Emergency Aircraft—Fixed (Reserved)

Chapter 61. Automated External Defibrillators

§6101. Definitions

A. The Department of Health and Hospitals, Office of Public Health, Bureau of Emergency Medical Services (BEMS) in the exercise of its regulatory authority has adopted the following meaning for the following terms.

Athletic Department—high schools, the division or department of an institution of higher education, including college, university, or community college, which schedules and compete in interscholastic athletics and intercollegiate athletics.

Automated External Defibrillator (AED) (as defined under R.S. 40:1236.12)—a medical device heart monitor and defibrillator that:

a. has received approval of its pre-market notification filed pursuant to 21 U.S.C. 360(k) from the United States Food and Drug Administration;

b. is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia and

is capable of determining whether defibrillation should be performed;

c. upon determining that defibrillation should be performed, the AED automatically charges and delivers an electrical impulse to an individual's heart;

d. is capable of delivering the electrical impulse to an individual's heart;

e. pediatric AED capabilities are required.

Bureau—the Department of Health and Hospitals, Office of Public Health, BEMS.

Cardiopulmonary Resuscitation (CPR)—the process of ventilating and circulating blood for a patient in cardiopulmonary arrest usually in combination mouth to mouth with external chest compressions.

Certification—adult and pediatric CPR and AED users must be certified after successful completion of an adult and pediatric CPR and AED course recognized by a nationally recognized organization or association such as American Heart Association, American Red Cross, National Safety Council and Emergency Medical Physicians of America, which certification must be updated before the expiration listed on the certificate.

Emergency Care—the occurrence of a sudden, serious and unexpected sickness or injury that would lead a reasonable person, possessing an average knowledge of medicine and health, to believe that the sick or injured person requires urgent or unscheduled medical care.

Expected AED Users—any person designated by the possessor to render emergency care.

Health Club—a physical fitness facility emphasizing exercise to achieve physical fitness, or weight loss.

Physical Fitness Facility—a facility for profit or nonprofit with a membership of over 50 persons that offers physical fitness services. This term includes but is not limited to clubs, gymnasium, studios, health spas, weight control centers, clinics, figure salons, tanning centers, athletic or sport clubs, and YWCA and YMCA organizations. It shall not include a business limited solely to the practice of physical therapy, as defined in R.S. 37:2401, by a therapist licensed by the Louisiana State Board of Medical Examiners, nor shall it apply to medically related services performed by a physician licensed by the Louisiana State Board of Medical Examiners in a private office, clinic, or hospital. It shall also not include a tanning salon, which does not have a membership of over 50 persons and does not offer physical fitness services, and is not inside, adjacent to or connected with a physical fitness facility.

Physical Fitness Services—services for the development of physical fitness through exercise or weight control.

Physical Fitness Center—any person or organization which, for profit or nonprofit, offers physical fitness services, whether at multiple outlets or single outlet. Any subsidiary of a center offering such services shall be deemed part of said center.

Possessor—any person, service, business, industry, physical fitness facility, institution of higher learning participating in intercollegiate sport, or security vehicle possessing an AED.

Premises—physical fitness facility or possessor, a distinct and definite locality, and may mean a room, shop, building, field or other definite area.

Sudden Cardiac Arrest—a medical emergency where expected person is unconscious, not breathing and has no pulse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1236.11.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Bureau of Emergency Medical Services, LR 38:2928 (November 2012).

§6103. General Provisions

A. Possessor's Program

1. Possessor's Responsibility and Requirements

a. The AED is maintained and tested according to the manufacturer's guidelines; in accordance with state and federal rules and polices, including review of product warranty expirations for AED machine, pads and batteries.

b. A licensed physician or advanced practice nurse in the state of Louisiana who is authorized to prescribe in the state of Louisiana is involved in the possessor's program to ensure compliance with the requirements for training, emergency medical service (EMS) notification, and maintenance.

c. Expected AED users regularly, on the premises of a particular entity, such as a work site or users, who carry an AED in a private security patrol vehicle, receive appropriate training in CPR and in the use of an AED by the AHA or by any other nationally recognized course in CPR and AED use.

i. For purposes of this Paragraph, "expected AED users" shall be any person designated by the possessor to render emergency care.

d. The EMS system is activated as soon as possible when an individual renders emergency care to an individual in cardiac arrest by using CPR or an AED.

e. Any clinical use of the AED is reported to the licensed physician or advanced practice registered nurse involved in the possessor's program and BEMS, using the cardiac arrest profile/data collection form obtained from the BEMS office. A determination by the licensed physician or advanced practice registered nurse, whether or not the patient was treated in accordance with the pre-established protocol. A copy of the cardiac arrest profile/data collection form should be mailed

2. Any person or entity which possesses an AED shall notify BEMS and a local provider of emergency medical

services, such as 911 service, local ambulance service, or the fire department of the acquisition, location and type of AED.

3. Any manufacturer, wholesale supplier, or retailer of an AED shall notify purchasers of AED's intended for use in the state of Louisiana of the requirements of R.S. 40:1236.13.

4. The owner of or the entity responsible for a physical fitness facility or fitness centers, shall keep an AED on its premises.

5. Any institution of higher education that competes in intercollegiate athletics shall have an AED on its premises in its athletic department, with posters approved by AHA/ARC on how to safely perform CPR and use the AED. The AED is to be placed in open view within two feet of a telephone to be able to access 911 in department and placed with easy access to coaches and athletic where games are to be completed.

a. Each high school that participates in interscholastic athletics shall have an AED on its premises, if funding is available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1236.11.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Bureau of Emergency Medical Services, LR 38:2929 (November 2012).

§6105. Regulations and Reports

A. Regulate/Self Report

1. Compliance of notification upon prescribing AED by completion, signing, and submission of BEMS automated external defibrillator acquisition notification form, to the BEMS office and notification to local provider of emergency services of BEMS notification information.

2. A written CPR/AED Protocol or Plan must exist for use in a sudden cardiac arrest (SCA) occurring at a physical fitness facility and file a copy of this protocol/plan with BEMS.

3. Every event in which an AED is placed on a person, the use must be reported to BEMS on the cardiac arrest profile/data collection form and reviewed by the medical oversight of possessor, in accordance with the AED protocol/plan and further determine if the AED protocol/plan should be modified. The review of use by medical oversight shall be privileged and confidential.

B. Non-Complying Provisions/Failure to Report

1. BEMS shall inspect the premises in response to a complaint which specifies the name, address and telephone number of the alleged violator filed with BEMS alleging a violation of R.S. 40:1236. BEMS may inspect facilities or premises at other times to ensure compliance with this Rule.

a. Penalties for violations:

i. if an AED possessor, inclusive of physical fitness facility, and/or athletic department violates this rule by failing to have on the premises an accessible and operational AED, or certified AED user, and to adopt or implement a plan for responding to medical emergencies then the following penalties will be assessed per violation. BEMS or its designee may issue to the facility a written administrative warning without monetary penalty for the initial violation with a 30 day notice to comply with corrective measures from date of violation;

ii. at least $100 but less than $150 for a second violation;

iii. at least $150 but less than $200 for a third or subsequent violation.

(a). After a third violation against the facility, BEMS or its designee may report violations to the Louisiana attorney general's office or governing authorities for prosecution or further warning.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1236.11.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, Bureau of Emergency Medical Services, LR 38:2930 (November 2012).

Chapter 62. Therapeutic Group Homes

Subchapter A. General Provisions

§6201. Introduction

A. The purpose of this Chapter is to provide for the development, establishment and enforcement of statewide licensing standards for the care of clients in therapeutic group homes (TGHs), to ensure the maintenance of these standards, and to regulate conditions in these facilities through a program of licensure which shall promote safe and adequate treatment of clients of TGHs.

B. Therapeutic group homes provide a 24 hours per day, seven days per week, structured and supportive living environment. The purpose of a TGH is to provide community-based services in a secured, homelike environment to clients under the age of 21 who are determined to need psychiatric or psychological services.

C. Each TGH shall deliver an array of clinical treatment and related services, including psychiatric supports, integration with community resources, and skill building taught within the context of a safe home-like setting under the supervision of a professional staff person.

D. The goal of a TGH is to maintain the client's connections to their community, yet receive and participate in a more intensive level of treatment in which the client lives safely in a 24-hour setting.

1. Community reintegration may be progressive and with individual consideration of the client's safety, prior involvement in and potential for aberrant and criminal activity, mental health status, and elopement consideration.

E. The care and services rendered by a TGH shall include, but not be limited to:

1. behavioral health services;
2. medication management;
3. assistance with independent living skills;
4. recreational services;
5. rehabilitative services; and
6. transportation services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:401 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:773 (April 2018).

§6203. Definitions

Active Treatment—implementation of a professionally developed and supervised comprehensive treatment plan that is developed no later than seven days after admission and designed to achieve the client's discharge from inpatient status within the shortest practicable time. To be considered active treatment, the services shall contribute to the achievement of the goals listed in the comprehensive treatment plan. Tutoring, attending school, and transportation are not considered active treatment. Recreational activities can be considered active treatment when such activities are community based, structured and integrated within the surrounding community.

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

Comprehensive Treatment Plan—the comprehensive plan of care which is developed by the TGH for each client receiving services that includes all of the services each client needs, including medical/psychiatric, nursing, psychological and psychosocial therapies.

Core Mental Health Discipline—academic training programs in psychiatry, psychology, social work and psychiatric nursing.

Department—the Louisiana Department of Health, or "LDH."

DCFS—the Louisiana Department of Child and Family Services.

Direct Care Staff—any member of the staff, including an employee or contractor, that provides the services delineated in the comprehensive treatment plan. Food services, maintenance and clerical staff and volunteers are not considered as direct care staff.

Division of Administrative Law—the Louisiana Department of State Civil Service, Division of Administrative Law or "DAL."

Employed—performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is hired for a staff position.

Health Standards Section—the Louisiana Department of Health, Health Standards Section or "HSS."

Human Services Field/Mental Health-Related Field—an academic program with a curriculum content in which at least 70 percent of the required courses for the major field of study are based upon the core mental health disciplines.

Licensed Mental Health Professional (LMHP)—an individual who meets one of the following education and experience requirements:

1. a physician duly licensed to practice medicine in the state of Louisiana and has completed an accredited training program in psychiatry;

2. a psychologist licensed as a practicing psychologist under the provisions of R.S. 28:2351-2370;

3. a medical psychologist licensed to practice under the provisions of R.S. 37:1360.51 et seq.;

4. a social worker who holds a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701-2718, as amended;

5. an advanced practice registered nurse licensed as a registered nurse in the state of Louisiana by the Board of Nursing who may practice to the extent that services are within the nurse's scope of practice:

a. is a nurse practitioner specialist in adult psychiatric and mental health and family psychiatric and mental health; or

b. is a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health;

6. a licensed professional counselor who is licensed as such under the provision of R.S. 37:1101-1115;

7. a licensed marriage and family therapist who is licensed as such under the provisions of R.S. 37:1116-1121; or

8. a licensed addiction counselor who is licensed as such under the provisions of R.S. 37:3387.

Licensee—the person, partnership, company, corporation, association, organization, professional entity, or other entity to whom a license is granted by the licensing agency and upon whom rests the ultimate responsibility and authority for the conduct of and services provided by the TGH.

LSUCCC—the Department of Public Safety and Corrections, Louisiana State Uniform Construction Code Council.

Mental Health Professional (MHP)—an individual who is supervised by a LMHP and meets the following criteria as documented by the provider:

1. the individual has a Master of Social Work degree; or

2. the individual has a Master of Arts degree, Master of Science degree or a Master of Education degree in a mental health-related field and has a minimum of 15 hours of graduate level course work and/or practicum in applied intervention strategies/methods designed to address behavioral, emotional and/or mental problems. These hours may have been obtained as a part of, or in addition to, the master's degree.

Non-Operational—the TGH location is not open for business operation as stated on the licensing application and business location signage.

OSFM—the Department of Public Safety and Corrections, Office of State Fire Marshal.

Passive Physical Restraint—the least amount of direct physical contact required on the part of a staff member to prevent a client from harming himself/herself or others.

Pretreatment Assessment (PTA)—the documented examination of a client which provides clinical information to support the medical necessity of the referral to the therapeutic group home and establishes that TGH services are the most appropriate services to meet the client's needs.

Secretary—the secretary of the Louisiana Department of Health, or his designee.

Supervising Practitioner—the qualified psychiatrist or psychologist who supervises and oversees the therapeutic group home's services and programs.

Therapeutic Group Home (TGH)—a facility that provides community-based residential services to clients under the age of 21 in a home-like setting of no greater than 10 beds under the supervision and oversight of a psychiatrist or psychologist.

Time Out—the restriction of a client for a period of time to a designated area from which the client is not physically prevented from leaving, for the purpose of providing the client an opportunity to regain self-control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:402 (February 2012), amended LR 41:1293 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:773 (April 2018).

Subchapter B. Licensing

§6207. General Provisions

A. All TGH providers shall be licensed by the Department of Health. The department is the only licensing authority for TGH providers in Louisiana. It shall be unlawful to operate as a therapeutic group home without possessing a current, valid license issued by the department. Each TGH shall be separately licensed.

B. A TGH license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the TGH to which it is issued and only for the specific geographic address of that TGH;

3. enable the provider to operate as a TGH within a specific LDH region;

4. be valid for up to one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;

5. expire on the expiration date listed on the license, unless timely renewed by the TGH;

6. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

7. be posted in a conspicuous place on the licensed premises at all times.

C. In order for the TGH to be considered operational and retain licensed status, the provider shall meet the following conditions.

1. There shall be adequate direct care staff and professional services staff employed and available to provide services to clients at the TGH at all times.

2. There shall always be at least two employees on duty at the TGH at all times.

D. The licensed TGH shall abide by and adhere to any state and federal law, rules, policy, procedure, manual or memorandum pertaining to such facilities.

E. A separately licensed TGH shall not use a name which is substantially the same as the name of another TGH licensed by the department or by DCFS. A TGH provider shall not use a name which is likely to mislead the client or family into believing it is owned, endorsed or operated by the state of Louisiana.

G. No branches, satellite locations or offsite campuses shall be authorized for a TGH.

H. No new TGH shall accept clients until the TGH has written approval and/or a license issued by HSS. If the provider is currently maintaining a license as a child residential facility from DCFS, the provider may remain operational under its DCFS license during the TGH application process.

I. Plan Review. Construction documents (plans and specifications) are required to be submitted and approved by both the OSFM and the Department of Health as part of the licensing procedure and prior to obtaining a license.

1. Applicable Projects. Construction documents require approval for the following types of projects:

a. new construction;

b. any entity that intends to operate and be licensed as a TGH in a physical environment that is not currently licensed by DCFS as a child residential facility; and

c. major alterations;

i. cosmetic changes to the TGH, such as painting, flooring replacement or minor repairs shall not be considered an alteration or substantial rehabilitation.

2. Submission Plans

a. Submittal Requirements

i. One set of the final construction documents shall be submitted to the OSFM for approval. The fire marshal's approval letter and final inspection shall be sent to the LDH.

ii. One set of the final construction documents shall be submitted to the OSFM, or its designated plan review entity, along with the required review fee and a "plan review application form" for approval.

b. Design Criteria. The project shall be designed in accordance with the regulations and requirements of LAC Title 51, *Public Health Sanitary Code* and of the OSFM applicable to residential facilities/group homes.

c. Construction Document Preparation. Construction documents submitted to OSFM, or its designated plan review entity, shall be prepared in accordance with the regulations and requirements of LAC Title 51, *Public Health Sanitary Code* and of the OSFM applicable to residential facilities/group homes.

3. Waivers. The secretary of LDH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of or otherwise required under the provisions of the state *Sanitary Code*. The provider shall submit a waiver request in writing to HSS. The provider shall demonstrate how patient safety and quality of care offered is not compromised by the waiver, and shall demonstrate the undue hardship imposed on the TGH if the waiver is not granted. The provider shall demonstrate its ability to completely fulfill all other requirements of service. The department will make a written determination of the requests.

a. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related to the waiver.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:403 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:773 (April 2018).

§6209. Initial Licensing Application Process

A. An initial application for licensing as a TGH shall be obtained from the department. A completed initial license application packet for a TGH shall be submitted to and approved by the department prior to an applicant providing TGH services.

B. Currently licensed DCFS providers that are converting to TGHs shall comply with all of the initial licensure requirements, except plan review, and may be eligible for the exception to the bedroom space requirement of this Chapter.

C. An applicant shall submit a completed initial licensing application packet to the department, which shall include:

1. a completed TGH licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural plans for the TGH from the department and from the OSFM, and any other office/entity designated by the department required to review and approve the provider's architectural plans;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health (OPH);

5. a copy of statewide criminal background checks, including sex offender registry status, on all individual owners with a 5 percent or more ownership interest in the TGH, and on all managing employees;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

7. an organizational chart, including the names and position titles of key administrative personnel and the governing body; and

8. an 8 1/2 x 11 inch floor sketch or drawing of the premises to be licensed;

9. a letter of intent as to the types of services or specialization that will be provided by the TGH (i.e. sexually offending behaviors, etc.); and

10. any other documentation or information required by the department for licensure, including but not limited to, proof of approvals from local agencies such as local zoning boards and ordinances.

D. Any person convicted of one of the following felonies is prohibited from being the health care provider, owner, supervising practitioner or clinical director or any managing employee of a TGH. For purposes of these provisions, the licensing application shall be rejected by the department for any felony conviction, guilty plea or *nolo contendere* plea relating to:

1. the violence, abuse, or negligence of a person;

2. the misappropriation of property belonging to another person;

3. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

4. a drug offense;

5. crimes of a sexual nature;

6. a firearm or deadly weapon;

7. Medicare or Medicaid fraud; or

8. fraud or misappropriation of federal or state funds.

E. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of the notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a TGH provider shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

F. Once the initial licensing application packet has been approved by the department, notification of the approval shall be forwarded to the applicant. Within 90 days of receipt of the approval notification, the applicant shall notify the department that the TGH is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application has been closed, an applicant who is still interested in becoming a TGH shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

G. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the TGH provider will be issued an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:404 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:774 (April 2018).

§6210. Criminal Background Checks; Prohibitions to Ownership of and Employment at a Therapeutic Group Home; Process; Fees

A. The provisions of this Section shall apply to the following persons:

1. any person who owns, operates, or manages a licensed therapeutic group home (TGH);

2. any person who has applied for a license to operate a therapeutic group home;

3. any person who is employed by, is contracted by, volunteers at, or interns with a therapeutic group home;

4. any person who has applied to be employed or contracted by a therapeutic group home; and

5. any person who has applied to volunteer or intern with a therapeutic group home.

B. The provisions of this Section shall not apply to contractors or other individuals providing a service at the therapeutic group home who are not employees, volunteers, interns, or contracted members of the staff of the therapeutic group home, including but not limited to plumbers, landscapers, or visiting resources.

1. For purposes of this Section only, a volunteer is defined as an individual who offers direct care services to clients at the TGH on behalf of the provider for the benefit of the provider willingly and without pay.

2. For purposes of this Section only, an intern is defined as a student or trainee, either paid or unpaid, who offers direct care services to clients of the TGH on behalf of the provider in order to gain work or clinical experience.

C. No person who has been convicted of, or pled guilty to, or pled nolo contendere to a crime listed in §6210.C.1–5, or whose name is recorded on the State Central Registry within the Department of Children and Family Services (DCFS) as a perpetrator for a justified finding of abuse or neglect of a child, or whose name is on any other state's child abuse and neglect registry or repository, may be the owner, operator, manager or administrator of a TGH, be employed by or contracted with a TGH, or be a volunteer or intern, paid or unpaid, at a TGH:

1. R.S. 14:28.1, 14:30, 14:30.1, 14:31, 14:32.6, 14:32.7, 14:32.8, 14:32.12, 14:35.2, 14:38.1; 14:40.1, 14:40.3, 14:40.7, 14:41, 14:42, 14:42.1, 14:43, 14:43.1, 14:43.1.1, 14:43.2, 14:43.3, 14:43.4, 14:43.5, 14:44, 14:44.1, 14:44.2, 14:45, 14:46.4, 14:66, 14:74, 14:79.1, 14:80, 14:80.1, 14:81, 14:81.1., 14:81.2, 14:81.3, 14:81.4, 14:81.5, 14:82, 14:82.1, 14:82.2, 14:83, 14:83.1, 14:83.2, 14:83.3, 14:83.4, 14:85, 14:86, 14:89, 14:89.1, 14:89.2, 14:92, 14:93, 14:93.2.1, 14:93.3, 14:93.4, 14:93.5, 14:106, 14:282, 14:283, 14:283.1, 14:284, 14:286, crimes of violence as defined in R.S. 14:2(B), sex offenses as defined in R.S. 15:541, or the attempt or conspiracy to commit any of these offenses;

2. R.S. 40:966(A), 40:967(A), 40:968(A), 40:969(A), and 40:970(A), or the attempt or conspiracy to commit any of these offenses;

3. a felony offense involving theft, pursuant to R.S. 14:67, or theft of assets of an aged person or person with a disability, pursuant to R.S. 14:67.1, in excess of $500; or, a felony offense involving theft in any case in which the offender has been previously convicted of theft, pursuant to either R.S. 14:67 or R.S. 14:67.1, regardless of the value of the instant theft; or the attempt or conspiracy to commit any of these offenses;

4. those of a jurisdiction other than Louisiana which, in the judgment of the department, would constitute a crime under the provisions cited in this Section; and

5. those under the Federal Criminal Code having analogous elements of criminal and moral turpitude.

D. Notwithstanding the provisions of §6210.C, LDH may, at its discretion, approve a waiver for a person who has a felony conviction for physical assault or battery as provided for in R.S. 14:34 and 14:37, or for a drug-related offense provided for in R.S. 40:966(A), 967(A), 968(A), 969(A), or 970(A), provided that the conviction was at least five years from the date of the request for waiver.

E. Criminal Background Checks, Process and Fees

1. The enhanced criminal background check described in §6210 is now required for each TGH, pursuant to the federal Family First Prevention Services Act (Public Law 115-123 enacted February 9, 2018) on child care institutions and Act 243 of the 2019 Regular Session of the Louisiana Legislature. This new enhanced criminal background check process encompasses the state requirements in R.S. 40:1203.1 et seq. A TGH's compliance with this new enhanced criminal background check process will be deemed in compliance with the requirements in R.S. 40:1203.1.

2. The Department of Health shall request, consistent with the provisions of R.S. 15:587.1.2, from the Bureau of Criminal Identification and Information (the bureau), information concerning whether or not any of the persons listed in §6210.A has been arrested for, convicted of, or pled nolo contendere to any criminal offense.

a. The request shall be on a form prepared by the bureau and signed by a responsible official of LDH making the request;

b. The request shall include a statement signed by the person about whom the request is made which gives his/her permission for such information to be released; and

c. The person about whom the request is made shall submit his/her fingerprints in a form acceptable to the bureau.

F. In responding to a request for information regarding criminal history, the bureau shall make available a record of all criminal arrests and convictions prior to the date of request.

G. Upon receiving a request for information regarding criminal history, pursuant to R.S. 15:587.1.2 and R.S. 40:2008.10 (or their successor statutes) and this licensing rule, the bureau shall survey its criminal history records and identification files and make a simultaneous request of the Federal Bureau of Investigation for like information from other jurisdictions. The bureau shall provide a report to HSS promptly and in writing, but provide only such information as is necessary to specify whether or not that person has been arrested for, or convicted of, or pled guilty to, or pled nolo contendere to any crime or crimes, the crimes for which he has been arrested, or convicted, or to which he has pled nolo contendere, and the date or dates on which they occurred.

1. The report provided by the bureau to HSS shall include arrests, convictions, or other dispositions, including convictions dismissed pursuant to Code of Criminal Procedure Articles 893 or 894.

2. When an individual's record contains information which has been expunged, the bureau shall include in its report to HSS the date of the arrest and a notation that the individual's record contains information which has been expunged and that HSS may contact the bureau in order to obtain further information regarding the expunged information.

H. The LDH, as recipient of the criminal background report and information from the bureau, shall maintain the confidentiality of such criminal history information in accordance with applicable federal and/or state law.

1. The bureau's criminal background report, and any information contained therein, including expunged information, shall not be deemed a public record.

2. The information may be used or admitted as evidence in any court proceeding, or employment or disciplinary hearing, in which LDH is an authorized participant.

I. State Central Registry

1. In addition to the criminal background checks, HSS requires that the TGH request information from the DCFS concerning whether or not any of the persons listed in §6210.A is recorded on the State Central Registry as a perpetrator for a justified finding of abuse or neglect of a child.

a. Upon request by HSS, such information shall be submitted to HSS for its review in §6210.K.

b. If the TGH fails to timely submit this information to HSS for its review, HSS may seek the information directly from DCFS and may sanction the TGH for failing to submit such information to LDH.

J. Other State Registries of Abuse/Neglect

1. For any persons listed in §6210.A who has lived in any other state within the last five years, HSS shall request information from the child abuse and neglect registry or repository of each of those states as to whether the individual's name is recorded on that state's registry or repository.

2. If such information is not readily available or sent to HSS within 15 days of the request, HSS shall complete its review under §6210.K; however, if HSS subsequently receives information from other states' registries or repositories, HSS reserves the right to re-open its review and send a supplemental determination on the individual.

K. For the persons listed in §6210.A, HSS shall review the criminal background check, the State Central Registry (for abuse/neglect of a child), and any other applicable states' child abuse and neglect registry or repository, to determine if the person is eligible to be an owner, operator, manager, or administrator of a TGH, is eligible to be employed by or contracted with a TGH, or is eligible to be a volunteer or intern, paid or unpaid, at a TGH.

1. Notification shall be sent to the TGH.

2. The HSS shall retain such records and determination within a section of the TGH's licensing file for a period of five years, and may be shared with state or federal agencies with authority to access such information; however, such records and determinations are not public records.

L. The costs of any criminal background checks and reviews/checks of abuse/neglect registries or repositories required under statute or this licensing rule shall be the responsibility of the TGH.

1. The HSS may charge a processing fee not to exceed $15 for the processing of the criminal background check and the review of abuse/neglect registries or repositories.

2. Additionally, HSS hereby requires that the TGH pay the charges and fees of the bureau for a state criminal history report, of the Federal Bureau of Investigation for a federal criminal history report, of the DCFS State Central Registry, and of any other state's registry or repository of abuse/neglect; such payments shall be made directly to those bureaus and agencies.

M. The HSS may request any information necessary from the TGH, from any person subject to the provisions of this Section, or from any other appropriate agency to ensure compliance with the requirements of criminal background checks and abuse/neglect registries or repositories.

N. Existing, Active TGH Licensed Before October 1, 2019

1. For any existing, operating TGH licensed as of October 1, 2019, the licensee shall submit to HSS on or before October 15, 2019, the following:

a. A list of all owners, operators, managers, administrators, employees, contractors, volunteers, and interns of the TGH as of October 15, 2019; such list shall indicate whether any such person has worked in another state within the last five years, including the states where worked, if applicable; and

b. Evidence to HSS that none of these individuals are recorded on the State Central Registry (for abuse/neglect of a child) via DCFS.

2. Each such person listed shall:

a. Submit a signed form or statement by October 15, 2019, giving permission for a criminal background check to be conducted by the bureau, and for the results/report to be submitted to HSS, pursuant to statute and this licensing rule; and

b. Submit his/her fingerprints to the bureau by October 15, 2019;

c. Submit an attestation to HSS on a form provided by HSS wherein the person attests that his/her signed form/statement and his/her fingerprints have been so submitted; this attestation must be received by HSS by October 18, 2019.

3. A person who has timely submitted his/her signed form/statement and his/her fingerprints to the bureau, who has timely submitted the attestation in §6210.N.2, and who is not recorded on the State Central Registry for abuse/neglect of a child or any other states' abuse/neglect registry or repository, may continue to own, operate, manager, administer, be employed, be contracted, volunteer, and/or intern with the TGH until HSS receives and reviews the information or report from the bureau and receives and reviews any information or report from the State Central Registry for abuse/neglect of a child or any other states' abuse/neglect registry or repository.

4. If such information reveals that the person cannot be an owner pursuant to this Section, the department shall notify the licensed TGH, and the TGH shall immediately remove the person from ownership or shall immediately surrender its license.

5. If such information reveals that the person cannot be an operator, manager, administrator, employee, contractor, volunteer, or intern with the TGH pursuant to this Section, HSS shall notify the licensed TGH and the TGH shall immediately terminate the person.

6. No new owner may be obtained and no new operator, administrator, manager, employee, contractor, volunteer, or intern may be hired after October 15, 2019, until that person has submitted his/her signed form/statement and his/her fingerprints to the bureau and HSS has:

a. received and reviewed the information or report from the bureau;

b. received and reviewed the information or report regarding the State Central Registry for abuse/neglect of a child or any other states' abuse/neglect registry or repository; and

c. confirmed that the person can be an owner, operator, administrator, manager, employee, contractor, volunteer, or intern pursuant to the provisions of this Section or of the applicable statutes.

O. A TGH licensed after October 1, 2019, or that has an inactivated license re-activated after October 1, 2019

1. Any TGH licensed after October 1, 2019, or any inactive TGH that has its license re-activated after October 1, 2019, shall submit with its licensing application to HSS, a list of all proposed owners, operators, administrators, managers, employees, contractors, volunteers, and interns.

2. For the initial licensing application process of any TGH licensed after October 1, 2019, or for the reactivation licensing application process of any inactive TGH that has its license re-activated after October 1, 2019, the HSS processing of the application shall not begin until such time that all owners have submitted signed forms/statements and fingerprints to the bureau, and HSS has:

a. received and reviewed the information or report from the bureau;

b. received and reviewed the information or report regarding the State Central Registry for abuse/neglect of a child or any other states' abuse/neglect registry or repository; and

c. confirmed that the person can be an owner pursuant to the provisions of this Section or of the applicable statute.

3. Once HSS has confirmed that each owner is compliant with the provisions of this Section and is eligible to be an owner of the TGH, then HSS will proceed with processing the licensing application; however, the on-site licensing survey or the on-site reactivation survey at the TGH will not be scheduled by HSS, until such time that all operators, administrators, managers, employees, contractors, volunteers, and interns listed per Section 6210.O.1 have submitted signed forms/statements and fingerprints to the bureau, and HSS has:

a. received and reviewed the information or report from the bureau;

b. received and reviewed the information or report regarding the State Central Registry for abuse/neglect of a child or any other states' abuse/neglect registry or repository; and

c. confirmed that the person can be an operator, administrator, manager, employee, contractor, volunteer, or intern pursuant to the provisions of this Section or of the applicable statute.

4. No new TGH may be licensed after October 1, 2019, and no inactive TGH may have its license re-activated after October 1, 2019 until all persons listed in Section 6210.O.1 have been determined in compliance with this Section or have been removed from ownership or employ of the TGH.

5. At the on-site licensing survey or the on-site re-activation survey, the TGH shall have sufficient approved staff to admit and treat at least one client continuously for 24 hours.

a. The TGH shall have sufficient approved staff to meet the needs of any client admitted to the TGH.

6. No new owner or operator may be obtained and no new administrator, manager, employee, contractor, volunteer, or intern may be hired by the TGH after submitting the initial license application or reactivation license application, until the TGH has submitted notice of the new person to HSS, and that person has submitted his/her signed form/statement and his/her fingerprints to the bureau, and HSS has:

a. received and reviewed the information or report from the bureau;

b. received and reviewed the information or report regarding the State Central Registry for abuse/neglect of a child or any other states' abuse/neglect registry or repository; and

c. confirmed that the person can be an owner, operator, administrator, manager, employee, contractor, volunteer, or intern pursuant to the provisions of this Section or of the applicable statutes.

P. Subject to §6210.P.1, LDH's review and determination regarding criminal background check and abuse/neglect registry verification(s) for any person subject to the provisions of this Section, is specific to that licensed TGH only. A separate review and determination, along with new criminal background check and abuse/neglect registry verifications, shall be necessary for any person (who is subject to the provisions of this Section) who is an owner, operator, manager, administrator, employee, contractor, volunteer, or intern at a separately licensed TGH.

1. If two or more licensed TGHs are owned by the same corporate entity and such is noted on the license application and license, then LDH, in its discretion, may allow its review and determination regarding criminal background check and abuse/neglect registry verification for a particular owner, operator, manager, administrator, employee, contractor, volunteer, or intern who will be at both (or multiple) of the owned TGHs, to be based on the same criminal background check and abuse/neglect registry verifications, provided that the background check and verifications were conducted within the last 90 days.

Q. In addition to other sanctions that may be imposed on a TGH, LDH may also deny initial licensure, revoke an existing license, or deny renewal or reactivation of a license of a TGH that violates the provisions of this Section or of the applicable statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Act 243 the 2019 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 46:346 (March 2020).

§6211. Types of Licenses

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the TGH provider when the initial licensing survey finds that the provider is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license for a TGH shall be valid until the expiration date shown on the license, unless the license is revoked, suspended, or modified prior to that time.

2. Provisional Initial License. The department may issue a provisional initial license to the TGH provider when the initial licensing survey finds that the provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients. The provisional license shall be valid for a period not to exceed six months.

a. At the discretion of the department, the provisional initial license may be extended for an additional period not to exceed 90 days in order for the TGH to correct the noncompliance or deficiencies.

b. The TGH provider shall submit a plan of correction to the department for approval and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional initial license.

c. A follow-up survey shall be conducted prior to the expiration of the provisional initial license.

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

ii. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional initial license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed TGH provider who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional Renewal License. The department, in its sole discretion, may issue a provisional license to an existing licensed TGH for a period not to exceed six months.

a. At the discretion of the department, the provisional renewal license may be extended for an additional period not to exceed 90 days in order for the TGH to correct the noncompliance or deficiencies.

b. A provisional renewal license may be issued for the following reasons:

i. the existing TGH has more than five deficient practices or deficiencies cited during any one survey;

ii. the existing licensed TGH has more than three substantiated complaints in a one-year period;

iii. the existing TGH provider has been issued a deficiency that involved placing a client at risk for serious harm or death;

iv. the existing TGH provider has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

v. the existing TGH provider is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

c. When the department issues a provisional renewal license to an existing licensed TGH provider, the provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct an on-site follow-up survey at the TGH prior to the expiration of the provisional license.

i. If the on-site follow-up survey determines that the TGH has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the TGH license.

ii. If the on-site follow-up survey determines that the TGH has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional renewal license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee, if no timely informal reconsideration or administrative appeal of the deficiencies is filed pursuant to this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:404 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:774 (April 2018).

§6213. Changes in Licensee Information or Personnel

A. Any change regarding the TGH's name, "doing business as" name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the change. Any change regarding the TGH name or "doing business as" name requires a change to the provider license and shall require a $25 fee for the issuance of an amended license.

B. Any change regarding the TGH's key administrative personnel shall be reported in writing to the department within five days of the change.

1. Key administrative personnel shall include the:

a. supervising practitioner;

b. clinical director; and

c. house manager.

2. The TGH provider's notice to the department shall include the individual's:

a. name;

b. hire date; and

c. qualifications.

C. A change of ownership (CHOW) of a TGH shall be reported in writing to the department at least five days prior to the change of ownership.

1. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all of the application requirements are completed and approved

by the department, a new license shall be issued to the new owner.

2. A TGH that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

D. A TGH that intends to change the physical address of its geographic location is required to have plan review approval, Office of State Fire Marshal approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the relocation of the TGH.

1. A written notice of intent to relocate shall be submitted to HSS when the plan review request is submitted to the department for approval.

2. Relocation of the TGH's physical address results in a new anniversary date and the full licensing fee shall be paid.

E. Any request for a duplicate license shall be accompanied by the required fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:405 (February 2012), amended LR 41:1293 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:775 (April 2018).

§6215. Renewal of License

A. To renew a license, a TGH shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. a copy of the current on-site inspection report with approval for occupancy from the Office of the State Fire Marshal and the Office of Public Health;

3. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

4. the license renewal fee; and

5. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the TGH license.

D. The renewal of a license does not in any manner affect any sanction, civil fine, or other action imposed by the department against the provider.

E. If an existing licensed TGH has been issued a notice of license revocation, suspension, or termination, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:775 (April 2018).

§6217. Deemed Status

A. A licensed TGH may request deemed status from the department. The department may accept accreditation in lieu of a routine on-site licensing survey provided that:

1. the accreditation is obtained through an organization approved by the department;

2. all services provided under the TGH license shall be accredited; and

3. the provider forwards the accrediting body's findings to the Health Standards Section within 30 days of its accreditation.

B. If approved, accreditation will be accepted as evidence of satisfactory compliance with all of the provisions of these requirements.

C. Occurrence of any of the following may be grounds for the department to perform a licensing survey on an accredited TGH provider with deemed status:

1. any valid complaint in the preceding 12-month period;

2. addition of services;

3. a change of ownership in the preceding 12-month period;

4. issuance of a provisional license in the preceding 12-month period;

5. serious violations of licensing standards or professional standards of practice that were identified in the preceding 12-month period that placed clients at risk for harm;

6. a report of inappropriate treatment or service resulting in death or serious injury; or

7. a change in geographic location.

D. A TGH with deemed status is responsible for complying with all of the provisions of this Rule and is subject to all of the provisions of this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:775 (April 2018).

§6219. Licensing Surveys

A. Prior to the initial license being issued to the TGH, an initial licensing survey shall be conducted on-site at the facility to assure compliance with licensing standards. Except for providers currently maintaining a license as a child residential facility from DCFS, a TGH shall not provide services to any client until the initial licensing survey has been performed and the provider found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. Once an initial license has been issued, the department may conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

C. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices. The department shall issue written notice to the provider of the results of the follow-up survey.

D. An acceptable plan of correction may be required for any survey where deficiencies have been cited.

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. civil fines;

2. directed plans of correction;

3. provisional licensure;

4. denial of renewal; and/or

5. license revocations.

F. Surveyors and staff on behalf of the department shall be:

1. given access to all areas of the facility and all relevant files during any licensing survey or other survey; and

2. allowed to interview any provider staff, client, or participant as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012), amended LR 41:1293 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:775 (April 2018).

§6221. Complaint Surveys

A. The department shall conduct complaint surveys in accordance with R.S. 40:2009.13 et seq., on any TGH, including those with deemed status.

B. Complaint surveys shall be unannounced surveys.

C. An acceptable plan of correction may be required by the department for any complaint survey where deficiencies have been cited. If the department determines other action, such as license revocation is appropriate, a plan of correction may not be required and the TGH will be notified of such action.

D. A follow-up survey may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices. If the department determines that other action, such as license revocation, is appropriate, a follow-up survey may not be required. The TGH will be notified of any action.

E. The department may issue appropriate sanctions, including but not limited to, civil fines, directed plans of correction, and license revocations, for deficiencies and non-compliance with any complaint survey.

F. LDH surveyors and staff shall be given access to all areas of the TGH and all relevant files during any complaint survey. LDH surveyors and staff shall be allowed to interview any TGH staff, client, or participant, as necessary or required to conduct the survey.

G. A TGH which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department shall receive the written request within 10 calendar days of the provider's receipt of the notice of the violations or deficiencies.

H. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation that resulted from his/her complaint. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department shall receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

I. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as a desk review. The provider or complainant, as applicable shall submit all documentation or information for review for the informal reconsideration and the department shall consider all documentation or information submitted. There is no right to appear in person at the informal reconsideration of a complaint survey or investigation. Correction of the violation or deficiency shall not be the basis for the reconsideration. The provider and the complainant, as applicable, shall be notified in writing of the results of the informal reconsideration.

J. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the informal reconsideration shall constitute final action by the department regarding the complaint survey or investigation, and there shall be no right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:1293 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:775 (April 2018).

§6223. Statement of Deficiencies

A. The following statements of deficiencies issued by the Department to the TGH shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any complaint survey statement of deficiencies issued after the most recent annual survey.

B. Any statement of deficiencies issued by the department to a TGH shall be available for disclosure to the public after the provider submits an acceptable plan of correction to the department or 30 calendar days after the survey/investigation is conducted, whichever occurs first.

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

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

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:1293 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:776 (April 2018).

§6225. Cessation of Business

A. Except as provided in §6295 or 6297 of this Chapter, a license shall be immediately null and void if a TGH ceases to operate.

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

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

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

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

1. give 30 days' advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the parent(s) or legal guardian or legal representative of each client; and

2. provide for an orderly discharge and transition of all of the clients in the facility.

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

1. the effective date of the voluntary closure;

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

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

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

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

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

H. Once the TGH has ceased doing business, the TGH shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:1293 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:776 (April 2018).

§6227. Denial of License, Revocation of License, or Denial of License Renewal

A. In accordance with the provisions of the Administrative Procedure Act, the department may:

1. deny an application for an initial license;

2. deny a license renewal; or

3. revoke a license.

B. Denial of an Initial License

1. The department shall deny an initial license when the initial licensing survey finds that the TGH applicant is noncompliant with any licensing laws or regulations or with any other required statutes, laws, ordinances, rules or regulations and such noncompliance presents a potential threat to the health, safety, or welfare of the clients who will be served by the provider.

2. The department shall deny an initial license for any of the reasons in this Chapter that a license may be revoked or non-renewed.

C. Voluntary Non-Renewal of a License

1. If a TGH fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

2. If a provider fails to timely renew its license, the TGH shall immediately cease providing services, unless the provider is actively treating clients, in which case the provider shall:

a. immediately provide written notice to the department of the number of clients that are receiving treatment at the TGH;

b. immediately provide written notice to the prescribing physician and to every client, parent, legal guardian, or legal representative of the following:

i. voluntary non-renewal of the provider's license;

ii. date of closure of the facility; and

iii. plans for orderly transition of the client;

c. discharge and transition of each client within 15 days of voluntary non-renewal; and

d. notify the department of the location where records will be stored and the contact person for the records.

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

D. Revocation of License or Denial of License Renewal. A TGH license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the TGH licensing laws, rules and regulations, or with other required statutes, laws, ordinances, rules, or regulations;

2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the department, the Attorney General's Office, any regulatory agency, or any law enforcement agency;

3. failure to uphold a client's rights whereby deficient practices result in harm, injury, or death of a client;

4. negligence or failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

5. failure to notify the proper authorities, as required by federal or state law, rules, or regulations, of all suspected cases of the acts outlined in §6227.D.4;

6. knowingly making a false statement in any of the following documentation, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. records, including:

i. clinical;

ii. client; or

iii. provider;

d. matters under investigation by the department or the Office of Attorney General; or

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to department employees or to law enforcement agencies;

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

9. fraudulent operation of a TGH by the owner, administrator, manager, member, officer, or director;

10. an owner, officer, member, manager, administrator, director, or person designated to manage or supervise client care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court.

a. For purposes of these provisions, conviction of a felony means a felony relating to any of the following:

i. violence, abuse, or neglect of another person;

ii. misappropriation of property belonging to another person;

iii. cruelty, exploitation, or sexual battery of a juvenile or the infirmed;

iv. a drug offense;

v. crimes of a sexual nature;

vi. possession or use of a firearm or deadly weapon; or

vii. fraud or misappropriation of federal or state funds, including Medicare or Medicaid funds;

11. failure to comply with all of the reporting requirements in a timely manner as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey, or to interview provider staff or the clients;

13. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

14. failure to allow or refusal to allow access to the provider or client records by authorized departmental personnel;

15. bribery, harassment, or intimidation of any client or family member designed to cause that client or family member to use or retain the services of any particular TGH provider;

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions, or other debts owed to the department; or

18. failure to maintain accreditation, or for a new TGH that has applied for accreditation, the failure to obtain accreditation.

E. If a TGH license is revoked or renewal is denied or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such TGH may be prohibited from opening, managing, directing, operating, or owning another TGH for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. The denial of the license renewal application shall not affect in any manner the license revocation, suspension, or termination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:408 (February 2012), amended LR 41:1294 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:776 (April 2018).

§6229. Notice and Appeal of License Denial, License Revocation, Denial of License Renewal, and Appeal of Provisional License

A. Notice of a license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The TGH provider has a right to an informal reconsideration of the license denial, license revocation, or denial of license renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The TGH provider shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the Health Standards Section.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the provider shall receive written notification of the date of the informal reconsideration.

4. The provider shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or non-renewal shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The provider shall be notified in writing of the results of the informal reconsideration.

C. The TGH provider has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the TGH.

1. The TGH shall request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or denial of license renewal.

a. The TGH provider may forego its rights to an informal reconsideration, and if so, the TGH shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, license revocation, or denial of license renewal.

2. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL or its successor, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the DAL issues a final administrative decision.

a. If the secretary of the department determines that the violations of the provider pose an imminent or immediate threat to the health, welfare, or safety of a client, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. The TGH shall be notified of this determination in writing.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation, or denial of license renewal shall not be a basis for the administrative appeal.

D. If an existing licensed TGH has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect in any manner the license revocation.

E. If a timely administrative appeal has been filed by the provider on a license denial, denial of license renewal, or license revocation, the DAL or its successor shall conduct the hearing pursuant to the Administrative Procedure Act.

1. If the final DAL decision is to reverse the license denial, the denial of license renewal, or the license revocation, the provider's license will be re-instated or granted upon the payment of any licensing fees or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to affirm the denial of license renewal or the license revocation, the provider shall discharge any and all clients receiving services according to the provisions of this Chapter. Within 10 days of the final agency decision, the provider shall notify the department's licensing section in writing of the secure and confidential location of where the clients' records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new TGH or a provisional license to an existing TGH. The issuance of a provisional license is not considered to be a denial of license, a denial of license renewal, or a license revocation.

G. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal regarding the deficiencies cited at the follow-up survey.

1. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The provider shall request the informal reconsideration in writing, which shall be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department.

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

H. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge the clients unless the DAL issues a stay of the expiration.

1. A stay may be granted upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing and upon a showing that there is no potential harm to the clients being served by the provider.

I. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the DAL or its successor shall conduct the hearing pursuant to the Administrative Procedure Act.

1. If the final DAL decision is to remove all deficiencies, the provider's license will be reinstated upon the payment of any licensing fees or other fees due to the department, and the payment of any outstanding sanctions due to the department.

2. If the final DAL decision is to uphold the deficiencies and affirm the expiration of the provisional license, the provider shall discharge all clients receiving services. Within 10 calendar days of the final agency decision, the provider shall notify HSS in writing of the secure and confidential location of where the client's records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

38:409 (February 2012), amended LR 41:1294 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:776 (April 2018).

Subchapter C. Administration and Organization

§6233. General Provisions

A. Purpose and Organizational Structure. The purpose of the TGH shall be clearly defined in a statement filed with the department. The statement includes the:

1. program philosophy;

2. program goals and objectives;

3. ages, sex and characteristics of clients accepted for care;

4. geographic area served;

5. types of services provided;

6. description of admission policies; and

7. needs, problems, situations or patterns best addressed by the provider's program; and

8. an organizational chart of the TGH which clearly delineates the line of authority.

B. A TGH shall provide supervision and services that:

1. conform to the department's rules and regulations;

2. meet the needs of the clients as identified and addressed in the comprehensive treatment plan;

3. provide for the full protection of clients' rights; and

4. promote the social, physical and mental well-being of clients.

C. A TGH shall make any required information or records, and any information related to assessment of compliance with these requirements, available to the department.

D. A TGH shall allow designated representatives of the department, in performance of their mandated duties, to:

1. inspect all aspects of the TGH's operations which directly or indirectly impact clients; and

2. conduct interviews with any staff member or client of the provider.

E. A TGH shall make available, upon request, the legal ownership documents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:410 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:777 (April 2018).

§6237. Governing Body

A. A TGH shall have an identifiable governing body with responsibility for and authority over the policies and operations of the home.

1. A TGH shall have documents identifying all members of the governing body, their addresses, their terms of membership, officers of the governing body and terms of office of any officers.

2. The governing body shall be comprised of three or more persons and shall hold formal meetings at least twice a year.

3. There shall be written minutes of all formal meetings of the governing body and by-laws specifying frequency of meetings and quorum requirements.

B. The governing body of a TGH shall:

1. ensure the provider's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. ensure that the provider is adequately funded and fiscally sound;

3. review and approve the provider's annual budget;

4. designate qualified persons to act as supervising practitioner and clinical director and delegate sufficient authority to these persons to manage the TGH;

5. formulate and annually review, in consultation with the clinical director and supervising practitioner, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

6. annually evaluate the supervising practitioner's and clinical director's performance;

7. meet with designated representatives of the department whenever required to do so;

8. inform the department, or its designee, prior to initiating any substantial changes in the services provided by the provider;

9. ensure statewide criminal background checks in accordance with R.S. 15:587.1; and

10. ensure direct service worker registry checks in accordance with LAC 48:I.Chapter 92.

C. A TGH provider shall maintain the following documents:

1. minutes of formal meetings and by-laws of the governing body;

2. documentation of the provider's authority to operate under state law;

3. all leases, contracts and purchases-of-service agreements to which the provider is a party;

4. insurance policies;

5. annual budgets and audit reports; and

6. a master list of all the community resources used by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:410 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:777 (April 2018).

§6239. Policies and Procedures

A. The TGH shall have written policies and procedures approved by the owner or governing body, which shall be implemented and followed, that address at a minimum the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;

4. personnel;

5. client rights;

6. grievance procedures;

7. client funds;

8. emergency preparedness;

9. abuse and neglect;

10. incidents and accidents, including medical emergencies;

11. universal precautions;

12. documentation;

13. admission and discharge procedures;

14. bedroom assignment for clients; and

15. behavior management.

B. A TGH shall have written personnel policies, which shall be implemented and followed, that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members, whether directly employed, contract or volunteer;

2. written job descriptions for each staff position, including volunteers;

3. policies that shall, at a minimum, be consistent with Office of Public Health guidelines, to indicate whether, when and how staff have a health assessment;

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment, whether that abuse or mistreatment is done by another staff member, a family member, a client or any other person;

6. a nondiscrimination policy;

7. a policy that requires all employees to report any signs or symptoms of a communicable disease or personal illness to their supervisor or the Clinical Director as possible to prevent the disease or illness from spreading to other clients or personnel.

C. A TGH shall maintain the requirements for financial viability under this rule at all times.

D. Behavior Management

1. The TGH shall develop and implement written policies and procedures for the management of behaviors to be used on facility-wide level, insuring that procedures begin with the least restrictive, most positive measures and follow a hierarchy of acceptable measures. The policies and procedures shall be provided to all TGH staff and shall include:

a. appropriate and inappropriate behaviors of clients;

b. consequences of inappropriate behaviors of clients;

c. the phases of behavior escalation and appropriate intervention methods to be used at each level.

d. documentation in the client's record of the use of any behavioral management measures.

E. House Rules and Regulations. A TGH shall have a clearly written list of rules and regulations governing conduct for clients in care and shall document that these rules and regulations are made available to each staff member, client and, where appropriate, the client's parent(s) or legal guardian(s). A copy of the house rules shall be given to clients and, where appropriate, the client's parent(s) or legal guardian(s) upon admission and shall be posted and accessible to all employees and clients.

F. Limitations on Potentially Harmful Responses or Punishments. A TGH shall have a written list of prohibited responses and punishments to clients by staff members and shall document that this list is made available to each staff member, client and, where appropriate, the client's parent(s) or legal guardian(s).

1. This list shall include the following prohibited responses/punishments:

a. any type of physical hitting or other painful physical contact except as required for medical, dental or first aid procedures necessary to preserve the child's life or health;

b. physical, chemical and mechanical restraints;

c. requiring a client to take an extremely uncomfortable position;

d. verbal or psychological abuse, ridicule or humiliation;

e. withholding of a meal, except under a physician's order;

f. denial of sufficient sleep, except under a physician's order;

g. requiring a child to remain silent for a long period of time;

h. denial of shelter, warmth, clothing or bedding;

i. assignment of harsh physical work.

j. physical exercise or repeated physical motions;

k. excessive denial of usual services;

l. denial of visiting or communication with family or legal guardian;

m. extensive withholding of emotional response;

n. any other cruel, severe, unusual, degrading or unnecessary discipline.

2. A TGH shall not discipline groups of clients for actions committed by an individual.

3. Children shall neither discipline nor supervise other children except as part of an organized therapeutic self-government program that is conducted in accordance with written policy and is supervised directly by staff. Such programs shall not be in conflict with regulations regarding behavior management.

4. Discipline shall not be administered by any persons who are not known to the client.

G. Restraints

1. A TGH shall develop and implement a written policy which prohibits the use of any form of mechanical, physical or chemical restraints. TGH providers may have a policy that allows passive physical restraint, but it shall be utilized only when the child's behaviors escalate to a level of possibly harming himself/herself or others.

2. The TGH's policy shall provide that passive physical restraints are only to be performed by two trained staff personnel in accordance with an approved curriculum. A single person restraint can be initiated in a life threatening crisis with support staff in close proximity to provide assistance.

H. Time-Out Procedures

1. A provider using time-out rooms for seclusion of clients for brief periods shall have a written policy governing the use of time-out procedures. This policy shall ensure that:

a. the room shall be unlocked;

b. time-out procedures are used only when less restrictive measures have been used without effect. Written documentation of less restrictive measures used shall be required;

c. emergency use of time-out shall be approved by the clinical director for a period not to exceed one hour;

d. time-out used as an individual behavior management plan shall be part of the overall plan of treatment;

e. the plan shall state the reasons for using time-out and the terms and conditions under which time-out will be terminated or extended, specifying a maximum duration of the use of the procedure that shall under no circumstances exceed eight hours;

f. when a child is in time-out, a staff member shall exercise direct physical supervision of the child at all times;

g. a child in time-out shall not be denied access to bathroom facilities, water or meals.

I. Copies of the behavior management policy, the prohibited response and punishment policy, including restraint prohibitions and time out procedures, shall be provided in triplicate upon admission. The child and parent(s) or legal guardian(s) shall sign all three copies. The child and parent(s) or legal guardian(s) shall retain one copy each and the provider shall retain the other copy in the child's record.

J. Copies of the behavior management policy, the prohibited response and discipline policy, including restraint prohibitions and time out procedures, shall be provided in duplicate to each new employee upon hiring. The employee shall sign both copies. The employee shall retain one copy and the provider shall retain the other copy in the employee's personnel record.

K. A TGH shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:411 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:778 (April 2018).

§6241. Personnel Records

A. A TGH shall have a personnel file in the facility for each staff member who provides services for the TGH. Each record shall contain:

1. the application for employment and/or resume;

2. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

3. any required medical examinations;

4. evidence of current applicable professional credentials/certifications according to state law or regulations;

5. annual performance evaluations;

6. personnel actions, other appropriate materials, reports and notes relating to the individual's employment with the center;

7. the employee's starting and termination dates; and

8. the results of criminal history and registry checks.

B. The staff member shall have reasonable access to his/her file and shall be allowed to add any written statement that he/she wishes to make to the file at any time.

C. A TGH shall retain the staff member's personnel file for at least three years after the staff member's termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:412 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:778 (April 2018).

Subchapter D. Provider Responsibilities

§6245. General Provisions

A. The TGH shall have at least one staff member on duty per shift to have current CPR and first aid certification.

B. For contract services, the TGH shall have formal written agreements with professionals or other entities to provide services which may or may not be directly offered by facility staff. Both parties shall review and document review of each agreement annually.

C. The TGH shall ensure that a criminal background check is conducted on employees in accordance with the provisions of R.S. 15:587.1 and R.S. 46:51.2.

1. The TGH shall have a written policy and procedure for obtaining the criminal background check.

2. No person, having any supervisory or other interaction with clients, shall be hired until such person has submitted his or her fingerprints to the Louisiana Bureau of Criminal Identification and Information, and it has been determined that such person has not been convicted of or pled nolo contendere to a crime listed in R.S. 15:587.1(C). This shall include any employee or non-employee, including independent contractors, consultants, students, volunteers, trainees, or any other associated person, who performs paid or unpaid work with or for the TGH.

3. Contractors hired to perform work which does not involve any contact with clients shall not be required to have a criminal background check if accompanied at all times by a staff person if clients are present in the facility.

4. Any employee who is convicted of or has pled nolo contendere to any crime listed in R.S. 15:587.1(C) shall not continue employment after such conviction or nolo contendere plea.

D. The TGH shall check the Louisiana State Nurse Aide Registry and the Louisiana Direct Service Worker Registry to ensure that each member of its direct care staff does not have a finding placed against him/her on either registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:413 (February 2012).

§6247. Staffing Requirements

A. There shall be a single organized professional staff that has the overall responsibility for the quality of all clinical care provided to clients, for the ethical conduct and professional practices of its members, as well as for accounting therefore to the governing body. The manner in which the professional staff is organized shall be consistent with the TGH's documented staff organization and policies and shall pertain to the setting where the TGH is located. The organization of the professional staff and its policies shall be approved by the TGH's governing body.

B. The staff of a TGH shall have the appropriate qualifications to provide the services required by its clients comprehensive treatment plans. Each member of the direct care staff may not practice beyond the scope of his/her license or certification.

C. Staffing Ratios

1. All staffing shall be adequate to meet the individualized treatment needs of the clients and the responsibilities of the staff. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of client treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child.

2. A TGH shall have a minimum of two staff on duty per shift in each living unit, with at least one staff person awake during overnight shifts with the ability to call in as many staff as necessary to maintain safety and control in the facility, depending upon the needs of the current population at any given time.

3. A ratio of not less than one staff to five clients is maintained at all times; however, two staff shall be on duty at all times with at least one being direct care staff when there is a client present.

D. The staff shall have the following acceptable hours and ratios:

1. Supervising Practitioner. The supervising practitioner's hours shall be adequate to provide the necessary direct services and to meet the administrative and clinical responsibilities of supervision and of directing the care in a TGH. The number of hours the supervising practitioner needs to be on-site is dependent upon the size of program and the unique needs of each individual client.

2. Clinical Director. The clinical director shall have adequate hours to fulfill the expectations and responsibilities of the clinical director.

3. Nurse. The TGH shall have at least one licensed nurse available to meet the nursing health care needs of the clients and who is on-call 24 hours a day and can be on-site within 30 minutes as needed.

4. Therapist. Each therapist shall be available at least three hours per week for individual and group therapy and two hours per month for family therapy.

5. Direct Care Staff. The ratio of direct care staff to clients served shall be 1:5 with a minimum of two staff on duty per shift for a 10 bed capacity. This ratio may need to be increased based on the assessed level of acuity of the youth or if treatment interventions are delivered in the community and offsite.

E. Orientation

1. All staff shall receive orientation prior to being assigned to provide client care without supervision.

2. Orientation includes, but is not limited to:

a. confidentiality;

b. grievance process;

c. fire and disaster plans;

d. emergency medical procedures;

e. organizational structure;

f. program philosophy;

g. personnel policy and procedure;

h. detecting and mandatory reporting of client abuse, neglect or misappropriation;

i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

j. basic skills required to meet the health needs and problems of the client;

k. crisis intervention and the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations;

l. the safe use of time out and passive physical restraint (including a practice element in the chosen method); and

m. recognizing side effects of all medications including psychotropic drugs.

F. Training. All staff shall receive training according to provider policy at least annually and as deemed necessary depending on the needs of the clients. The TGH shall maintain documentation of all training provided to its staff. The TGH shall meet the following requirements for training.

1. Staff shall have ongoing education, training and demonstrated knowledge of at least the following:

a. techniques to identify staff and client behaviors, events, and environmental factors that may trigger emergency safety situations;

b. the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;

c. the safe use of time out for behavior management, including the ability to recognize any adverse effects as a result of the use of time out; and

d. the safe use of passive physical restraint (including a practice element in the chosen method).

2. Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required within 30 days of hire.

3. Training shall be provided only by staff who are qualified by education, training, and experience.

4. Staff training shall include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

5. Staff shall be trained and demonstrate competency before participating in an emergency safety intervention.

6. All training programs and materials used by the TGH shall be available for review by HSS.

G. Staff Evaluation. The TGH shall complete an annual performance evaluation of all staff members. For any person who interacts with clients, the provider's performance evaluation procedures shall address the quality and nature of a staff member's relationships with clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:413 (February 2012), amended LR 41:1294 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:778 (April 2018).

§6249. Personnel Qualifications and Responsibilities

A. Professional Staffing Standards. The following are the minimum staffing requirements for TGHs.

1. Supervising Practitioner

a. A supervising practitioner shall be one of the following:

i. a physician with an unrestricted license to practice in Louisiana and who meets all of the following qualifications:

(a). an unrestricted drug enforcement agency (DEA) and Louisiana controlled substance license;

(b). if the physician holds an additional license(s) in another state or jurisdiction, that license(s) shall be unrestricted and be documented in the employment record;

(c). board-certification in general psychiatry; and

(d). satisfactory completion of a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director, which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If training was completed in a psychiatric residency program not accredited by the ACGME, the physician shall demonstrate that he/she meets the most current requirements as set forth in the American Board of Psychiatry and Neurology's Board policies, rules and regulations regarding information for applicants for initial certification in psychiatry;

ii. a psychologist/medical psychologist shall have the following:

(a). an unrestricted license to practice psychology in Louisiana issued by the Louisiana State Board of Examiners of Psychologists under R.S. 37:2351 et seq., or an unrestricted license to practice medical psychology issued by the Louisiana State Board of Medical Examiners under R.S. 37.1360.51 et seq.;

(b). unrestricted DEA and Louisiana controlled substance licenses, if the supervising practitioner is a medical psychologist;

(c). demonstrated competence and experience in the assessment, diagnosis, and treatment of children and adolescents who have mental and emotional disorders or disabilities, alcoholism and substance abuse. Acceptable competence/experience is specialized training at the internship or post-doctoral level before licensure and/or being in the independent practice of child/adolescent psychology in private practice, as a consultant, or within an outpatient or inpatient treatment facility for a period of at least two years post-licensure.

b. A supervising practitioner's responsibilities shall include, but are not limited to:

i. reviewing the referral PTA and completing an initial diagnostic assessment at admission or within 72 hours of admission and prior to service delivery;

ii. assuming accountability to direct the care of the client at the time of admission and during the entire TGH stay;

iii. supervising the development of a comprehensive treatment plan in the seven days following admission.

iv. providing clinical direction in the development of the comprehensive treatment plan;

v. at least every 28 days or more often as necessary, providing:

(a). a face-to-face assessment/service to the client;

(b). a review of the need for continued care; and

(c). continued supervision of the comprehensive treatment plan;

vi. providing crisis management including supervision and direction to the staff to resolve any crisis of the client's condition;

vii. monitoring and supervising an aggressive plan to transition the client from the program into less intensive treatment services as medically necessary;

viii. providing 24-hour on call coverage, seven days a week;

ix. assuming professional responsibility for the services provided and assure that the services are medically appropriate.

2. Clinical Director

a. A clinical director shall be an LMHP.

b. The clinical director shall have the appropriate qualifications to meet the responsibilities of the clinical director and the needs of the TGH's clients. A clinical director may not practice beyond his/her scope of practice license.

c. If the TGH treats clients with both mental health and substance abuse conditions, then the clinical director shall have the training and experience necessary to practice in both fields.

d. Practitioners who meet the criteria of the clinical director may also serve as the TGH's therapist.

e. The responsibilities of a clinical director include, but are not limited to:

i. overseeing, implementing, and coordinating treatment services;

ii. continually incorporating new clinical information and best practices into the program to assure program effectiveness and viability;

iii. overseeing the process to identify, respond to, and report crisis situations on a 24-hour per day, 7 day per week basis;

iv. clinical management for the program in conjunction with and consultation with the supervising practitioner;

v. assuring confidentiality and quality organization and management of clinical records and other program documentation; and

vi. applying and supervising the gathering of outcome data and determining the effectiveness of the program.

3. TGH Therapist

a. A TGH therapist shall be an LMHP or an individual with a Master's degree in social work, counseling, psychology or a related human services field.

b. The role and the responsibilities of the TGH Therapist include but are not limited to:

i. reporting to the clinical director and supervising practitioner for clinical and non-clinical guidance and direction;

ii. communicating treatment issues to the clinical director and to the supervising practitioner as needed;

iii. providing individual, group, family, psychotherapy and/or substance abuse counseling;

iv. assisting in developing/updating treatment plans for clients in TGH care in conjunction with the other multidisciplinary team members;

v. providing assistance to direct care staff and implementing the treatment plan when directed by the clinical director;

vi. providing clinical information to the multidisciplinary team and attending treatment team meetings; and

vii. providing continuous and ongoing assessments to assure clinical needs of clients and parents(s)/caregivers(s) are met.

4. Nursing Services

a. The TGH shall have a licensed registered nurse who shall supervise the nursing services of the TGH. He or she shall be operating within his/her scope of practice and have documented experience and training in the treatment of children or adolescents.

b. All nursing services shall be furnished by licensed nurses. All nursing services furnished in the TGH shall be provided in accordance with acceptable nursing professional practice standards.

c. The responsibilities of the registered nurse include, but are not limited to:

i. providing a nursing assessment within 24 hours of admission for each client;

ii. establishing a system of operation for the administration and supervision of the clients' medication and medical needs;

iii. training staff regarding the potential side effects of medications, including psychotropic drugs;

iv. coordinating psychiatric and medical care per physician's direction; and

v. monitoring and supervising all staff providing nursing care and services to clients.

d. The responsibilities of all licensed nurses include, but are not limited to:

i. reporting to the clinical director for programmatic guidance;

ii. reporting to the supervising practitioner as necessary regarding medical, psychiatric, and physical treatment issues;

iii. reviewing all medical treatment orders and implementing orders as directed;

iv. serving as a member of the multidisciplinary treatment team;

v. administering medications and monitoring the clients' responses to medications;

vi. providing education on medication and other health issues as needed;

vii. abiding by all state and federal laws, rules, and regulations; and

viii. identifying and assessing the clients for dental and medical needs.

5. House Manager

a. The house manager shall have the following qualifications:

i. be at least 21 years of age and at least 3 years older than the oldest client; and

ii. possess one of the following:

(a). a Bachelor's degree in a human services field and one year of documented employment with a health care provider that treats clients with mental illness; or

(b). two years of course work toward a Bachelor's degree in a human services field and two years of documented employment with a health care provider that treats clients with mental illness.

b. The house manager's responsibilities include, but are not limited to the following:

i. supervising the activities of the TGH when the professional staff is on call, but not on duty;

ii. identifying, respond to, and report any crisis situation to the clinical director on a 24-hour, seven day per week basis;

iii. reporting incidents of abuse, neglect and misappropriation to the clinical director;

iv. assessing situations related to relapse;

v. coordinating and consulting with the clinical director as needed; and

vi. providing access to appropriate medical care when needed.

6. Direct Care Staff

a. All direct care staff shall have at least the following qualifications:

i. a high school diploma or equivalent;

ii. at least 18 years of age, but shall also be at least three years older than all clients under the age of 18;

iii. a minimum of two years of experience working with clients of the population served, be equivalently qualified by education in the human services field, or have a combination of work experience and education with one year of education substituting for one year of experience;

iv. not have a finding on the Louisiana State Nurse Aide Registry and the Louisiana Direct Service Worker Registry against him/her;

v. be certified in crisis prevention/management (example: CPI, Mandt, etc.); and

vi. be proficient in de-escalation techniques.

b. The responsibilities of direct care staff include, but are not limited to:

i. completing the required program orientation and training, and demonstrating competency prior to being assigned to direct care;

ii. having a clear understanding of the treatment plan;

iii. assisting clients in developing social, recreational, and other independent living skills as appropriate;

iv. being aware of safety issues and providing safety intervention within the milieu;

v. reporting all crisis or emergency situations to the clinical director or his/her designee in the absence of the clinical director;

vi. reporting to the therapist or clinical director as necessary regarding treatment issues;

vii. understanding the program philosophy regarding behavior management and applying this philosophy in daily interactions with clients in TGH care; and

viii. having the ability to effectively implement de-escalation techniques.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:414 (February 2012), amended LR 41:1294 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:779 (April 2018).

§6251. Client Records

A. Client records shall be maintained in the TGH and shall be kept secure and confidential. The provider shall have a written record for each client which shall include:

1. identifying data including:

a. name;

b. date of birth;

c. address;

d. telephone number;

e. social security number; and

f. legal status;

2. the client's pretreatment assessment, the referral and documentation pertaining to admission from Medicaid or its designee, initial diagnostic interview, nursing assessment and comprehensive treatment plan plus any modifications or updates;

3. the client's history including, where applicable:

a. family data;

b. next of kin;

c. educational background;

d. employment record;

e. prior medical history; and

f. prior service history;

4. written authorization signed by the client or, in the case of a minor, the legally responsible person for emergency care;

5. written authorization signed by the client or, in the case of a minor, the legally responsible person for maintaining the client's money, if applicable;

6. a current balance sheet, containing all financial transactions and required signatures, involving the personal funds of the client deposited with the provider;

7. required assessment(s) and additional assessments that the provider may have received or is privy to;

8. the names, addresses, and telephone numbers of the client's physician(s).

9. legible written progress notes or equivalent documentation and reports of the services delivered for each client for each visit. The written progress notes shall include, at a minimum:

a. the date and time of the visit and services;

b. the services delivered;

c. who delivered or performed the services;

d. observed changes in the physical or mental condition(s) of the client if applicable; and

e. doctor appointments scheduled or attended that day;

10. health and medical records of the client, including:

a. a medical history, including allergies; and

b. a description of any medical treatment or medication necessary for the treatment of any medical condition;

11. a copy of any advance directive that may have been executed by the client;

12. reports of any incidents of abuse, neglect, accidents or critical incidents, including use of passive physical restraints; and

13. reports of any client's grievances and the conclusions or dispositions of these reports. If the client's grievance was in writing, a copy of the written grievance shall be included.

B. TGHs shall maintain client records for a period of 10 years from discharge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:416 (February 2012).

§6253. Client Funds and Assets

A. The TGH shall develop and implement written policies and procedures governing the maintenance and protection of client funds. These policies and procedures shall have provisions which include, but are not limited to, the following:

1. the amount each client can have;

2. the criteria by which clients can access their money;

3. the procedure for disbursement; and

4. staff who can access such funds.

B. If the TGH manages a client's personal funds, the provider shall furnish a written statement listing the client's rights regarding personal funds to the client and/or his/her legal or responsible representative.

C. If a client chooses to entrust funds with the TGH, the TGH shall obtain written authorization from the client and/or his/her legal or responsible representative for the safekeeping and management of the funds.

D. The TGH shall:

1. provide each client with an account statement upon request with a receipt listing the amount of money the provider is holding in trust for the client;

2. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;

3. provide a list or account statement regarding personal funds upon request of the client; and

4. not commingle the clients' funds with the provider's operating account.

E. If the TGH is managing funds for a client and he/she is discharged, any remaining funds shall be refunded to the client or his/her legal or responsible representative within five business days of notification of discharge. Upon the death of a client, any remaining funds shall be refunded to the client's legal or responsible representative within five business days of the client's death.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:417 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:779 (April 2018).

§6255. Quality Improvement Plan

A. A TGH shall have a quality improvement (QI) plan which puts systems in place to effectively identify issues for which quality monitoring, remediation, and improvement activities are necessary. The QI plan shall include plans of action to correct identified issues including monitoring the effect of implemented changes and making needed revisions to the action plan.

B. The QI plan shall include:

1. a process for obtaining input annually from the client/guardian/authorized representatives and family members, as applicable. This process shall include, but not be limited to:

a. satisfaction surveys done by mail or telephone;

b. focus groups; and

c. other processes for receiving input regarding the quality of services received;

2. a 10 percent sample review of client case records on a quarterly bases to assure that:

a. individual treatment plans are up to date;

b. records are complete and current; and

c. the treatment plans have been developed and implemented as ordered.

3. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or the clients of the TGH receiving services which includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

4. a process to review and resolve individual client issues that are identified; and

5. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above.

C. The QI program outcomes shall be documented and reported to the supervising practitioner for action, as necessary, for any identified systemic problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:417 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:779 (April 2018).

Subchapter E. Admission, Transfer, and Discharge

§6259. Admission Requirements

A. A TGH shall have written admissions policies and criteria which shall include the following:

1. intake policy and procedures;

2. admission criteria and procedures;

3. policy regarding the determination of legal status, according to appropriate state laws, before admission;

4. the age of the populations served;

5. the services provided by the TGH; and

6. criteria for discharge.

B. The written description of admissions policies and criteria shall be provided to the department upon request, and made available to the client and his/her legal representative.

C. A TGH shall not refuse admission to any client on the grounds of race, national origin, ethnicity or disability.

D. A TGH shall admit only those clients whose needs, pursuant to the pretreatment assessment and comprehensive treatment plan, can be fully met by the TGH.

E. When refusing admission to a client, the TGH shall provide a written statement to the client with the reason for the refusal. This shall be provided to the designated representative(s) of the department upon request.

F. Pretreatment Assessment. To be admitted into a TGH, the individual must have received a pretreatment assessment by the Medicaid Program, or its designee, that recommends admission into the TGH. The TGH must ensure that requirements for pretreatment assessment are met prior to treatment commencing. The referral PTA shall contain clinical information to support medical necessity to the therapeutic group home and to establish that TGH is the most appropriate service to meet the client's treatment needs.

G. The TGH shall use the pretreatment assessment to develop an initial plan of care to be used upon admission until a comprehensive treatment plan is completed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:417 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:779 (April 2018).

§6261. Transfer and Discharge Requirements

A. The goal of the TGH is to return the client to a less restrictive level of service as early as possible in the development of the plan.

B. Discharge planning begins at the date of admission, and goals toward discharge shall be continually addressed in the multi-disciplinary team meetings and when the comprehensive treatment plan is reviewed. Discharge may be determined based on the client no longer making adequate improvement in this TGH (and another TGH being recommended) or the client no longer having medical necessity at this level of care.

C. Continued TGH stay should be based on a clinical expectation that continued treatment in the TGH can reasonably be expected to achieve treatment goals and improve or stabilize the client's behavior, such that this level of care will no longer be needed and the client can return to the community.

D. Transition should occur to a more appropriate level of care if the client is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., client's behavior and/or safety needs requires a more restrictive level of care or, alternatively, client's behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

E. Voluntary Transfer or Discharge. Upon notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services, the TGH shall have the responsibility of planning for a client's voluntary transfer or discharge.

1. The transfer or discharge responsibilities of the TGH shall include:

a. holding a transfer or discharge planning conference with the client, family, support coordinator, legal representative and advocate, if such are known, in order to facilitate a smooth transfer or discharge, unless the client declines such a meeting;

b. providing a current comprehensive treatment plan. Upon written request and authorization by the client or authorized representative, a copy of the current comprehensive treatment plan shall be provided to the client or receiving provider;

c. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary on the health, developmental issues, behavioral issues, social issues, and nutritional status of the client. Upon written request and authorization by the client or authorized representative, a copy of the discharge summary shall be disclosed to the client or receiving provider. The written discharge summary shall be completed within five business days of the notice by the client or authorized representative that the client has selected another provider or has decided to discontinue services. The provider's preparation of the discharge summary shall not impede or impair the client's right to be transferred or discharged immediately if the client so chooses; and

d. not coercing or interfering with the client's decision to transfer. Failure to cooperate with the client's decision to transfer to another provider will result in adverse action by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

38:418 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:780 (April 2018).

Subchapter F. Services

§6265. General Provisions

A. Upon admission, the TGH shall conduct an initial diagnostic interview. A nursing assessment shall be completed by a registered nurse within 24 hours of admission.

B. The TGH shall develop and implement an initial plan of care after completion of the initial diagnostic interview and utilizing the information contained in the pretreatment assessment to implement care for the client up to and until the comprehensive treatment plan is developed.

C. The TGH shall ensure that requirements for pretreatment assessment are met prior to treatment commencing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:780 (April 2018).

§6267. Comprehensive Treatment Plan

A. Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

B. The multi-disciplinary team shall be made up of at least the supervising practitioner, clinical director, registered nurse, and therapist. The client and the client's guardian/family shall be included as treatment planning members in the development of the comprehensive treatment plan and in the update of treatment goals as clinically indicated.

C. In the event the supervising practitioner is not present at a treatment team meeting during a review of a comprehensive treatment plan, the supervising practitioner shall review and sign the comprehensive treatment plan within 10 calendar days following the meeting.

D. The TGH shall have an original completed, dated and signed team meeting document with signatures of all who attended as well as evidence of invitations extended to the meeting, such as copies of letters, emails or service logs, as clinically indicated.

E. The multi-disciplinary team shall identify any barriers to treatment and modify the plan in order to continue to facilitate active movement toward the time-limited treatment goals identified in the plan.

F. The TGH shall use a standardized assessment and treatment planning tool such as the *Child and Adolescent Needs and Strengths* (CANS).

G. Each client's treatment plan shall identify individualized strength-based services and supports. The individualized, strengths-based services and supports:

1. are identified in partnership with the client and his or her family and support system to the fullest possible extent and if developmentally appropriate;

2. are based on both clinical and functional assessments;

3. are clinically monitored and coordinated, with 24-hour availability;

4. are implemented with oversight from a licensed mental health professional; and

5. assist with the development of skills for daily living and support success in community settings, including home and school.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012), amended LR 41:1295 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:780 (April 2018).

§6269. Client Services

A. The TGH shall ensure services in the following areas to meet the specialized needs of the client:

1. psychological and psychiatric services;

2. physical and occupational therapy;

3. speech pathology and audiology; and

4. other medical and dental services as needed.

B. The TGH is required to provide at least 16 hours of active treatment per week to each client. This treatment shall be provided and/or monitored by qualified staff.

C. The TGH shall have a written plan for insuring that a range of daily indoor and outdoor recreational and leisure opportunities are provided for clients. Such opportunities shall be based on both the individual interests and needs of the client and the composition of the living group.

1. The provider shall be adequately staffed and have appropriate recreation spaces and facilities accessible to clients.

2. Any restrictions of recreational and leisure opportunities shall be specifically described in the treatment plan, together with the reasons such restrictions are necessary and the extent and duration of such restrictions.

D. The TGH shall have a program to ensure that clients receive training in independent living skills appropriate to their age and functioning level. This program shall include instruction in:

1. hygiene and grooming;

2. laundry and maintenance of clothing;

3. appropriate social skills;

4. housekeeping;

5. budgeting and shopping;

6. cooking; and

7. punctuality, attendance, and other employment related matters.

E. The TGH shall have a written description regarding the involvement of the client in work including:

1. the description of any unpaid tasks required of the client;

2. the description of any paid work assignments including the pay scales for such assignments;

3. the description of the provider's approach to supervising work assignments;

4. assurance that the conditions and compensation of such work are in compliance with applicable state and federal laws; and

5. all work assignments shall be in accordance with the client's treatment plan.

F. The provider shall assign as unpaid work for the client only housekeeping tasks similar to those performed in a normal family home. Any other work assigned shall be compensated at a rate and under such conditions as the client might reasonably be expected to receive for similar work in outside employment.

G. When a client engages in off-grounds work, the provider shall maintain written documentation that:

1. such work is voluntary and in accordance with the client's treatment plan;

2. the clinical director approves such work;

3. such work is supervised by qualified personnel; and

4. the conditions and compensation of such work are in compliance with applicable state and federal laws;

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:419 (February 2012), amended LR 41:1295 (July 2015).

§6271. Medications

A. All TGHs that store and/or dispense scheduled narcotics shall have a site-specific Louisiana controlled substance license and a United States Drug Enforcement Administration (DEA) controlled substance registration for the provider in accordance with the Louisiana Uniform Controlled Dangerous Substance Act and title 21 of the *United States Code*.

B. The TGH shall have written policies and procedures that govern the safe administration and handling of all prescription and nonprescription medications.

C. The TGH shall have a written policy governing the self-administration of all medications. Such policy shall include provisions regarding age limitations for self-administration, multi-disciplinary team recommendations, and parental consent, if applicable. Those clients that have been assessed to be able to safely self-administer medications shall be monitored by licensed or qualified staff to ensure medication is taken as prescribed in the comprehensive treatment plan.

D. The TGH shall ensure that medications are either self-administered or administered by licensed persons according to state law.

E. The TGH shall have a written policy for handling medication taken from the facility by clients on pass.

F. The TGH shall ensure that any medication given to a client for therapeutic and medical purposes is in accordance with the written order of a physician.

1. There shall be no standing orders for prescription medications.

2. There shall be standing orders, signed by the physician, for nonprescription drugs with directions from the physician indicating when he/she is to be contacted. Standing orders shall be updated annually by the physician.

3. Copies of all written orders shall be kept in the client's file.

G. The TGH shall develop and implement procedures for all discontinued and/or expired medications and containers with worn, illegible or missing labels.

H. All medications shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

1. Medications used externally and medications taken internally shall be stored on separate shelves or in separate cabinets.

2. All medications, including those that are refrigerated, shall be kept under lock and key.

I. Any TGH using psychotropic medications shall have written policies and procedures concerning the use of psychotropic medications including:

1. when used, there is medical monitoring to identify specific target symptoms;

2. procedures to ensure that medications are used as ordered by the physician for therapeutic purposes and in accordance with accepted clinical practice;

3. procedures to ensure that medications are used only when there are demonstrable benefits to the client unobtainable through less restrictive measures;

4. procedures to ensure continual physician review of medications and discontinuation of medications when there are no demonstrable benefits to the client;

5. an ongoing program to inform clients, staff, and where appropriate, client's parent(s) or legal guardian(s) on the potential benefits and negative side-effects of medications and to involve clients and, where appropriate, their parent(s) or legal guardian(s) in decisions concerning medication; and

6. training of staff to ensure the recognition of the potential side effects of the medication.

J. Current and accurate records shall be maintained on the receipt and disposition of all scheduled drugs. An annual inventory, at the same time each year, shall be conducted for all Schedule I, II, III, IV and V drugs.

K. Medications are to be administered only upon written orders, electromechanical facsimile, or oral orders from a physician or other legally authorized prescriber, taken by a licensed nurse.

L. All drug containers shall be labeled to show at least the client's full name, the chemical or generic drug's name, strength, quantity and date dispensed unless a unit dose system is utilized. Appropriate accessory and cautionary statements as well as the expiration date shall be included.

M. Medications and biologicals that require refrigeration shall be stored separately from food, beverages, blood, and laboratory specimens.

N. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician. An entry shall be made in the client's record.

O. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the clinical director, the Louisiana Board of Pharmacy, DHH Controlled Dangerous Substances Program and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:419 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:780 (April 2018).

§6273. Food and Diet

A. The TGH shall ensure that all dietary services are provided in consultation with a Louisiana licensed registered dietician. The registered dietician shall be available regarding the nutritional needs, the special diets of individual clients and to assist in the development of policies and procedures for the handling, serving and storage of food.

B. The provider shall have written policies and procedures that ensure that a client is, on a daily basis, provided with food of such quality and in such quantity as to meet the recommended daily dietary allowances adjusted for age, gender and activity of the Food Nutrition Board of the National Research Council and doesn't deny any rights of the client.

C. Meals, whether prepared by the provider or contracted from an outside source, shall meet the following conditions:

1. menus shall be written in advance, shall provide for a variety of nutritional foods and shall be reviewed and approved by a licensed registered dietician;

2. records of menus, as served, shall be filed and maintained for at least 30 days;

3. modified diets shall be prescribed by a physician;

4. food preparation areas and utensils shall be maintained in accordance with state and local sanitation and safe food handling standards. Pets are not allowed in food preparation and serving areas; and

5. the clinical director or house manager shall designate one staff member who shall be responsible for meal preparation/serving if meals are prepared in the facility.

D. Drinking water shall be readily available.

E. Dining areas shall be adequately equipped with tables, chairs, eating utensils and dishes designed to meet the functional needs of clients.

F. All food shall be procured, stored, prepared, distributed, and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink according to State Sanitary Code. Refrigerator temperatures shall be maintained according to State Sanitary Code. Hot foods shall leave the kitchen or steam table according to State Sanitary Code.

G. The provider shall ensure that any prescribed modified diet for a client shall be implemented and planned, prepared and served by persons who have received instruction from the registered dietician who has approved the menu for the modified diet.

H. The provider shall ensure that a client is provided at least three meals or their equivalent daily at regular times with not more than 14 hours between the evening meal and breakfast on the following day. Specific times for serving meals shall be established and posted.

I. Bedtime nourishments shall be offered nightly to all clients, unless contraindicated by the client's medical practitioner, as documented in the client's comprehensive treatment plan.

J. The provider shall ensure that the food provided to a client in care of the provider is in accordance with his/her religious beliefs.

K. No client shall be denied food or force-fed for any reason except as medically required pursuant to a physician's written order. A copy of the order shall be maintained in the client's file.

L. When meals are provided to staff, the provider shall ensure that staff members eat the same food served to clients

in care, unless special dietary requirements dictate differences in diet.

M. The provider shall ensure that food served to a client that is not consumed is discarded.

N. Written reports of inspections by the Office of Public Health shall be posted in the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:420 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:780 (April 2018).

§6275. Transportation

A. A TGH provider shall arrange for or provide transportation necessary for implementing the client's treatment plan.

B. Any vehicle used to transport clients, whether such vehicle is operated by a staff member or any other person acting on behalf of the provider, shall be:

1. properly licensed and inspected in accordance with state law;

2. maintained in a safe condition;

3. operated at a temperature that does not compromise the health, safety or needs of the client; and

4. operated in conformity with all of the applicable motor vehicle laws.

C. The provider shall have documentation of current liability insurance coverage for all owned and non-owned vehicles used to transport clients. The personal liability insurance of a provider's employee shall not be substituted for the required coverage.

D. Any staff member of the TGH, or other person acting on behalf of the TGH, who is operating a vehicle for the purpose of transporting clients shall be properly licensed to operate that class of vehicle in accordance with state law.

E. Upon hire, the provider shall conduct a driving history record of each employee, and annually thereafter.

F. The TGH provider shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the vehicle.

G. The TGH provider shall ascertain the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff responsible for transporting clients.

H. The following additional arrangements are required for transporting non-ambulatory clients and those who cannot otherwise be transferred to and from the vehicle.

1. A ramp device to permit entry and exit of a client from the vehicle shall be provided for vehicles. A mechanical lift may be utilized, provided that a ramp is also available in case of emergency, unless the mechanical lift has a manual override.

2. Wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners.

3. The arrangement of the wheelchairs shall not impede access to the exit door of the vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:421(February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:781 (April 2018).

Subchapter G. Client Protections

§6279. Client Rights

A. A TGH shall develop and implement policies to protect its client's rights and to respond to questions and grievances pertaining to these rights. A TGH and its staff shall not violate a client's rights.

B. A client shall be granted at least the following rights:

1. the right to be informed of the client's rights and responsibilities in advance of furnishing or discontinuing client care;

2. the right to have a family member, chosen representative and/or his or her own physician notified promptly of admission to the TGH;

3. the right to receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment;

4. the right to be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment;

5. the right to receive, as soon as possible, the services of a translator or interpreter, if needed, to facilitate communication between the client and the TGH's health care personnel;

6. the right to participate in the development and implementation of his/her treatment plan;

7. the right to make informed decisions regarding his/her care by the client or in the case of a minor, the client's parent, guardian or responsible party, whichever is applicable in accordance with appropriate laws and regulations;

8. the right to be informed of his/her health status, and be involved in care planning and treatment;

9. the right to be included in experimental research only when he/she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent client or a minor client in accordance with appropriate laws and regulations. The client may refuse to

participate in experimental research, including the investigations of new drugs and medical devices;

10. the right to be informed by the attending physician and other providers of health care services about any continuing health care requirements after the client's discharge from the TGH. The client shall also have the right to receive assistance from the physician and appropriate TGH staff in arranging for required follow-up care after discharge;

11. the right to consult and communicate freely and privately with his/her parent(s) or legal guardian(s), if permitted in the comprehensive treatment plan;

12. the right to consult freely and privately with legal counsel;

13. the right to make complaints without fear of reprisal;

14. the right to communicate via a telephone, as allowed by the comprehensive treatment plan;

15. the right to send and receive mail as allowed by the comprehensive treatment plan;

16. the right to possess and use personal money and belongings, including personal clothing, subject to rules and restrictions imposed by the TGH;

17. the right to visit or be visited by family and friends subject only to reasonable rules and to any specific restrictions in the client's treatment plan. The reasons for any special restrictions shall be recorded in the client's treatment plan;

18. the right to have the individual client's medical records, including all computerized medical information, kept confidential;

19. the right to access information contained in his/her medical records within a reasonable time frame, subject to restrictions imposed in the comprehensive treatment plan;

20. the right to be free from all forms of abuse and harassment;

21. the right to receive care in a safe setting;

22. the right to be informed in writing about the TGH's policies and procedures for initiation, review and resolution of client complaints;

23. the right to have access to appropriate educational services consistent with the client's abilities and needs, taking into account his/her age and level of functioning;

24. the right to indoor and outdoor recreational and leisure opportunities;

25. the right to attend religious services in accordance with his/her faith. Clients shall not be forced to attend religious services; and

26. the right to choose a provider, the right to be discharged from his current provider and be transferred to another provider, and the right to discontinue services altogether unless prohibited by court order.

C. In addition to the rights listed herein, clients have the rights provided in the Louisiana Mental Health Law and the *Louisiana Children's Code*.

D. A TGH shall provide a copy of the client's rights to each client upon admission and shall have documentation of each client who received a copy of them.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:421 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:781 (April 2018).

§6281. Grievances

A. The provider shall have a written grievance procedure for clients designed to allow clients to make complaints without fear of retaliation. The procedure shall include, but not be limited to:

1. a time line for responding to grievances;
2. a method of responding to grievances;
3. a procedure for filing a grievance; and
4. staff responsibilities for handling grievances.

B. The provider shall have documentation reflecting that the client and the client's parent(s) or legal guardian(s) are aware of and understand the grievance procedure.

C. The provider shall have documentation reflecting the resolution of the grievance in the client's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:422 (February 2012).

Subchapter H. Physical Environment

§6285. General Provisions

A. Location of Therapeutic Group Homes. To ensure a more home-like setting, the TGH shall be located in a residential community to facilitate community integration through public education, recreation, and maintenance of family connections as applicable. The setting shall be geographically situated to allow ongoing participation of the child's family. The child or adolescent shall attend a school in the community (e.g., a school integrated with children not from the institution and not on the institution's campus). In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

1. The child or adolescent may attend school in an alternative setting, as approved by the local parish school board and in accordance with state law, as applicable.

B. The living setting shall more closely resemble normal family existence than would be possible in a larger facility or institution.

C. Providers shall develop an environment conducive to the client safely restoring previous levels of functioning and enhancing existing levels of functioning. In addition the provider shall maintain a community-based non-institutional environment.

D. The TGH shall have an effective pest control plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:422 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:781 (April 2018).

§6287. Interior Space

A. The arrangement, appearance and furnishing of all interior areas of a TGH shall be similar to those of a normal family home within the community.

B. The provider shall ensure that there is evidence of routine maintenance and cleaning programs in all areas of the home.

C. A home shall have a minimum of 60 square feet of floor area per client in living areas accessible to the clients and excluding halls, closets, bathrooms, bedrooms, staff or staff's family quarters, laundry areas, storage areas and office areas.

D. Client Bed Rooms

1. Single rooms shall contain at least 80 usable square feet and multi-bed rooms shall contain at least 50 usable square feet per bed. Rooms shall have at least a 7 1/2 foot ceiling height.

2. Any client bedrooms shall not contain more than two beds.

a. Exception. If a child residential facility currently licensed by DCFS is converting to a TGH and has more than two clients per bedroom, then the converted TGH may have bedroom space that allows no more than four clients per designated bedroom.

3. There shall be at least three feet between beds.

4. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of clients.

5. There shall be a door for privacy to each individual bedroom. The doors shall not be equipped with locks or any other device that would prohibit the door from being opened from either side.

6. There shall be a functional window in each bedroom.

7. The provider shall ensure that sheets, pillow, bedspread and blankets are provided for each client.

8. Each client shall have his/her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the client.

9. No client over the age of five years shall occupy a bedroom with a member of the opposite sex.

10. The provider shall ensure that the age of client sharing bedroom space is not greater than four years in difference unless contraindicated based on diagnosis, the treatment plan or the behavioral health assessment of the client.

11. Each client shall have his/her own bed. A client's bed shall be longer than the client is tall, no less than 30 inches wide, of solid construction and shall have a clean, comfortable, nontoxic fire retardant mattress.

E. Dining Areas

1. The facility shall have dining areas that permit clients, staff and guests to eat together in small groups.

2. A facility shall have dining areas that are clean, well lit, ventilated and attractively furnished.

F. Bathrooms

1. A facility shall have wash basins with hot and cold water, flush toilets, and bath or shower facilities with hot and cold water according to client care needs. Plumbing fixtures delivering hot water shall be protected by an approved scald control mechanism at the fixture.

2. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene unless clients are individually given such items. Clients shall be provided individual items such as hair brushes and toothbrushes.

3. Tubs and showers shall have slip proof surfaces.

4. A facility shall have toilets and baths or showers that allow for individual privacy unless the clients in care require assistance.

5. Toilets, wash basins and other plumbing or sanitary facilities in a facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

6. A TGH shall have at least one separate toilet, lavatory, and bathing facility for the staff.

7. In a multi-level home, there shall be at least one toilet bowl with accessories, lavatory basin and bathing facility reserved for client use on each client floor.

8. The TGH shall meet the following ratios:

a. one lavatory per six clients;

b. one toilet per six clients; and

c. one shower or tub per six clients.

9. Bathrooms shall contain shatterproof mirrors secured to the walls at convenient heights and other

furnishings necessary to meet the clients' basic hygienic needs.

G. Kitchens

1. Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving, storage and clean up of all meals regularly served to all of the clients and staff. If clients prepare meals, additional equipment and space is required. All equipment shall be maintained in proper working order.

2. The provider shall ensure that all dishes, cups and glasses used by clients are free from chips, cracks or other defects and are in sufficient number to accommodate all clients.

3. There shall be trash containers in the kitchen and dining area. Trash containers in kitchens and dining area shall be covered.

H. Laundry. The provider shall have a laundry space complete with washer and dryer.

I. Staff Quarters. The provider utilizing live-in staff shall provide adequate, separate living space with a private bathroom for these staff.

J. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from client's living areas to serve as an administrative office for records, secretarial work and bookkeeping.

2. The provider shall have a designated space to allow private discussions and counseling sessions between individual clients and staff, excluding, bedrooms and common living areas.

K. Furnishings

1. The provider shall have comfortable customary furniture as appropriate for all living areas. Furniture for the use of clients shall be appropriately designed to suit the size and capabilities of the clients.

2. The provider shall promptly replace or repair broken, run-down or defective furnishings and equipment.

L. Doors and Windows

1. The provider shall provide insect screens for all windows that can be opened. The screens shall be in good repair and readily removable in emergencies.

2. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

3. Windows or vents shall be arranged and located so that they can be opened from the inside to permit venting of combustion products and to permit occupants direct access to fresh air in emergencies. The operation of windows shall be restricted to inhibit possible escape or suicide. If the home has an approved engineered smoke control system, the windows may be fixed. Where glass fragments pose a hazard to certain clients, safety glazing and/or other appropriate security features shall be used. The windows shall be covered for privacy, and the coverings shall pose no safety hazard for the clients living in the home.

M. Storage

1. The provider shall ensure that there are sufficient and appropriate storage facilities.

2. The provider shall have securely locked storage space for all potentially harmful materials. Keys to such storage spaces shall only be available to authorized staff members.

N. Electrical Systems

1. The provider shall ensure that all electrical equipment, wiring, switches, sockets and outlets are maintained in good order and in safe condition.

2. The provider shall ensure that any room, corridor or stairway within a facility shall be well lit.

O. Heating, Ventilation and Air Conditioning

1. The provider shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of all clients.

2. The provider shall not use open flame heating equipment or portable electrical heaters.

3. All gas heating units and water heaters shall be vented adequately to carry the products of combustion to the outside atmosphere. Vents shall be constructed and maintained to provide a continuous draft to the outside atmosphere in accordance with the recommended procedures of the American Gas Association Testing Laboratories, Inc.

4. All heating units shall be provided with a sufficient supply of outside air so as to support combustion without depletion of the air in the occupied room.

P. Smoking shall be prohibited in all areas of the TGH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:422 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:781 (April 2018).

§6289. Exterior Space Requirements

A. The provider shall maintain all areas of the facility that are accessible to the clients in good repair and free from any reasonably foreseeable hazard to health or safety. All structures on the grounds of the facility shall be maintained in good repair.

1. Garbage and rubbish stored outside shall be secured in noncombustible, covered containers and shall be removed on a regular basis.

2. Trash collection receptacles and incinerators shall be separate from recreation/play areas and located as to avoid being a nuisance.

3. Clients shall have access to safe, suitable outdoor recreational space and age appropriate equipment. Recreation/playground equipment shall be so located, installed and maintained as to ensure the safety of the clients.

4. Areas determined unsafe, including steep grades, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced or have natural barriers to protect clients.

5. Fences that are in place shall be in good repair.

6. The provider shall ensure that exterior areas are well lit at night.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:424 (February 2012).

§6291. Equipment

A. Equipment shall be clean and in operating condition for the safety and well-being of the clients.

B. Therapeutic, diagnostic and other client care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. Methods for cleaning, sanitizing, handling and storing of all supplies and equipment shall be such as to prevent the transmission of infection.

D. After discharge of a client, the bed, mattress, cover, bedside furniture and equipment shall be properly cleaned. Mattresses, blankets and pillows assigned to clients shall be in a sanitary condition. The mattress, blankets and pillows used for a client with an infection shall be sanitized in an acceptable manner before they are assigned to another client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:424 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:781 (April 2018).

Subchapter I. Facility Operations

§6293. Safety and Emergency Preparedness

A. General Safety Practices

1. A provider shall not maintain any firearms or chemical weapons at any time.

2. A provider shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers and labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of clients, staff and visitors.

3. Adequate supervision/training shall be provided where potentially harmful materials such as cleaning solvents and/or detergents are used.

4. A provider shall ensure that a first aid kit is available in the facility and in all vehicles used to transport clients.

5. Medication shall be locked in a secure storage area or cabinet.

6. Fire drills shall be performed at least once a month.

B. Emergency Preparedness

1. A disaster or emergency may be a local, community-wide, regional or statewide event. Disasters or emergencies may include, but are not limited to:

a. tornados;

b. fires;

c. floods;

d. hurricanes;

e. power outages;

f. chemical spills;

g. biohazards;

h. train wrecks; or

i. declared health crisis.

2. Continuity of Operations. The provider shall have a written emergency preparedness plan to maintain continuity of the provider’s operations in preparation for, during and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that disrupt the provider’s ability to render care and treatment, or threatens the lives or safety of the clients.

3. The provider shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency. The plan shall include, at a minimum:

a. provisions for the evacuation of each client, delivery of essential services to each client, whether the client is in a shelter or other location or the provider has elected to shelter in place;

b. provisions for the management of staff, including provisions for adequate, qualified staff as well as for distribution and assignment of responsibilities and functions;

c. provisions for back-up staff;

d. the method that the provider will utilize in notifying the client’s family or caregiver if the client is evacuated to another location either by the provider or with the assistance or knowledge of the provider. This notification shall include:

i. the date and approximate time that the facility or client is evacuating;

ii. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

iii. a telephone number that the family or responsible representative may call for information regarding the provider's evacuation;

e. provisions for ensuring that supplies, medications, clothing and a copy of the service plan are sent with the client, if the client is evacuated; and

f. the procedure or methods that will be used to ensure that identification accompanies the client. The identification shall include the following information:

i. current and active diagnosis;

ii. medication, including dosage and times administered;

iii. allergies;

iv. special dietary needs or restrictions; and

v. next of kin, including contact information.

4. If the state, parish or local Office of Homeland Security and Emergency Preparedness (OHSEP) orders a mandatory evacuation of the parish or the area in which the provider is serving, the provider shall ensure that all clients are evacuated according to the provider's emergency preparedness plan.

5. The provider shall not abandon a client during a disaster or emergency. The provider shall not evacuate a client to a shelter without ensuring staff and supplies remain with the client at the shelter, in accordance with the client's treatment plan.

6. Emergency Plan Review and Summary. The provider shall review and update its emergency preparedness plan at least annually.

7. The provider shall cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and shall provide information as requested.

8. The provider shall monitor weather warnings and watches as well as evacuation order from local and state emergency preparedness officials.

9. All TGH employees shall be trained in emergency or disaster preparedness and shall be knowledgeable of the provider's emergency preparedness policies and procedures. Training shall include orientation, ongoing training and participation in planned drills for all personnel.

10. Upon request by the department, the TGH shall submit a copy of its emergency preparedness plan and a written summary attesting how the plan was followed and executed. The summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of clients that occurred during execution of the plan, evacuation or temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

11. At any time that the TGH has an interruption in services or a change in the licensed location due to an emergency situation, the provider shall notify the HSS no later than the next business day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:424 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 44:781 (April 2018).

§6295. Inactivation of License due to a Declared Disaster or Emergency

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

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

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

b. the licensed TGH intends to resume operation as a TGH in the same service area;

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

d. includes an attestation that all clients have been properly discharged or transferred to another provider; and

e. provides a list of clients and the location of the discharged or transferred clients;

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

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

4. the licensed TGH continues to submit required documentation and information to the department.

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

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

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

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

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

2. The provider resumes operating as a TGH in the same service area within one year.

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

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

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:425 (February 2012).

§6297. Inactivation of License due to a Non-Declared Emergency or Disaster

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

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

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

b. the licensed TGH provider intends to resume operation as a TGH provider in the same service area;

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

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

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

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

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

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

C. Upon the provider's receipt of the department's approval of request to inactivate the provider's license, the provider shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to the OSFM and the LDH-OPH as required.

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

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

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

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

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall

request scheduling of a licensing or physical environment survey, where applicable; and

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

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

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

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

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the TGH provider license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:782 (April 2018).

Chapter 67. Hospitals

§6700. General

A. Through contract with Department of Health and Human Services, the state has agreed to enforce certain federal regulations (Conditions of Participation) in addition to the licensure regulations listed below. The federal regulations which apply to this chapter are 42 CFR 405.1011- 405.1042, 405.1317.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6701. Definitions

A. Definitions

Accredited—approval by the Joint Commission on Accreditation of Hospitals.

Appeals Section DHHR—the board authorized to hear appeals as provided in R. S. 40:2110 B and C.

Dentist—a doctor of dental surgery duly licensed in the state of Louisiana.

Director—the director of the Division of Licensing and Certification of the state of Louisiana.

Division—the Division of Licensing and Certification of the state of Louisiana.

Geriatric Unit—any part of a hospital which is licensed under the provisions of the nursing home licensing law (R. S. 40:2009-2009.12) to provide nursing care for the infirm and aged.

Hospital—any institution, place, building, or agency, public or private, whether for profit or not, devoted primarily to the maintenance and operation of facilities for ten or more individuals for the diagnosis, treatment, or care of persons admitted for overnight stay or longer who are suffering from illness, injury, infirmity, or deformity or other physical condition for which obstetrical, medical, or surgical services would be available and appropriate. The term "hospital" does not include the following:

a. physicians' offices or clinics where patients are not regularly kept as bed patients for 24 hours or more;

b. nursing homes as defined by and regulated under the provisions of R. S. 40:2009-2009.12;

c. persons, schools, institutions, or organizations engaged in the care and treatment of mentally retarded children and which are required to be licensed by the provisions of R.S. 28:562-566;

d. hospitalization or care facilities maintained by the state at any of its penal or correctional institutions;

e. hospitalization or care facilities maintained by the federal government or agencies thereof;

f. hospitalization or care facilities maintained by any university or college.

Licensed Practical Nurse, abbreviated *L.P.N.*,—a person duly licensed by the Louisiana State Board of Practical Nurse Examiners.

Medical Staff—those physicians and dentists who are authorized to practice in the hospital.

New Construction—includes any of the following started after promulgation of these standards:

a. new buildings to be used as a hospital;

b. additions to existing buildings to be used as a hospital;

c. conversions of existing buildings or portions thereof for use as a hospital;

d. alterations other than minor alterations to an existing building.

Nursing Home—a place which provides maintenance, personal care, or nursing for persons who by reason of illness or physical infirmity or age are unable to properly care for themselves and is distinguishable from a "hospital" in that it does not provide obstetrical or major surgical services.

Person—the state, and any political subdivision or municipal corporation thereof, an individual, firm, partnership, corporation, company, association, or joint stock association, or the legal successor thereof.

Physician—a doctor of medicine duly licensed in the state of Louisiana.

Psychiatric Unit—a separate portion of the hospital specifically reserved for the care of mental patients (a part of which may be "open" and a part locked) as distinguished from "seclusion rooms" which are part of a general nursing unit in which psychiatric care and treatment are not the primary service.

Registered Nurse—a graduate or professional nurse duly licensed by the Louisiana State Board of Nurse Examiners.

Standards—the rules, regulations, and minimum standards duly adopted and promulgated by the Hospital Licensing Council with approval of the State Hospital Board.

B. All adjectives and adverbs, such as adequate, approved, qualified, reasonable, reputable, satisfactory, sufficiently, suitable, or substantial, used in these standards to qualify a person, a procedure, equipment, or building shall be determined by the director without prejudice.

1. Where the word "shall" is used in these standards, the rule or regulation is mandatory.

2. Where the word "should" is used, it indicates suggestion or recommendation but not requirements.

3. Where the word "may" is used in these standards, it is permissive or discretionary.

4. Temporary Permit is a written authorization issued by the division in accordance with the law or these standards to a hospital which has not qualified for licensing to continue to operate for the limited period of time as specified in the permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6703. Licensing Procedures

A. The licensing procedures, as set forth in various sections of the law, may be summarized as follows.

1. Application for license shall be submitted annually by applicants on forms supplied by the division.

2. The hospital shall complete the application form and return it to the division at least 30-60 days prior to the expiration date of the current license, accompanied by the following: per annum license fee of $100 plus $3 per bed (State owned hospitals are exempt from fee); a Certificate of Compliance from the state fire marshal, and a Certificate of Compliance from the Office of Preventive and Public Health Services.

a. Primary responsibility for obtaining forms, submitting application, fee, and Certificates of Compliance from the state fire marshal and the Office of Preventive and Public Health Services shall rest with the applicant.

3. If a hospital is in compliance with the minimum standards, a license shall be issued by the division.

4. If a hospital fails to meet the minimum standards within one year after adoption by the council of such standards, but is correcting existing deficiencies, a temporary permit may be issued pending compliance with the minimum standards.

5. If a hospital fails to meet the minimum standards within one year after adoption by the council of such standards or after any subsequent temporary permit issued to it has expired, a license will be denied or revoked.

6. If a license is denied or revoked, an appeal may be made from the decision as outlined under Chapter IX.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6705. Exceptions

A. If a hospital that is required to be licensed under the law does not normally provide a particular service or department, the Chapter, Section, or Sections of these standards relating to such service or department will not be applicable.

1. If a hospital that is required to be licensed under the law is accredited by the Joint Commission on Accreditation of Hospitals, the division shall accept such accreditation as evidence of satisfactory compliance with all provisions of these standards, except those relating to fire prevention and sanitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6707. Approval of Plans

A. All new construction, other than minor alterations, shall be done in accordance with the specific minimum requirements of the state fire marshal and the Office of Preventive and Public Health Services covering new construction in hospitals, including submission of preliminary plans and the submission of final working drawings and specifications to the Division of Licensing and Certification.

B. Before any new hospital is licensed or before any alteration or expansion of a licensed hospital can be approved, the applicant must furnish three complete sets of plans and specifications to the Division of Licensing and Certification, together with such other information as may be required by the division. Plans and specifications for new construction other than minor alterations shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

C. The division will forward one copy of the plans and specifications to the state fire marshal, whose approval must

be obtained before the division will take final action. The state fire marshal should file his report of approval or disapproval within 30 days of notice to him that his inspection should be made.

D. The division will also forward a copy of the plans and specifications to the Office of Preventive and Public Health Services whose approval must also be obtained before the division will take final action. The Office of Preventive and Public Health Services should file its report of approval or disapproval within 30 days of notice to it that an inspection should be made.

E. The division will retain one copy of the plans and specifications and study them in relation to all applicable requirements of these standards, and make investigations as it may deem necessary.

F. When the plans and specifications have been fully reviewed and all inspections and investigations have been made, including those of the state fire marshal and the Office of Preventive and Public Health Services, the division will within 30 days of receipt by it of reports from the state fire marshal and the Office of Preventive and Public Health Services notify the applicant whether or not the plans for the proposed hospital building, alteration, or expansion have been approved. In case of disapproval the division will within a like 30 days specify in writing the reasons therefore.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6709. Medical Staff

A. Rules, regulations and policies covering the activities of the medical staff should be established.

B. The organization and functions of the medical staff, insofar as practicable, shall be in accordance with the standards of the Joint Commission on Accreditation of Hospitals.

C. Each person admitted to the hospital shall be under the professional care of a member of the medical staff and shall not be admitted except on the recommendation of an attending physician.

D. Arrangements shall be made to have a physician on call at all times for emergencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6711. Personnel

A. There shall be sufficient qualified personnel to properly operate each department of the hospital.

B. The department of nursing shall be under the direction of a registered nurse. There shall be an adequate number of nurses on duty at all times.

C. All non-professional employees performing nursing service functions shall be under the supervision of a registered nurse.

D. Each employee shall have a health examination as required by hospital policy an in accordance with the State Sanitary Code.

E. Employees with a communicable disease in an infectious stage shall not be on duty.

F. Employees handling food and working in food service shall have an annual bacteriological stool examination.

G. All new employees before entering upon duty shall be given a general physical examination including a chest survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6713. Functions of the State Fire Marshal

A. All hospitals required to be licensed by the law shall comply with the requirements of this Chapter relating to fire protection and it shall be the primary responsibility of the state fire marshal to determine if applicants are complying with these requirements. No license shall be issued or renewed without the applicant furnishing certificate from the state fire marshal that such applicant is complying with the provisions of this Chapter; provided if the state fire marshal issues the applicant a conditional certificate, a temporary permit may be issued to the applicant.

B. Scope of Chapter. The requirements of this Chapter are for the information of applicants, principally owners of existing hospitals of other than fire resistive or non-combustible construction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6715. New Hospitals

A. All new hospitals shall be of fire resistive or non-combustible construction as defined in the National Building Code of the National Board of Fire Underwriters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6717. Existing Hospitals

A. Fire Control Equipment. Existing hospitals of other than fire resistive or non-combustible construction shall be equipped with fire control equipment that has been acceptable and was in operation prior to the effective date of these standards.

B. Additions. Additions to existing hospitals may be of the same construction as the existing buildings; provided that authorized additions to buildings of other than fire resistive and non-combustible construction must be equipped with automatic sprinkler systems.

C. Mechanical Equipment, Service and Utility Rooms. Rooms containing boilers, machinery, transformers, air conditioning equipment, equipment repair areas, storage or other service equipment, subject to high fire hazard or explosion shall not be located directly under or adjacent to required exits. Such areas shall have at least one outside wall with windows and shall be effectively cut off from other parts of the building by fire partitions and fire doors.

D. Exits. There shall be a minimum of two widely separated exits, the minimum width of which shall be three feet, six inches. All exit doors, including screen doors and doors in exit ways, shall swing in the direction of egress. In hospitals of any type construction dead ends should not exceed 25 feet.

E. Stairs. There shall be a minimum of two widely separated stairs. Stairs shall be fully enclosed by fire partitions and fire doors shall swing in the direction of egress and shall open to the exterior on the ground floor. Stairs shall have a minimum width of 36 inches, a maximum rise of seven and one half inches and a minimum tread of 11 inches with nosing. The maximum number of risers in any one run shall be 15 and the minimum three. Ramps may be used at exterior exits, ground floor. Minimum fire protection of stair enclosure shall be one hour. Entrance doors to stair enclosures shall not be less than Class "B" fire doors as defined by the National Fire Protection Association, shall swing in the direction of egress and shall be provided with liquid door closers and latches. Exterior stairs from upper floors are permitted, provided width, rise, and run are the same as for interior stairs. All stairs shall be provided with handrails on both sides. No windows or steps on platforms will be permitted on any stairs. The requirements of this Section may be waived in whole or in part in favor of an existing hospital whenever the state fire marshal determines that strict compliance would be impracticable because the cost to the hospital of making indicated structural changes would be prohibitive and that reasonable steps have been taken in connection therewith to protect life and property from the hazards of fire and panic which might arise from fire or from the threat of fire or explosion.

F. Vertical Openings. All vertical openings, such as clothes chutes, pipe shafts, and elevator shafts, shall be fully enclosed.

G. Corridors and Doors. The minimum unobstructed width of corridors and doors shall be such as to minimize the possibility of congestion in the event of fire or other hazard and adequate for the free movement of patients on standard size wheel stretchers. Doors shall not swing into the corridors so as to constitute a hazard.

H. Panic Hardware All required exterior exit doors shall be equipped with panic type hardware. Locks on occupied rooms used for sleeping purposes and in exit passageways shall be such that they cannot be locked against egress. This Section shall not apply to areas of hospitals where the safety of disturbed patients requires their confinement.

I. Fire Alarm. An adequate fire alarm system shall be provided. In buildings which are equipped with sprinkler systems the alarm on the sprinkler system will be acceptable.

J. Fire Extinguishing Equipment. Fire extinguishers of a type approved by the state fire marshal shall be provided for each floor. One such extinguisher is required for each 2500 square feet of closed floor area. Additional extinguishers adequate for use in areas such as the laboratory, kitchen, boiler room, laundry, and storage room shall also be provided.

K. Heating. Where gas is used for heating, all piping shall be exposed and no gas pipe shall be installed in any concealed, unventilated, or inaccessible space. Direct gas fired duct type heaters will not be accepted. Open flame heaters are not permissible unless properly vented to the exterior of the building and equipped with automatic pilot and safety cutoff.

L. Electrical Wiring, Equipment and Materials. All electrical wiring, equipment, and materials shall conform to the standards of the National Electrical Code and shall be installed and maintained in accordance with such Code. All electrical equipment and materials shall bear the underwriter's label.

M. Exit and Emergency Lighting

1. Illuminated exit and directional signs and emergency illumination shall be provided for all exits and exitways. A minimum of one foot candle of illumination at floor level shall be continuously maintained at all required exits and exitways. The control of this system shall be from a central point accessible only to authorized persons. Individual control switches are not approved. Exit, directional, and emergency lighting fixtures shall be wired for two circuits and each fixture shall contain two lamps, each on a separate circuit. Wiring shall be independent of all other wiring. Dry batteries, automobile batteries, and portable and semi-portable devices are not recommended. It is highly desirable that other equipment be supplied by the emergency electrical system, such as elevators, food and medical preserving refrigerators, call and fire alarm systems, incubators, respirators, heating plant, operating room, delivery room, and emergency room. The normal and emergency source of power should be inter-connected by an automatic device which will transfer the energy to either system in the event of failure of either source of current. The current supply for the exit and emergency system shall be from a motor-generator set for emergency use. The motor-generator set shall not be located in the confines of the hospital unless it is separated by a fire-resistive enclosure. If the source of fuel for the motor-generator is gasoline, diesel, kerosene, propane, butane, or other fuels that are supplied independent of the public utilities, a secondary source of fuel will not be necessary.

2. If the fuel be natural gas or other fuel supplied by the public utilities, piped to the power unit, then a secondary source of fuel shall be provided such as gasoline, diesel fuel, kerosene, propane, butane, or other fuel, and the automatic start will be on the secondary fuel source. A sufficient amount of secondary fuel shall be maintained to insure the operation of the power plant for at least two days or 48 hours. The system should be tested at no less than weekly intervals.

N. Attic and Window Ventilating Fans. Attic and window fans shall be provided with thermostatically controlled switches. The active element of the switch shall be located in the air stream and so regulated that with any appreciable rise in temperature the current to the fan motor will be disconnected.

O. Oil Heaters and Lamps. The use of oil and gasoline heaters and oil and gasoline lamps is prohibited.

P. Heating Systems. All heating systems shall be constructed, maintained, and operated in a manner to provide a comfortable temperature for patients and personnel and in conformity with the "Construction Requirements" of the state fire marshal.

Q. Explosive Anaesthetics. In areas such as operating rooms, x-ray, laboratories, nuclear radiation equipment areas and other places where explosive anaesthetics are used the requirements of the state fire marshal shall be observed.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:2100 through 2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6717. Functions of the Office of Preventive and Public Health Services

A. All hospitals required to be licensed by the law shall comply with the requirements of this Chapter and the Office of Preventive and Public Health Services, and it shall be the primary responsibility of the Office of Preventive and Public Health Services to determine if applicants are complying with these requirements. No license shall be issued or renewed without the applicant furnishing certificate from the Office of Preventive and Public Health Services that such applicant is complying with the Provisions of this Chapter; provided if the Office of Preventive and Public Health Services issues the applicant a conditional certificate, a temporary permit may be issued to the applicant.

AUTHORITY NOTE: Promulgated in accordance with R. S.40:2100 through 2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6719. Scope of Chapter

A. The requirements of this Chapter are for the information of all applicants for license.

AUTHORITY NOTE: Promulgated in accordance with R. S.40:2100 through 2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6721. Buildings

A. General. The buildings shall reflect good housekeeping and shall be free of insects and rodents and when necessary, dust control measures should be employed. Equipment must be clean and in good repair for the safety and well-being of the patients.

B. Staff Facilities. Facilities shall be provided for surgical, delivery, and nursery department personnel. Such facilities should include dressing rooms with toilet and lavatory facilities, including soap and towels.

C. Doors. All doors to the outside shall open outward and be provided with self-closing devices. (See also §6717.G.)

D. Stairways, Ramps, and Elevators. All stairways, ramps, and elevators shall be provided with nonskid floor surfaces and shall have handrails on both sides.

E. Heating Systems. Heating systems shall be of such type and maintained and operated in such a manner to provide a comfortable temperature for patients and hospital personnel. Space heaters, if used, shall be screened and vented to the outside.

F. Ventilation. All rooms in general use shall be provided with adequate ventilation.

G. Lighting and Wiring. Usable rooms and general areas of the hospitals shall be lighted adequately by natural or artificial light including rooms where food is prepared and handled. Adequate emergency lighting shall be provided for surgery, delivery, and emergency rooms. Flashlights or battery operated lamps for emergency use shall be available for hospital personnel and kept in operational condition.

H. Toilet Facilities. Adequate toilet facilities of the proper type shall be provided. Water closets shall be of the elongated bowl type with open front seats. Toilet rooms shall be adequately ventilated. Hot and cold water shall be provided in all lavatories, sinks, and similar fixtures.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:2100 through 2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6723. Food Service

A. General. There shall be adequate facilities for the sanitary storage, preparation, and serving of food. Such facilities must include those for baby food formula, storage, preparation, delivery, and serving.

B. All food, drink, and ice shall be stored, handled, and served in a sanitary manner and all food and drink shall be purchased from a source having an approved manufacturer's number.

C. All milk and cream shall be pasteurized, be of Grade "A" quality, and shall be served from the original container

received from the distributor or from a bulk container equipped with an approved dispensing device.

D. All readily perishable food or drink, including that furnished to patients by sources other than hospitals, shall be kept at or below 45 degrees F except when being prepared or served.

E. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized, and stored.

F. No room used for food preparation may be used for sleeping purposes and said preparation room shall be free form overhead contamination.

G. Ice shall be handled and stored in such a manner as to eliminate contamination. Common use of nursing station ice bins or similar facilities by visitors must be controlled.

AUTHORITY NOTE: Promulgated in accordance with R.S.40:2100 through 2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6725. Equipment and Storage

A. Storage. There shall be sufficient amount of suitable storage space throughout the hospital for all supplies and equipment, which shall include provisions for the safe separation of different items and location thereof away from foot traffic and overhead contamination.

B. Laundry and Movement of Washable Goods. The hospital shall make provisions and be responsible for the proper handling, cleaning, sanitizing, and storage of linen and other washable goods. Dray carts shall be handled in a way as not to transmit communicable diseases from one section of the hospital to another and the carts shall be properly sanitized. Disposable bags shall be used as containers for the handling of bandages and other contaminated items from communicable disease areas. Linens shall be placed in a clean bag or other container and sterilized.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6727. Water Supply

A. All hospitals shall be provided with an adequate supply of safe and palatable water under pressure. Water must be from an approved public water supply or a private water supply properly constructed and maintained. Bacterial samples collected semi-annually must show an absence of bacteriological contamination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6729. Plumbing, Sewerage, Garbage, and Wastes

A. Plumbing shall be installed and maintained in a manner so as not to create a health hazard.

B. Drinking fountain, when provided, shall be of an approved angle jet type.

C. Approved type equipment shall be provided for cleaning and sterilizing bedpans.

D. Sewerage shall be disposed of in a manner so as not to create a health hazard or nuisance.

E. Garbage shall be stored in covered containers of a capacity and type approved by the Office of Preventive and Public Health Services and such wastes shall be disposed of in a manner approved by the Office of Preventive and Public Health Services.

F. Contaminated dressings, surgical, and obstetrical wastes shall be handled in a sanitary manner and disposed of in an incinerator or by other approved method or methods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6731. Radiation

A. All equipment providing a source of radiation shall be adequately shielded so as to protect operators, patients, and staff members at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6733. Nursing Service Facilities

A. Nurses' Station. A nurses' station of adequate size with chart desk and telephone shall be provided in a suitable location on each nursing unit.

B. Utility Room of Space. On each nursing unit an adequate, properly equipped utility space or area shall be provided for the preparation, cleaning, and storage of nursing supplies and equipment which is carried out on the nursing unit. This utility space shall be so arranged as to provide for separation of clean and soiled supplies and equipment.

C. Toilet and Bathing Facilities. There shall be at least one water closet, lavatory basin, and bathing facility reserved for patient use on each patient floor and such additional toilets, lavatories, and bathing facilities to adequately meet the needs of employees, professional personnel, and patients on each nursing unit.

1. Grab bars properly located and securely mounted shall be provided at patient bathing facilities and water closets.

2. A lavatory basin shall be provided in or convenient to every water closet.

3. Paper towels in a satisfactory dispenser or some other acceptable type of single use towel and a satisfactory receptacle for used towels shall be provided at all lavatories, except those in patients' rooms.

D. Isolation Room or Unit. Facilities for isolation of patients with communicable diseases may be established on a temporary basis as the need arises. A private room or a corridor wing may be used provided strict isolation techniques are enforced, including identifying signs to warn and restrict the public.

E. Seclusion Room. When special accommodations are provided for seriously disturbed patients, the layout, design of details, equipment, and furnishings shall be such that patients may be under close observation and will not be afforded opportunities for hiding, escape, or injury to self or others.

F. Storage and Handling of Drugs. Medicines, poisons, and other drugs shall be stored in a specifically designated and well illuminated medicine cupboard, closet, cabinet, or room accessible only to persons authorized to administer or dispense drugs. Separate compartments appropriately marked shall be provided for the storage of drugs for internal use and those for external use.

G. Narcotic Storage and Records. A separate locked drawer, compartment, cabinet, or safe shall be provided for the storage of narcotics and accurate records as to receipt and disposition of such narcotics shall be kept.

H. Facilities for Preparation of Drugs. Suitable facilities, including ample light, running water, and sufficient work area, shall be provided for the preparation of dosages for patients.

I. Labeling of Drugs. All drugs shall be plainly labeled with the name of the drug or prescription number, the strength whenever practicable, and the date of issue. Individual prescriptions shall be labeled with the patient's name, the name of the drug or prescription number, the date of issue, and the name of the physician who prescribed the drug.

J. Patient Room Facilities

1. All patient rooms shall be outside rooms with a window area of clear glass of not less than one eighth of the floor area except in rooms below grade where the window area shall be not less than one-fifth the floor area.

2. Single rooms shall contain at least 80 square feet and multi-bed rooms shall contain at least 70 square feet per bed.

3. Rooms shall have at least seven and one half foot ceiling height over the required area.

4. There shall be at least three feet between beds.

5. Rooms shall be arranged so as to permit the movement of a wheeled stretcher to the side of each bed.

6. There shall be sufficient and satisfactory storage space for clothing, toilet articles, and other personal belongings of patients.

K. Patient Room Furnishings

1. A hospital type bed with suitable mattress, pillow, and necessary

2. Coverings shall be provided for each patient.

3. There shall be a bedside stand or cabinet and chair for each patient.

4. Means for signaling nurses shall be provided within easy reach of each bed when appropriate.

5. A sufficient number of cubicle curtains or screens shall be available to assure privacy for patients when indicated.

6. A properly designed lamp, which can be operated by the patient, shall be provided at each bed when appropriate.

L. Supplies and Equipment for Patient Care

1. Each patient shall be provided with individual bedside utensils.

2. All supplies and equipment used in patient care shall be properly cleaned and in appropriate cases shall be sterilized between use for different patients.

3. Methods for cleaning, sanitizing, handling, and storing of all supplies and equipment shall be such as to prevent the transmission of infection through their use.

4. After discharge of a patient, the bed, mattress, cover, bedside furniture, and equipment shall be properly cleaned.

5. Mattresses, blankets, and pillows assigned to patients shall be in a sanitary condition. The mattress, blankets, and pillows used for a patient with an infection shall be sanitized in an acceptable manner before they are assigned to another patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6735. General Patient Care

A. Written orders signed by a member of the medical staff shall be required for all medications and treatments given to patients. Telephone orders for medication shall be initiated by the prescribing physician within 24 hours from the time they are given.

B. A recognized standard procedure for the administration of medications shall be established and carried out. This procedure shall be written and readily available to all personnel responsible for medications.

C. A standard isolation technique shall be established and practiced in caring for patients with known or suspected communicable diseases.

D. There shall be a reliable method for personal identification of each patient.

E. A recognized standard procedure, including proper labeling, for the handling and administration of blood shall be established to insure the safety of the patient. This procedure shall be written and readily available to all personnel responsible for the administration of blood.

F. There shall be provision for personnel to gain immediate access to patient rooms, toilets, showers, and bathrooms should any emergency occur to a patient in any one of these areas.

G. The hospital shall establish safety policies and procedures for the care of patients who because of their condition are not responsible for their acts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6737. Pediatric Department

A. Hospitals admitting children shall have proper facilities for their care apart from the obstetrical facilities.

B. Children under 14 year of age should not be placed in rooms with adult patients.

C. Children under 14 years of age should not be admitted as visitors to the pediatric department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6739. Obstetrical Department

A. Obstetrical patients should not be placed in rooms with other types of patients.

B. A number of beds at least equal to the average daily maternity census shall be in rooms reserved exclusively for obstetrical patients.

C. At least one toilet and lavatory basin shall be provided for the use of obstetrical patients.

D. The arrangement of the rooms and areas used for obstetrical patients shall be such as to minimize traffic of patients, visitors, and personnel from other departments and prevent traffic through the delivery room or rooms.

E. There shall be an isolation room provided with handwashing facilities for immediate segregation and isolation of a mother and/or baby with a known or suspected communicable disease.

F. When necessary for the same nurse to care for both obstetrical and other types of patients, strict handwashing and gown technique shall be employed in giving nursing care to the obstetrical patient or newborn infant.

G. Gowns worn in the nursery or delivery room shall not be worn outside either of such rooms and shall not be worn outside the obstetrical department.

H. Children under 14 years of age shall not be admitted as visitors to the obstetrical department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6741. Delivery and Post-Partum

A. There shall be satisfactory provision for patients in labor, either in the patient's private room used exclusively during labor for obstetrical patients or in a designated special labor room. A crib style bed or beds provided with side rails shall be available.

B. Additional labor bed or beds shall be provided as required by the patient load.

C. There shall be a special room properly equipped as a delivery room and used for obstetrical purposes.

D. There shall be hand scrub facilities, including a sink with foot, knee, or elbow faucet control, adjacent to or in the delivery room.

E. There shall be adequate provision for washing instruments, utensils, and equipment which are cleaned within the delivery suite.

F. A nurse shall be in attendance during labor and delivery of a patient.

G. A standard technique in postpartum nursing care shall be established and practiced at the discretion of the attending physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6743. Nursery

A. A properly equipped nursery shall be provided for the care of the newborn and shall not be used for any purpose.

B. A nursery room shall provide a minimum of 20 square feet per bassinet.

C. Bassinets should be spaced at least two feet apart unless there are six or less bassinets in a nursery room.

D. The nursery should have window area equal to at least one-eighth of the floor area and shall be provided with air conditioning to control temperature and air motion.

E. There shall be work and examining space of adequate area preferably in a separate room, adjacent to a nursery or pair of nurseries.

F. There shall be running hot and cold water in the work room and in the nursery with foot, knee, or elbow faucet control.

G. There shall be a glass observation window in the nursery area.

H. The nursery shall be maintained at a temperature of approximately 75 degrees F, and shall have a reliable thermometer mounted four feet from the floor.

I. Adequate facilities shall be provided for the care of premature infants.

J. Only such persons necessary to the care of the infant or the nursery unit shall be admitted to the nursery.

K. The nursing care of the newborn infant shall be under the supervision of a registered nurse.

L. Nurses and other personnel regularly assigned to the nursery shall wear short-sleeved scrub dresses or uniforms covered with a clean gown.

M. Anyone entering the nursery other than usual personnel shall wear cap, mask, and gown.

N. Strict handwashing technique shall be maintained by physicians and nurses.

O. Individual equipment shall be provided for each infant and individual technique shall be used in the care of each infant. Common bathing tables and common carriers for transporting babies to mothers shall not be used.

P. An infant who has symptoms of an infection shall be removed from the regular nursery and isolated without delay. Infants born outside the hospital shall be isolated upon admission. Infants of mothers who have an infectious disease shall be isolated.

Q. Strict isolation technique shall be observed in caring for any isolated infant.

R. Prophylactic treatment of the eyes of the newborn shall be carried out in accordance with the regulations of the Office of Preventive and Public Health Services.

S. Newborn infants shall be identified in the delivery room. The method of identification shall be such as to positively identify an infant with its mother.

T. Formula

1. There shall be a suitable, designated area for the preparation of milk mixtures. This area shall be equipped with sink, handwashing facilities, and storage space.

2. The sink shall be equipped with foot, knee, or elbow faucet control.

3. Formula for the milk mixtures for newborns shall be ordered and signed by the physician.

4. Formula and other fluids for infants requiring heat sterilization shall be prepared by terminal heat method. This is a process by which the completely assembled formula units (bottles filled with formula, with nipples applied and covered with nipple protectors) are exposed to heat treatment sufficient to make them bacteriologically safe.

5. The individually bottled formula, if requiring refrigeration, shall be stored in a refrigerator at a temperature of 40 degrees to 45 degrees F. Nothing else should be stored in the refrigerator which might be a possible source of contamination to the formula.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6745. Psychiatric Unit

A. The layout, design of details, equipment, and furnishings of a psychiatric unit shall be such that patients may be under close observation and will not be afforded opportunities for hiding, escape, or injury to self or others.

B. Separate toilet rooms shall be provided for men and women.

C. Adequate space suitably equipped shall be provided for a day room, a dining area, and occupational therapy. If large enough and properly arranged, one area may serve for more than one of these purposes.

D. A treatment room shall be provided within the unit.

E. Adequate provision shall be made for interviews with patients and their families in privacy.

F. There should be suitable outdoor space for patient recreation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6747. Surgery Suite

A. There shall be an operating room (or rooms) properly equipped and of adequate size to accommodate the equipment and personnel required and allow for aseptic technique.

B. The surgical suite shall be located in a segregated area out of the line of traffic of visitors and personnel from other departments.

C. The arrangement of the rooms and areas within the surgical suite shall be such as to prevent traffic through the operating room or rooms.

D. Adequate scrub-up facilities providing hot and cold running water and equipped with knee, foot, or elbow faucet control shall be provided.

E. There shall be adequate provision for washing instruments and equipment, which are to be cleaned within the surgery suite.

F. The surgery suite shall be under the supervision of a registered nurse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6749. Sterilizing and Supply Service

A. The hospital shall make adequate provisions within it for proper sterilization of supplies, equipment, utensils, and solutions.

B. Sterilizers and autoclaves of the proper type and necessary capacity for adequate sterilization shall be provided and maintained in a satisfactory condition.

C. Standard procedures for the sterilization of the various types of supplies, equipment, utensils, and solutions shall be established and carried out. These procedures shall be written and readily available to all personnel responsible for sterilization procedures.

D. The hospital shall adopt a recognized method of checking sterilizer performance. The function of the autoclaves/sterilizers shall be checked with viable spores at least monthly.

E. Clean and sterilized supplies and equipment shall be kept separate from soiled and contaminated supplies and equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6751. Diagnostic and Treatment Facilities

A. Emergency and Outpatient Services

1. The hospital shall provide space, facilities, and personnel for medical and dental emergency care and treatment including the administration of blood or blood plasma and parenteral solutions, suction, control of bleeding, the emergency reduction, and splinting of all types of fractures, and for the administration of oxygen.

2. If the hospital has an organized unit as an outpatient department or clinic, adequate waiting area, examining, and treatment rooms, toilets, and special rooms necessary for the services to be rendered shall be provided.

B. Laboratory

1. Laboratory services shall be sufficient to provide for the needs of all patients. In-house laboratories shall be well-organized and properly supervised in qualified personnel. The laboratory will be of sufficient size and adequately equipped to perform the necessary services of the center. Provisions shall be made for a preventive maintenance and an acceptable quality control program covering all types of analyses performed by the laboratory. Documentation will be maintained. Written policies and procedures shall be developed and approved for all services provided by the laboratory. The blood storage refrigerator shall be equipped with a recordings thermometer, alarm system and on emergency power. The alarm system must be monitored visually and audibly 24 hours a day.

2. The hospital shall make satisfactory provision for the typing and cross matching of blood for transfusions.

3. Bacteriological cultures that are contaminated shall be disposed of in a safe manner and in accordance with the requirements of the Office of Preventive and Public Health Services for the disposal of contaminated materials.

4. The hospital shall make adequate provision for the proper handling and storage of tissue specimens by a pathologist.

C. Pharmacy. The hospital shall provide for the proper handling and storage of drugs.

D. Oxygen

1. Oxygen gauges and manometers shall be tested for accuracy periodically and be conspicuously labeled "OXYGEN, USE NO OIL."

2. Oxygen shall not be used in rooms where there are gas burners, gas stoves, or gas heaters in operation.

3. No Smoking signs shall be posted where oxygen is being administered.

4. Oxygen tent canopies shall be fabricated of slow burning or noncombustible material.

5. Electric equipment used in connection with oxygen tents shall be properly designed for use with oxygen.

E. X-ray

1. Adequate radiologic services shall be provided.

2. Rooms in which fixed radiographic equipment is used shall have adequate shielding to protect personnel and patients. Equipment shall be properly maintained and registered with the Office of Preventive and Public Health Services. The use of fluoroscopy shall be limited to physicians.

F. Other Departments. If the hospital operates other departments, such as physical medicine (including physical therapy and occupational therapy), or a dental department, adequate space and facilities shall be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6753. Medical Records

A. Medical Record System. Each hospital shall have an organized medical record system.

B. Facilities. The medical records room or area shall be conveniently located, sufficiently large, and adequately equipped to permit the proper handling of hospital medical records.

C. Medical Records. An accurate and complete medical record shall be written for each patient and filed in an accessible manner in the hospital.

D. Patient's Basic Medical Records. The following minimum data shall be kept on all patients:

1. identifying and sociological data;

2. dates of admission and discharge;

3. medical history;

4. physical examination and findings;.

5. medical orders;

6. progress notes;

7. summary report of patient's course in the hospital and condition on discharge;

8. record of all medical care of treatments;

9. reports of diagnostic procedures such as laboratory and X-ray;

10. nurse's record of care given to patients;

11. the above data may be kept on separate or combined record forms;

12. items 3 through 8 shall be written, dictated, or prepared by or under the supervision of the attending physician and the face sheet of the complete chart shall be signed by him;

13. the following additional data shall be kept when indicated:

a. consultation notes, signed by the consultant;

b. authorization, consent, or release forms;

c. operative record;

d. anesthesia report;

e. pathological reports;

f. obstetrical records;

g. record of mother's labor, delivery, and postpartum period;

h. separate infant record:

i. date and time of birth;

ii. condition at birth;

iii. sex;

iv. weight at birth if condition permits weighing;

v. condition of infant at time of discharge.

E. Other Records and Reports. The following indexes, registers, and records are required. These may be separate or combined:

1. patients' register;

2. birth register;

3. delivery room register;

4. operating room register;

5. death register;

6. analysis of hospital service, based on patient statistics;

7. daily census report of admissions, births, discharges, and deaths.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6755. Denial, Suspension, or Revocation of License Appeals

A. Denial, Suspension, or Revocation of License. The director may deny, suspend, or revoke a license when he finds that there has been a substantial failure by the applicant or licensee to comply with requirements of R.S. 40:2101 through 2109 or the rules, regulations, and minimum standards adopted by the council with approval of the board; provided in all such cases the director shall furnish the applicant or licensee thirty (30) calendar days written notice specifying reasons for the action.

B. Conditions Under Which Appeal May be Taken. Any applicant or licensee who feel aggrieved by the action of the director in denying, suspending, or revoking a license shall have the right, within 30 calendar days from the date the notice required in Section A above is received by him, to appeal suspensively from the action of the director by filing in the office of the director within such 30-day period a written request addressed to the director asking for a hearing by the Appeals Board specified in R.S. 40:2110 B, which 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 director.

C. If a license is denied or revoked, the applicant has the right to appeal as specified within the law. The appeal procedure is subject to modifications according to the Administrative Procedure Act LSR 49:951-968.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2113.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

Chapter 68. Adult Residential Care Providers

Subchapter A. General Provisions

§6801. Introduction

A. These rules and regulations contain the minimum licensure standards for adult residential care providers (ARCPs), pursuant to R.S. 40:2166.1-2166.8, and shall become effective on August 15, 2015.

B. An adult residential care provider (ARCP) serves individuals in a congregate setting and is operational 24 hours per day, seven days per week, with a coordinated array of supportive personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities and health-related services that are designed to:

1. allow the individual to reside in the least restrictive setting of his/her choice;

2. accommodate the individual resident's changing needs and preferences;

3. maximize the resident's dignity, autonomy, privacy and independence; and

4. encourage family and community involvement.

C. An ARCP shall have at least one published business telephone number.

D. Adult residential care services include, at a minimum, assistance with activities of daily living, assistance with instrumental activities of daily living, lodging, and meals.

E. The Department of Health and Hospitals (DHH) does not require, and will not issue ARCP licenses for the provision of lodging and meals only or homeless shelters.

1. For the purposes of this Rule, *homeless shelters* shall be defined as entities that provide only temporary or emergency shelter to individuals who would otherwise be homeless and may provide services to alleviate homelessness.

F. There are four levels of adult residential care. The levels differ in the services they are licensed to offer and the physical environment requirements.

G. All levels of ARCPs shall comply with all regulations in this Chapter unless the language of the regulations pertains to a specific level.

H. All currently licensed adult residential care facilities shall be required to apply for an ARCP license at the time of renewal of their current license.

1. Upon approval of the application for renewal of licensure, an existing adult residential care (ARC) provider shall receive a new ARCP license with its level of service, pursuant to R.S. 40:2166.5 (Example: ARCP level 1-personal care homes; ARCP level 2-shelter care homes; ARCP level 3-assisted living facilities; ARCP level 4-adult residential care provider.)

2. An existing ARC provider shall be required to submit to the department a written attestation which certifies that the ARC provider is, and/or shall be in compliance with these provisions by August 15, 2015.

3. If an existing ARC provider is electing to begin providing medication administration after August 15, 2015, the ARC provider shall be required to submit to the department a written attestation which certifies that the licensing requirements to provide such services have been met.

4. Failure of an existing ARC provider to submit the required attestation(s) shall be grounds for either denial of license or revocation of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1086 (June 2015).

§6803. Definitions and Abbreviations

Abuse—the infliction of physical or mental injury or the causing of the deterioration of a resident by means including, but not limited to:

1. sexual abuse;

2. exploitation; or

3. extortion of funds or other things of value.

Activities of Daily Living—ambulating, transferring, grooming, bathing, dressing, eating, toileting, and for the purposes of this Rule, taking medication.

Adult—a person who has attained 18 years of age.

Adult Residential Care Provider—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group which provides adult residential care for compensation to two or more adults who are unrelated to the licensee or operator.

Alterations, *Additions*, or *Substantial Rehabilitation*—rehabilitation that involves structural changes in which hard costs are equal to or exceed the per unit cost for substantial rehabilitation as defined by the Louisiana Housing Finance Authority.

Change of Ownership (CHOW)—the sale or transfer of all or a portion of the assets or other equity interest in an ARCP. Examples of actions that constitute a change of ownership include:

1. unincorporated sole proprietorship. Transfer of title and property of another party constitutes change of ownership;

2. corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership. Admission of a new member to a nonprofit corporation is not a change of ownership;

3. limited liability company. The removal, addition or substitution of a member in a limited liability company does not constitute a change of ownership;

4. partnership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable state law, constitutes a change of ownership.

Chemical Restraint—a psychopharmacologic drug that is used for discipline or convenience and not required to directly treat medical symptoms or medical diagnoses. The use of chemical restraints is prohibited in ARCPs.

Common Area (Space)—the interior space(s) made available for the free and informal use by all residents or the guests of the ARCP. Common areas may include activity rooms, libraries, and other areas exclusive of resident's rooms and bathrooms. Corridors, passageways, kitchens and laundry areas are not included as common areas.

Controlled Dangerous Substance (CDS)—a drug, substance, or immediate precursor in schedule I through V of R.S. 40:964.

DAL—Division of Administrative Law or its successor.

Department—the Louisiana Department of Health and Hospitals (DHH).

Direct Care Staff—unlicensed staff who provide personal care or other services and support to persons with disabilities, or to the elderly to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Director—the person who is in charge of the daily operation of the ARCP.

Facility Need Review (FNR)—a review conducted for level 4 ARCPs to determine whether there is a need for additional ARCP residential living units to be licensed.

Health Care Services—any service provided to a resident by an ARCP or third-party provider that is required to be provided or delegated by a licensed, registered or certified health care professional. Any other service, whether or not ordered by a physician, that is not required to be provided by a licensed, registered or certified health care professional shall not be considered a health care service.

HSS—he Department of Health and Hospitals, Office of the Secretary, Office of Management and Finance, Health Standards Section.

Incident—any occurrence, situation or circumstance affecting the health, safety or well-being of a resident or residents.

Intermittent Nursing Services—services that are provided episodically or for a limited period of time by licensed nursing staff. Intermittent nursing services may be provided by level 4 ARCPs only.

Instrumental Activities of Daily Living—the functions or tasks that are not necessary for fundamental functioning but assist an individual to be able to live in a community setting. These include activities such as:

1. light house-keeping;
2. food preparation and storage;
3. grocery shopping;
4. laundry;
5. scheduling medical appointments;
6. financial management;
7. arranging transportation to medical appointments; and
8. accompanying the client to medical appointments.

Level 1 ARCP—an ARCP that provides adult residential care for compensation to two or more residents but no more than eight who are unrelated to the licensee or operator in a setting that is designed similarly to a single-family dwelling.

Level 2 ARCP—an ARCP that provides adult residential care for compensation to nine or more residents but no more than 16 who are unrelated to the licensee or operator in a congregate setting that does not provide independent apartments equipped with kitchenettes, whether functional or rendered nonfunctional for reasons of safety.

Level 3 ARCP—an ARCP that provides adult residential care for compensation to 17 or more residents who are unrelated to the licensee or operator in independent apartments equipped with kitchenettes, whether functional or rendered nonfunctional for reasons of safety.

Level 4 ARCP—an ARCP that provides adult residential care including intermittent nursing services for compensation to 17 or more residents who are unrelated to the licensee or operator in independent apartments equipped with kitchenettes, whether functional or rendered nonfunctional for reasons of safety.

Licensed Practical Nurse (LPN)—an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana.

May—indicates permissible practices or services.

Neglect—the failure to provide the proper or necessary medical care, nutrition, or other care necessary for a resident's well-being.

NFPA—National Fire Protection Association.

Nursing Director—a registered nurse licensed by the state of Louisiana who directs or coordinates nursing services in the ARCP.

OPH—Office of Public Health.

OSFM—Office of the State Fire Marshal.

Person-Centered Service Plan (PCSP)—a written description of the functional capabilities of a resident, the resident's need for personal assistance and the services to be provided to meet the resident's needs.

Personal Assistance—services that directly assist a resident with certain activities of daily living and instrumental activities of daily living.

Physical Restraint—any manual method, physical or mechanical device, material, or equipment attached to or adjacent to a resident's body that the individual cannot easily remove which restricts freedom of movement or normal

access to the body and is not used as an assistive device. The use of physical restraints is prohibited in ARCPs.

PRN—commonly used in medicine to mean as needed or as the situation arises.

Registered Nurse (RN)—an individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Resident Apartment—a separate unit configured to permit residents to carry out, with or without assistance, all the functions necessary for independent living, including:

1. sleeping;
2. sitting;
3. dressing;
4. personal hygiene;
5. storing, preparing, serving and eating food;
6. storing clothing and other personal possessions;
7. handling personal correspondence and paperwork; and
8. entertaining visitors.

Resident's Representative—a person who has been authorized by the resident in writing to act upon the resident's direction regarding matters concerning the resident's health or welfare, including having access to personal records contained in the resident's file and receiving information and notices about the overall care, condition and services for the resident. No member of the governing body, administration or staff or an ARCP or any member of their family shall serve as the resident's representative unless they are related to the resident by blood or marriage.

Shall—indicates mandatory requirements.

Specialized Dementia Care Program—as defined in R.S. 40:1101.2, a special program or unit that segregates residents with a diagnosis of probable Alzheimer's disease or a related disorder so as to prevent or limit access by a resident to areas outside the designated or separated area; and that advertises, markets, or otherwise promotes the ARCP as providing specialized Alzheimer's/dementia care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2166.1-2166.8 and R.S. 40:1101.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1086 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1976 (October 2017).

§6805. Licensure Requirements

A. All ARCPs shall be licensed by the Department of Health and Hospitals. The department is the only licensing authority for ARCPs in the state of Louisiana. It shall be unlawful to operate an ARCP without possessing a current, valid license issued by the department. The license shall:

1. be issued only to the person or entity named in the license application;
2. be valid only for the ARCP to which it is issued and only for the specific geographic address of that ARCP;
3. be valid for one year from the date of issuance, unless revoked, suspended, modified, or terminated prior to that date, or unless a provisional license is issued;
4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the ARCP;
5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary; and
6. be posted in a conspicuous place on the licensed premises at all times.

B. In order for the ARCP to be considered operational and retain licensed status, the ARCP shall meet the following conditions.

1. The ARCP shall always have at least one employee awake and on duty at the business location 24 hours per day, seven days per week.
2. There shall be staff employed, sufficient in number with appropriate training, available to be assigned to provide care and services according to each resident's PCSP.
3. The ARCP shall have provided services that included lodging, meals and activities of daily living to at least two residents unrelated to the licensee or operator within the preceding 12 months prior to their licensure renewal date.

C. The ARCP shall abide by and adhere to any state laws, rules, policies, procedures, manuals, or memorandums issued by the department pertaining to ARCPs.

D. A separately licensed ARCP shall not use a name which is substantially the same as the name of another ARCP licensed by the department.

E. The ARCP shall maintain insurance policies in force at all times with at least the minimum required coverage for general and professional liability and worker's compensation insurance at the levels specified in §6807. Failure to maintain compliance may constitute the basis for license revocation and/or sanction.

F. The ARCP shall market itself only as the level licensed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1088 (June 2015).

§6807. Initial Licensure Application Process

A. An initial application for licensing as an ARCP shall be obtained from the department. A completed initial license application packet for an ARCP shall be submitted to and approved by the department prior to an applicant providing

ARCP services. An applicant shall submit a completed initial licensing packet to the department, which shall include:

1. a completed ARCP license application and the appropriate non-refundable licensing fee as established by statute;

2. a copy of the on-site inspection report with approval for occupancy by the OSFM;

3. a copy of the health inspection report from the OPH;

4. a copy of criminal background checks on all owners;

5. proof of financial viability which entails:

a. verification of sufficient assets equal to $100,000 or the cost of three months of operation, whichever is less; or

b. a letter of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000 or the cost of three months of operation, whichever is less;

6. proof of general and professional liability insurance of at least $300,000;

7. proof of worker's compensation insurance;

8. if applicable, a clinical laboratory improvement amendments (CLIA) certificate or a CLIA certificate of waiver;

9. a completed disclosure of ownership and control information form;

10. a floor sketch or drawing of the premises to be licensed;

11. the days and hours of operation;

12. a facility need review approval for a level 4 ARCP;

13. a copy of the letter approving architectural plans from the OSFM;

14. the organizational chart of the ARCP; and

15. any documentation or information required by the department for licensure.

B. If the initial licensing packet is incomplete, the applicant will be notified of the missing information and shall have 90 days to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ARCP must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application packet has been approved by the department, the ARCP applicant shall notify the department of readiness for an initial licensing survey within 90 days. If an applicant fails to notify the department of readiness for an initial licensing survey within 90 days of approval, the initial licensing application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ARCP must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process subject to any facility need review requirements.

D. Applicants must be in compliance with all appropriate federal, state, departmental, or local statutes, laws, ordinances, rules, regulations and fees before the department will issue the ARCP an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1088 (June 2015).

§6809. Initial Licensing Surveys

A. Prior to the initial license being issued to the ARCP, an initial licensing survey shall be conducted on-site at the ARCP to assure compliance with ARCP licensing standards. No resident shall be provided services by the ARCP until the initial licensing survey has been performed, the ARCP has been found in compliance and the initial license has been issued to the ARCP by the department.

B. In the event that the initial licensing survey finds that the ARCP is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

C. In the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety, or welfare of the residents, the department shall deny the initial license.

D. In the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations, any required statutes, laws, ordinances, rules or regulations, but the department, in its sole discretion, determines that the noncompliance does not present a threat to the health, safety, or welfare of the residents, the department may issue a provisional initial license for a period not to exceed six months.

1. The provider shall submit an acceptable plan of correction to DHH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

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

3. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or if new deficiencies are cited on the follow-up survey, the provisional license shall expire and the provider shall be required to begin the initial

licensing process again by submitting a new initial license application packet, fee and any required facility need review approval.

E. When issued, the initial ARCP license shall specify the maximum number of apartments and/or resident capacity for which the ARCP is licensed.

F. The initial licensing survey of an ARCP shall be an announced survey. Follow-up surveys to the initial licensing surveys are unannounced.

G. Once an ARCP has been issued an initial license, the department shall conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

1. A plan of correction may be required from an ARCP for any survey where deficiencies have been cited. Such plan of correction shall be approved by the department.

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

H. The department may issue appropriate sanctions, including, but not limited to:

1. civil fine;

2. directed plans of correction;

3. denial of license renewal;

4. provisional licensure;

5. license revocation; and/or

6. any sanctions allowed under state law or regulation.

I. The department's surveyors and staff shall be given access to all areas of the ARCP and all relevant files during any licensing or other survey or investigation, and shall be allowed to interview any provider staff or residents as necessary to conduct the on-site investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1089 (June 2015).

§6811. Types of Licenses and Expiration Dates

A. The department shall have the authority to issue the following types of licenses.

1. Full License. In the event that the initial licensing survey finds that the ARCP is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. In the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, the department is authorized to issue a provisional initial license pursuant to the requirements and provisions of these regulations.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed ARCP who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional License

a. The department, in its sole discretion, may issue a provisional license to an existing licensed ARCP for a period not to exceed six months, for any of the following reasons, including but not limited to:

i. the existing ARCP has more than five deficient practices or deficiencies cited during any one survey;

ii. the existing ARCP has more than three validated complaints in one licensed year period;

iii. the existing ARCP has been issued a deficiency that involved placing a participant at risk for serious harm or death;

iv. the existing ARCP has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

v. the existing ARCP is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

b. When the department issues a provisional license to an existing licensed ARCP, the department shall conduct a follow-up survey of the ARCP prior to the expiration of the provisional license.

i. If that follow-up survey determines that the ARCP has corrected the deficient practices and has maintained compliance during the period of the provisional license, then the department may issue a full license for the remainder of the year until the anniversary date of the ARCP license.

ii. If that follow-up survey determines that the ARCP has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet, fee and any required facility need approval.

B. If an existing licensed ARCP has been issued a notice of license revocation, suspension, or termination, and the provider's license is due for annual renewal, the department shall deny the license renewal application.

1. If a timely administrative appeal has been filed by the provider regarding the license revocation, suspension, or termination, the administrative appeal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the Division of Administrative Law (DAL) or department issues a decision on the license revocation, suspension, or termination.

2. If the secretary of the department determines that the violations of the ARCP pose an imminent or immediate threat to the health, welfare, or safety of a participant, the imposition of such action may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the ARCP will be notified in writing.

3. The denial of the license renewal application does not affect in any manner the license revocation, suspension, or termination.

C. The renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1089 (June 2015).

§6813. Changes in Licensee Information or Personnel

A. Any change regarding the ARCP's entity name, doing business as name, geographical address, mailing address, telephone number, or any combination thereof, shall be reported in writing to the department five business days prior to the change.

B. Any change regarding the ARCP's key administrative personnel shall be reported in writing to the department within 10 business days of the change.

1. Key administrative personnel include the:

a. director;

b. assistant director; and

c. nursing director.

2. The ARCP's notice to the department shall include the individual's:

a. name;

b. address;

c. telephone;

d. facsimile (fax) number;

e. e-mail address;

f. hire date; and

g. qualifications.

C. A change of ownership (CHOW) of the ARCP shall be reported in writing to the department within five business days of the CHOW. The license of an ARCP is not transferable or assignable; the license of an ARCP cannot be sold. The new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Level 4 ARCPs shall also submit a facility need review application for approval. Once all application requirements have been completed and approved by the department, a new license shall be issued to the new owner.

D. If the ARCP changes its name without a CHOW, the ARCP shall report such change to the department in writing within five business days prior to the change. The notification of the name change shall include an updated license application and the required fee for such change.

E. Any request for a duplicate license shall be accompanied by the appropriate designated fee.

F. An ARCP that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1090 (June 2015).

§6815. Renewal of License

A. License Renewal Application. The ARCP shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. the days and hours of operation;

3. a current fire marshal inspection report;

4. a current OPH inspection report;

5. the non-refundable license renewal fee;

6. proof of financial viability to include:

a. verification and maintenance of a letter of credit issued from a federally insured, licensed lending institution in the amount of at least $100,000 or the cost of three months of operation, whichever is less; or

b. affidavit of verification of sufficient assets equal to $100,000 or the cost of three months of operation, whichever is less;

7. general and professional liability insurance of at least $300,000;

8. proof of worker's compensation insurance; and

9. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit to the department a completed license renewal application packet prior to the expiration of

the current license will be considered a voluntary non-renewal of the license and the license shall expire on its face.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1091 (June 2015).

§6817. Denial of License, Revocation of License, Denial of License Renewal, Operation without License, Penalty

A. The department may deny an application for a license, deny a license renewal or revoke a license in accordance with the provisions of the Administrative Procedure Act.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations that present a potential threat to the health, safety, or welfare of the residents.

2. The department shall deny an initial license in the event that the initial licensing survey finds that the ARCP is noncompliant with any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety, or welfare of the residents.

3. The department shall deny an initial license for any of the reasons stated in §6817.D for which a license may be revoked or a license renewal may be denied.

C. Voluntary Non-Renewal of a License. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily non-renewed or voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary cessation of business.

D. Revocation of License or Denial of License Renewal. An ARCP license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the ARCP licensing laws, rules and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules, or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. failure to uphold resident rights whereby deficient practices may result in harm, injury, or death of a resident;

5. failure to protect a resident from a harmful act of an employee or other resident including, but not limited to:

a. abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a resident's health and safety;

c. coercion;

d. threat or intimidation; or

e. harassment;

6. failure to notify the proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof;

7. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, resident records, or provider records;

d. matters under investigation by the department, Office of the Attorney General, or any law enforcement agency; or

e. information submitted for reimbursement from any payment source;

8. knowingly making a false statement or providing false, forged, or altered information or documentation to the department's employees or to law enforcement agencies;

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

10. fraudulent operation of an ARCP by the owner, director, officer, member, manager, or other key personnel as defined by §6813;

11. an owner, officer, member, manager, director or person designated to manage or supervise resident care who has been convicted of, or has entered a plea of guilty or nolo contendere (no contest) to, or has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court:

a. for purposes of this Paragraph, conviction of a felony means a felony relating to the violence, abuse, or negligence of a person, or a felony relating to the misappropriation of property belonging to another person;

12. failure to comply with all reporting requirements in a timely manner as required by the department;

13. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview provider staff or residents;

14. failure to allow or refusal to allow access to authorized departmental personnel to records; or

15. bribery, harassment, or intimidation of any resident designed to cause that resident to use the services of any particular ARCP.

E. In the event an ARCP license is revoked or renewal is denied, any owner, officer, member, manager, or director of such ARCP is prohibited from owning, managing, directing or operating another ARCP for a period of two years from the date of the final disposition of the revocation or denial action.

F. Operation Without License and Penalty

1. An adult residential care provider shall not operate without a license issued by the department. Any such provider operating without a license shall be guilty of a misdemeanor and upon conviction shall be fined not more than $100 for each day of operation without a license up to a maximum of $1,000 or imprisonment of not more than six months, or both. It shall be the responsibility of the department to inform the appropriate district attorney of the alleged violation to assure enforcement.

2. If an adult residential care provider is operating without a license issued by the department, the department shall have the authority to issue an immediate cease and desist order to that provider. Any such provider receiving such a cease and desist order from the department shall immediately cease operations until such time as that provider is issued a license by the department.

3. The department shall seek an injunction in the Nineteenth Judicial District Court against any provider who receives a cease and desist order from the department under Subsection B of this Section and who does not cease operations immediately. Any such provider against whom an injunction is granted shall be liable to the department for attorney fees, costs, and damages.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1091 (June 2015).

§6819. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal

A. Notice of a license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The ARCP has a right to an administrative reconsideration of the license denial, license revocation, or denial of license renewal. There is no right to an administrative reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The ARCP shall request the administrative reconsideration within 15 days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for administrative reconsideration shall be in writing and received by the department within 15 calendar days of the provider's receipt of the notice letter from the department.

2. The request for administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received by the Health Standards Section (HSS), an administrative reconsideration shall be scheduled and the provider will receive written notification.

4. The provider shall have the right to appear in person at the administrative reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the license denial, license revocation or denial of license renewal shall not be a basis for reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the administrative reconsideration.

C. The ARCP has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The ARCP shall request the administrative appeal within 30 days of the receipt of the results of the administrative reconsideration. The ARCP may forego its rights to an administrative reconsideration, and if so, the ARCP shall request an administrative appeal within 30 days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law (DAL) or its successor.

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL or its successor, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the DAL or its successor issues a final administrative decision.

4. If the secretary of the department determines that the violations of the ARCP pose an imminent or immediate threat to the health, welfare, or safety of a resident, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the ARCP will be notified in writing.

5. Correction of a violation or a deficiency which is the basis for the license denial, license revocation, or denial of license renewal, shall not be a basis for the administrative appeal.

D. If an existing licensed ARCP has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal application.

1. The denial of the license renewal application does not affect in any manner the license revocation.

2. If the final decision by DAL or its successor is to reverse the license denial, the denial of license renewal, or the license revocation, the provider's license will be re-

instated or granted upon the payment of any licensing or other fees due to the department.

E. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new ARCP. An existing provider who has been issued a provisional license remains licensed and operational and also has no right to an administrative reconsideration or an administrative appeal. The issuance of a provisional license to an existing ARCP is not considered to be a denial of license, a denial of license renewal, or a license revocation.

1. A follow-up survey may be conducted prior to the expiration of a provisional initial license to a new ARCP or the expiration of a provisional license to an existing provider.

2. A new provider that is issued a provisional initial license or an existing provider that is issued a provisional license shall be required to correct all noncompliance or deficiencies at the time the follow-up survey is conducted.

3. If all noncompliance or deficiencies have not been corrected at the time of the follow-up survey, or if new deficiencies that are a threat to the health, safety, or welfare of residents are cited on the follow-up survey, the provisional initial license or provisional license shall expire on its face and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

4. The department shall issue written notice to the provider of the results of the follow-up survey.

5. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an administrative reconsideration and the right to an administrative appeal of the deficiencies cited at the follow-up survey.

a. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the administrative reconsideration or for the administrative appeal.

b. The administrative reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

c. The provider must request the administrative reconsideration of the deficiencies in writing, which shall be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for an administrative reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

d. The provider must request the administrative appeal within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request for an administrative appeal must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

e. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this section must cease providing services unless the DAL or its successor issues a stay of the expiration. The stay may be granted by the DAL or its successor upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing, and only upon a showing that there is no potential harm to the residents being served by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1092 (June 2015).

§6821. Complaint Investigations

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

B. Complaint investigations shall be unannounced.

C. Upon request by the department, an acceptable plan of correction must be submitted to the department for any complaint investigation where deficiencies have been cited.

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

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

F. The department's surveyors and staff shall be given access to all areas of the ARCP and all relevant files during any complaint investigation. The department's surveyors and staff shall be allowed to interview any provider staff or resident as necessary or required to conduct the investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1093 (June 2015).

§6823. Statement of Deficiencies

A. Any statement of deficiencies issued by the department to the ARCP must be posted in a readily accessible place on the licensed premises.

B. Any statement of deficiencies issued by the department to an ARCP must be available for disclosure to the public 30 days after the provider receives the statement of deficiencies or after the receipt of an acceptable plan of correction, whichever occurs first.

C. Unless otherwise provided in statute or in this licensing rule, a provider shall have the right to an administrative reconsideration of any deficiencies cited as a result of a survey or investigation.

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

2. The administrative reconsideration of the deficiencies shall be requested in writing and received by the department within 10 calendar days of receipt of the statement of deficiencies.

3. The request for an administrative reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

4. The request for administrative reconsideration of the deficiencies must be made to the department's Health Standard Section.

5. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided for license denials, license revocations and denials of license renewals, the decision of the administrative reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

6. The provider shall be notified in writing of the results of the administrative reconsideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1093 (June 2015).

§6825. Cessation of Business

A. Except as provided in §6881 of these licensing regulations, a license shall be immediately null and void if an ARCP ceases to operate.

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

C. Upon the cessation of business, the provider shall immediately return the original license to the Department.

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

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

1. give 30 days' advance written notice to:

a. HSS;

b. each resident's physician; and

c. each resident or resident's legal representative, if applicable; and

2. provide for an orderly discharge and transition of all of the residents in the ARCP.

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

1. the effective date of the voluntary closure;

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

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

a. access to records and copies of records to the resident or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

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

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

H. Once the ARCP has ceased doing business, the ARCP shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1094 (June 2015).

Subchapter B. Administration and Organization

§6827. Governing Body

A. Each ARCP shall have an identifiable governing body with responsibility for, and authority over, the policies and activities of the ARCP and ultimate authority for:

1. the overall operation of the ARCP;

2. the adequacy and quality of care;

3. the financial solvency of the ARCP and the appropriate use of its funds;

4. the implementation of the standards set forth in these regulations; and

5. the adoption, implementation and maintenance, in accordance with the requirement of state and federal laws and regulations and these licensing standards, of adult

residential care and administrative policies governing the operation of the ARCP.

B. The ARCP shall have documents identifying the following information regarding the governing body:

1. names and addresses of all members;

2. terms of membership;

3. officers of the governing body; and

4. terms of office of any officers.

C. The governing body shall be composed of one or more persons. When the governing body is composed of only one person, this person shall assume all of the responsibilities of the governing body.

D. When the governing body is composed of two or more persons, the governing body shall hold formal meetings at least twice a year. There shall be written minutes of all formal meetings and bylaws specifying frequency of meetings and quorum requirements.

E. Responsibilities of a Governing Body. The governing body of an ARCP shall:

1. ensure the ARCP's compliance and conformity with the provider's charter or other organizational documents;

2. ensure the ARCP's continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;

3. ensure that the ARCP is adequately funded and fiscally sound;

4. review and approve the ARCP's annual budget;

5. designate a person to act as director and delegate sufficient authority to this person to manage the ARCP;

6. formulate and annually review, in consultation with the director, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

7. annually evaluate the director's performance;

8. have the authority to dismiss the director; and

9. meet with designated representatives of the department whenever required to do so.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1094 (June 2015).

§6829. Policy and Procedures

A. The ARCP shall have written policies and procedures approved by the governing body that, at a minimum, address the following:

1. confidentiality and security of files;

2. publicity and marketing;

3. personnel;

4. resident's rights;

5. grievance procedures;

6. resident's funds;

7. emergency preparedness planning procedures to include plans for evacuation and sheltering in place;

8. abuse and neglect;

9. incidents and accidents;

10. pre-residency screening and residency criteria and limitations;

11. medication management;

12. nursing services;

13. smoking;

14. pet policy;

15. resident responsibilities;

16. record-keeping;

17. infection control; and

18. any other area required in accordance with memorandums issued by the department's Health Standards Section.

B. Personnel Policies. An ARCP shall have written personnel policies that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members;

2. written job descriptions for each staff position;

3. policies which provide for staff, upon offer of employment, to have a health assessment as defined by the provider and in accordance with state *Sanitary Code*;

4. an employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment whether that abuse or mistreatment is done by another staff member, a family member, a resident or any other person;

6. a policy to prevent discrimination;

7. a policy that addresses the prohibitive use of social media;

8. a policy for conducting statewide criminal background history checks; and

9. a policy for checking the Direct Service Worker Registry and documentation of such checks.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1095 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1976 (October 2017).

Subchapter C. Residency Criteria, Person-Centered Service Plans, and Residency Agreements

§6833. Pre-Residency and Continued Residency

A. Information to prospective residents. The ARCP shall provide to prospective residents written information regarding conditions for residency, services, costs, fees and policies/procedures. This written information shall include, but is not limited to the following:

1. the application process and the possible reasons for rejection of an application;

2. types of residents suitable to the ARCP;

3. services offered and allowed in the ARCP;

4. resident's responsibilities;

5. policy regarding smoking;

6. policy regarding pets;

7. fee structure, including but not limited to any additional costs for providing services to residents during natural disasters (e.g. tropical storms, hurricanes, floods, etc.):

a. the ARCP shall develop and provide a formula with cost parameters for any additional charges incurred due to disasters; and

8. criteria for termination of residency agreement.

B. The ARCP shall complete and maintain a pre-residency screening of the prospective resident to assess the applicant's needs and appropriateness for residency.

1. The pre-residency screening shall include:

a. the resident's physical and mental status;

b. the resident's need for personal assistance;

c. the resident's need for assistance with activities of daily living and instrumental activities of daily living; and

d. the resident's ability to evacuate the ARCP in the event of an emergency.

2. The pre-residency screening shall be completed and dated before the residency agreement is signed.

C. Prohibited Health Conditions. There are individuals who are not eligible for residency in ARCPs because their conditions and care needs are beyond the scope of the ARCP's capacity to deliver services and ensure residents' health, safety, and welfare. ARCPs may not enter into agreements with residents with such conditions. These prohibited health conditions include:

1. stage 3 or stage 4 pressure ulcers;

2. nasogastric tubes;

3. ventilator dependency;

4. dependency on BiPap, CPAP or other positive airway pressure device without the ability to self-administer at all times:

a. exception. The resident may remain in the ARCP when a third party is available at all times to administer the positive airway pressure device during the hours of use;

5. coma;

6. continuous IV/TPN therapy (TPN—total parental nutrition, intravenous form of complete nutritional sustenance);

7. wound vac therapy (a system that uses controlled negative pressure, vacuum therapy, to help promote wound healing);

8. active communicable tuberculosis; and

9. any condition requiring chemical or physical restraints.

D. ARCP residents with a prohibited condition may remain in residence on a time limited basis provided that the conditions listed below are met. Time limited is defined as 90 days.

1. The resident, the resident's representative, if applicable, the resident's physician and the provider shall agree that the resident's continued residency is appropriate.

2. The resident's physician has certified that the condition is time limited and not permanent.

3. The ARCP is prepared to coordinate with providers who may enter the ARCP to meet time limited needs. Level 4 ARCPs may deliver or contract for the additional services to meet time limited needs pursuant to this Section.

4. In accordance with the terms of the residency agreement, the resident or the resident's representative, if applicable, shall provide for or contract with a third party provider for the delivery of services necessary to meet the residents' increased health and service needs which are beyond the scope of the services of the ARCP.

a. It is the responsibility of the ARCP to assure that needed services are provided, even if those services are provided by the resident's family or by a third party or contracted provider. A copy of such third party contract shall be verifiable, in writing, and retained in the resident's record. The ARCP retains responsibility for notifying the resident or the resident's representative, if applicable, if services are not delivered or if the resident's condition changes.

5. The ARCP or an affiliated business owned in full or in part by the owner or any member of the board of directors shall not be the third party providing the services.

6. The care provided, as allowed under this section, shall not interfere with ARCP operations or create a danger to others in the ARCP.

E. In level 4 ARCPs, residents whose health needs increase may continue to reside in the ARCP and receive

intermittent nursing services from the ARCP in accordance with the PCSP if the services are within the scope provided for in these regulations.

F. In accordance with the terms of the residency agreement, residents who are receiving hospice services may continue to reside in all levels of the ARCP as long as the resident's physician, the ARCP, the resident and/or resident's legal representative, if applicable, deem that the resident's needs can be met.

G. Residency Agreement. The ARCP shall complete and maintain individual residency agreements with all persons who move into the ARCP or with the resident's representative where appropriate.

1. The ARCP residency agreement shall specify the following:

a. clear and specific criteria for residency, continued residency and termination of residency agreements and procedures for termination of residency agreements;

b. basic services provided;

c. optional services;

d. payment provisions for both basic and optional services, including the following:

i. service packages and any additional charges for services;

ii. regular/ordinary and extra fees;

iii. payer source;

iv. due dates; and

v. deposits;

e. procedures for the modification of the residency agreement, including provision of at least 30 days prior written notice to the resident of any rate change;

f. requirements around notice before voluntarily terminating the residency agreement;

g. refund policy;

h. the delineation of responsibility among the following parties: the ARCP, the resident, the family, the resident's representative and/or others;

i. residents' rights; and

j. grievance procedures.

2. The ARCP shall allow review of the residency agreement by an attorney or other representative chosen by the resident.

3. The residency agreement shall be signed by the director, or designee, and by the resident or the resident's representative if applicable.

4. The residency agreement shall conform to all relevant federal, state and local laws and requirements.

5. The residency agreement shall provide a process for involuntary termination of the residency agreement that includes, at a minimum, the following:

a. written notice of any adverse action for violation(s) of the terms of the residency agreement that includes the following:

i. notice shall allow the resident a minimum of 30 calendar days from date of delivery of written notice to vacate the ARCP premises; however, the advance notice period may be shortened to 15 calendar days for nonpayment of a bill for a stay at the ARCP; and

ii. the notice shall allow a minimum of 10 calendar days for resident's corrective action.

6. The residency agreement shall include provisions for the opportunity for a formal appeal to the DAL for any involuntary termination of the residency agreement in accordance with §6837.B.2-4, including but not limited to, contact information for the DAL.

7. A request for appeal shall be made within 30 calendar days of receipt of the written notice and the hearing shall be conducted by the DAL in accordance with the Administrative Procedure Act.

H. When the resident moves in, the ARCP shall:

1. obtain from the resident or if appropriate, the resident's representative, the resident's plan for both routine and emergency medical care which shall include:

a. the name of physician(s); and

b. provisions and authorization for emergency medical care;

2. provide the resident with a copy of the ARCP's emergency and evacuation procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1095 (June 2015).

§6835. Person-Centered Service Plan

A. An assessment shall be initiated upon entry to the ARCP and completed within seven calendar days of the date that the resident moves into the ARCP to determine the service needs and preferences of the resident.

1. This assessment shall be kept in the resident's record.

2. If the resident's person-centered service plan includes staff administration of medication or intermittent nursing services, the assessment for those services shall be completed by a registered nurse.

B. Within 30 calendar days after the date the resident moves in, the ARCP designated staff in conjunction with the resident or the resident's representative, if applicable, shall develop a PCSP using information from the assessment. The PCSP shall include:

1. the services required to meet the resident's individual needs;

2. the scope, frequency, and duration of services;

3. monitoring that will be provided; and

4. who is responsible for providing the services, including contract or arranged services.

C. If the resident is enrolled in a home and community-based services waiver that includes ARCP as a service, a comprehensive plan of care prepared in accordance with policies and procedures established by Medicaid, or by a department program office, for reimbursement purposes may be substituted for the PCSP. If the resident needs services beyond those provided for in the comprehensive plan of care, the PCSP must be coordinated with the comprehensive plan of care.

D. A documented review of the PCSP shall be made at least every 90 calendar days and on an ongoing basis to determine its continued appropriateness and to identify when a resident's condition or preferences have changed. Changes to the plan may be made at any time, as necessary.

E. All plans, reviews and updates shall be signed by the resident or the resident's representative, if applicable, and the ARCP staff. If the resident's PCSP includes staff administration of medication or intermittent nursing services, a registered nurse shall also sign the plans, reviews and updates.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1096 (June 2015).

§6837. Termination of Residency Agreements

A. Voluntary Termination of Residency Agreement

1. The residency agreement shall specify:

a. the number of days and the process for notice required for voluntary termination of the residency agreement; and

b. the circumstances under which prepaid service charges and deposits are not refundable to the individual.

B. Involuntary Termination of Residency Agreements

1. The resident shall be allowed to continue residency in the ARCP unless one of the following occurs:

a. the resident's mental or physical condition deteriorates to a level requiring services that cannot be provided in accordance with these licensing regulations;

b. the resident's mental or physical condition deteriorates to a level requiring services that exceed those agreed upon in the residency agreement and PCSP;

c. the safety of other residents or staff in the ARCP is endangered;

d. the health of other residents or staff in the ARCP would otherwise be endangered;

e. the resident or resident's representative has failed to pay or has paid after timely notice in accordance with the residency agreement for a resident's stay at the ARCP; or

f. the ARCP ceases to operate.

2. Involuntary Termination Process

a. The resident, the resident's representative, if applicable, and the state and local long-term care ombudsman shall be notified in writing of the intent to terminate the residency agreement.

b. The notice shall be written in a language and in a manner that the resident and the resident's representative, if applicable, understand.

c. The written notice shall be given no less than 30 calendar days in advance of the proposed termination; however, the advance notice period may be shortened to 15 days for nonpayment of a bill for a stay at the ARCP.

d. The written notice shall contain:

i. the reason for the involuntary termination of the residency agreement;

ii. the right to formally appeal the involuntary termination of the residency agreement to the DAL; and

iii. contact information for the state and local long-term care ombudsman and for the DAL.

3. The resident and/or the resident's representative, if applicable, shall have the right to dispute any involuntary termination of the residency agreement in accordance with §6833.G.6-7.

4. The involuntary termination of the residency agreement shall be suspended until a final determination is made by the DAL.

5. If the involuntary termination of the residency agreement is upheld, the ARCP shall provide assistance in locating an appropriate residence and services.

C. Emergencies. If an emergency arises whereby the resident presents a direct threat of serious harm, serious injury or death to the resident, another resident, or staff, the ARCP shall immediately contact appropriate authorities to determine an appropriate course of action.

1. The resident's removal from the premises in response to an emergency does not constitute termination of the residency agreement. Required notice as described above shall be provided if the ARCP wishes to terminate the residency agreement.

2. The ARCP shall document the nature of the emergency and the ARCP's response to it.

3. The ARCP shall notify the resident's representative of all emergencies immediately after notification of the appropriate authorities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1097 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1252 (July 2018).

Subchapter D. Adult Residential Care Provider Services

§6839. General Provisions

A. The services provided by the ARCP are dependent in part upon the level for which they are licensed and in part upon the optional services that the ARCP elects to provide.

B. An ARCP shall ensure that services meet a resident's personal and health care needs as identified in the resident's PCSP, meet scheduled and unscheduled care needs, and make emergency assistance available 24 hours a day. These services shall be provided in a manner that does not pose an undue hardship on residents.

1. An ARCP shall respond to changes in residents' needs for services by revising the PCSP and, if necessary, by adjusting its staffing.

2. The ARCP shall provide adequate services and oversight/supervision including adequate security measures, 24 hours per day as needed for any resident.

3. The ARCP shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases with its policy meeting or exceeding the latest criteria established by the Centers for Disease Control and state *Sanitary Code*.

C. Number of Residents. The maximum number of residents that an ARCP shall serve will be based upon the level and plan as approved by the OSFM and/or the department's Health Standards Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1097 (June 2015).

§6841. Required and Optional Services

A. Required Services. The ARCP must provide or coordinate, to the extent needed or desired by each resident, the following required services:

1. assistance with activities of daily living and instrumental activities of daily living;

2. meals;

3. basic personal laundry services or laundry facilities;

4. opportunities for individual and group socialization including regular access to the community resources;

5. transportation either provided or arranged by the ARCP;

6. housekeeping services essential for health and comfort of the resident (e.g., floor cleaning, dusting, changing of linens); and

7. a recreational program.

B. Optional Services

1. All levels of ARCPs may provide the services listed below. If these optional services are provided, they must be provided in accordance with the PCSP:

a. medication administration;

b. financial management; and

c. specialized dementia care programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1098 (June 2015).

§6843. Medication Administration

A. The ARCP shall have written policies and procedures on medication administration including self-administration, assistance with self-administration, gratuitous administration or third party administration, and staff administration of medications. There shall also be policies regarding obtaining and refilling medications, storing and controlling medications, disposing of medications, and documentation of medication administration.

B. The ARCP shall record in the resident's PCSP whether the resident can self-administer medication, needs assistance with self-administration, has gratuitous administration, or third party administration or requires staff administration of medication. The determination of the need for staff administration of medication will be made by the resident's physician after assessment of the resident, and after consultation with the resident, resident's legal representative if applicable, and the ARCP staff. The PCSP shall also include how the medication will be obtained and stored.

C. Levels of Administration

1. Self-Administration. Unless otherwise indicated in the PCSP, residents shall have the option to self-administer their own medications. Residents who are appropriate for this service will be aware of what the medication is, what it is for and the need for the medication. Self-medication means residents can maintain possession and control of their medications. However, the ARCP shall require the resident to undertake reasonable precautions to ensure the safety of other residents.

2. Assistance with Self-Administration. Unless otherwise indicated in the PCSP, residents may elect assistance with self-medication if it is a service offered by the ARCP. Residents who are appropriate for this service will be aware of what the medication is, what it is for and the need for the medication.

a. Assistance with self-administration may be provided by staff members who hold no professional licensure, as long as that employee has documented training on the policies and procedures for medication assistance, including the limitations of assistance. This training must be repeated at least annually.

b. Assistance with self-administration of medication shall be limited to the following:

i. reminding residents that it is time to take medication(s), where such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed;

ii. reading the medication regimen as indicated on the container to the resident;

iii. physically assisting residents who are familiar with their medications by opening a medication container and/or providing assistance with pouring medications;

iv. offering liquids to residents who are familiar with their medications to assist that resident in ingesting oral medications; and

v. physically bringing a container of oral medications to residents.

c. Assistance with self-administration of medications shall not include:

i. administering injections of any kind;

ii. administering any prescription medications including, but not limited to, eye drops, ear drops, nose drops, liquid medications, inhalers, suppositories, or enemas;

iii. prompting or reminding a resident that it is time to take a PRN, or as-needed medication;

iv. crushing or splitting medications;

v. placing medications in a feeding tube; or

vi. mixing medications with foods or liquids.

3. Staff Administration of Medication

a. The ARCP shall administer medications to ARCP residents in accordance with their PCSP. Staff administration of medications may be provided by all levels of ARCPs.

b. Medications shall be administered only by an individual who is currently licensed to practice medicine or osteopathy by the appropriate licensing agency for the state, or by an individual who is currently licensed as an RN or LPN by the appropriate state agency.

c. In level 4 ARCPs only, staff administration of medication may include intravenous therapy. Intravenous therapy is permitted on a time limited basis and must be under the supervision of a licensed RN, physician, or advanced practice nurse.

d. The ARCP shall require pharmacists to perform a monthly review of all ordered medication regimens for possible adverse drug interactions and to advise the ARCP and the prescribing health care provider when adverse drug interactions are detected. The ARCP shall notify the prescribing health care provider of the pharmacist's review related to possible adverse drug interactions, and shall have documentation of this review and notification in the resident's record.

e. Medication Orders and Records

i. Medications, including over-the-counter medications, may be administered to a resident of an ARCP only after the medications have been prescribed specifically for the resident by an individual currently licensed to prescribe medications. All orders for medications shall be documented, signed and dated by the resident's licensed practitioner.

ii. Only an authorized licensed medical professional shall accept telephone orders for medications from a physician or other authorized practitioner. All telephone orders shall be documented in the resident's record. The telephone order shall be signed by the prescriber within 14 days of the issuance of the order.

iii. The ARCP is responsible for:

(a). complying with the physician orders, associated with medication administration;

(b). clarifying orders as necessary;

(c). notifying the physician of resident refusal of the medication or treatment; and

(d). notifying the physician of any adverse reactions to medications or treatments.

iv. All medications administered by staff to residents in an ARCP, including over the counter medications, shall be recorded on a medication administration record at the same time or immediately after the medications are administered.

v. The medication administration record shall include at least the following:

(a). the name of the resident to whom the medication was administered;

(b). the name of the medication administered (generic, brand or both);

(c). the dosage of the medication administered;

(d). the method of administration, including route;

(e). the site of injection or application, if the medication was injected or applied;

(f). the date and time of the medication administration;

(g). any adverse reaction to the medication; and

(h). the printed name and written or electronic signature of the individual administering the medication.

vi. Medication administration records and written physician orders for all over-the-counter medications, legend drugs and controlled substances shall be retained for period of not less than five years. They shall be available for inspection and copying on demand by the state regulatory agency.

vii. The most current edition of drug reference materials shall be available.

viii. All medication regimes and administration charting shall be reviewed by a licensed RN at least monthly to:

(a). determine the appropriateness of the medication regime;

(b). evaluate contraindications;

(c). evaluate the need for lab monitoring;

(d). make referrals to the primary care physician for needed monitoring tests;

(e). report the efficacy of the medications prescribed; and

(f). determine if medications are properly being administered in the ARCP.

4. Contracted Third Party Administration

a. The ARCP or the resident or the resident's representative, if applicable, may contract with an individual or agency to administer resident's prescribed medications. The ARCP shall ensure that medications shall be administered by an individual who is currently professionally licensed in Louisiana to administer medications.

b. A copy of such third party contract shall be verifiable in writing and retained in resident's record. The ARCP retains responsibility for notifying the resident or resident's legal representative, if applicable, if services are not delivered or if the resident's conditions changes.

D. Storage of Medications

1. An ARCP shall not stock or dispense resident medications. Where medications are kept under the control or custody of an ARCP, the medications shall be packaged by the pharmacy and shall be maintained by the ARCP as dispensed by the pharmacist.

2. Medication stored by the ARCP shall be stored in an area inaccessible to residents and accessible only to authorized personnel. This area must be kept locked. Any other staff (e.g., housekeeping, maintenance, etc.) needing access to storage areas must be under the direct visual supervision of authorized personnel.

3. All medications must be stored in accordance with industry standards or according to manufacturer's recommendations.

4. If controlled substances prescribed for residents are kept in the custody of the ARCP, they shall be stored in a manner that is compliant with local, state and federal laws. At a minimum, controlled substances in the custody of the ARCP shall be stored using a double lock system, and the ARCP shall maintain a system to account for the intake, distribution, and disposal of all controlled substances in its possession and maintain a written policy and procedure regarding such.

5. All other medications in the ARCP shall be stored using at least a single lock mechanism. This shall include medications stored in a resident's room whereby the staff and the resident have access to the medications. When residents self-administer their medications, the medications shall be stored in a locked area or container accessible only to the resident, resident's family and staff or may be stored in the resident's living quarters, if the room is single occupancy and has a locking entrance.

6. Any medication stored by the ARCP requiring refrigeration shall be kept separate from foods in separate containers within a refrigerator and shall be stored at appropriate temperatures according to the medication specifications. A daily temperature log must be maintained at all times for the refrigerator. No lab solutions or lab specimens may be stored in refrigerators used for the storage of medications or food.

7. The medication preparation area shall have an operable hand washing sink with hot and cold water, paper towels and soap or an alternative method for hand sanitization.

8. Medications shall be under the direct observation of the person administering the medications or locked in a storage area.

E. Labeling of Medications

1. All containers of medications shall be labeled in accordance with the rules of the Board of Pharmacy and any local, state, and federal laws.

2. Medication labels shall include appropriate cautionary labels (e.g., shake well, take with food, or for external use only).

3. Medications maintained in storage must contain the original manufacturer's label with expiration date or must be appropriately labeled by the pharmacy supplying the medications.

4. Any medications labeled for single resident use may not be used for more than one resident. One resident's medications cannot be used for another resident.

5. Any medication container with an unreadable label shall be returned to the issuing pharmacy for relabeling. Conditions that might affect readability include but are not limited to detachment, double labeling, excessive soiling, wear or damage.

F. Disposal of Medications

1. All medications and biologicals disposed of by the ARCP shall be according to ARCP policy and subject to all local, state and federal laws.

2. Expired medications shall not be available for resident or staff use. They shall be destroyed no later than 30 days from their expiration/discontinuation date.

3. Medications awaiting disposition must be stored in a locked storage area.

4. Medications of residents who no longer reside in the ARCP shall be returned to the resident or the resident's representative, if applicable. The resident or the resident's representative shall sign a statement that these medications have been received. The statement shall include the pharmacy, prescription number, date, resident's name, name and strength of the medication and amount returned. This statement shall be maintained in the resident's termination of services record.

5. When medication is destroyed on the premises of the ARCP, a record shall be made and filed at the ARCP according to ARCP policy.

a. This record shall include, but is not limited to:

i. name of ARCP;

ii. name of the medication;

iii. method of disposal;

iv. pharmacy;

v. prescription number;

vi. name of the resident;

vii. strength of medication;

viii. dosage of medication;

ix. amount destroyed; and

x. reason for disposition.

b. This record shall be signed and dated by the individual performing the destruction and by at least one witness.

c. The medication must be destroyed by a licensed pharmacist, RN or physician.

6. Controlled dangerous substances shall be destroyed in accordance with the provisions of LAC 46:LIII.2749.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1098 (June 2015).

§6845. Intermittent Nursing Services

A. Intermittent nursing services may be provided by level 4 ARCPs only. At no time shall an ARCP serve as provider for a resident whose condition is so unstable as to require continuous monitoring by licensed professional staff.

B. Where intermittent nursing services are provided, the following provisions shall apply.

1. All nursing services shall be provided in accordance with acceptable standards of practice and shall be delivered as prescribed by the resident's physician and in accordance with the PCSP.

2. The ARCP shall have written policies and procedures governing intermittent nursing services, including but not limited to the following:

a. responding to medical emergencies on all shifts;

b. ensuring that there is sufficient nursing staff to meet the needs of the residents;

c. ensuring that the ARCP's licensed nurse is notified of nursing needs as identified in the PCSP for each resident;

d. defining the duties, responsibilities and limitations of the ARCP licensed nurse in policy and procedures;

e. defining the policy for conducting nursing assessments;

f. delegating and training of ARCP staff to assist with nursing services;

g. coordinating with other third party contracted health service providers;

h. documentation by nursing personnel; and

i. infection control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1100 (June 2015).

§6847. Transportation

A. If the resident's condition is such that they are unable to manage their own transportation needs, the ARCP shall provide or arrange transportation for the following:

1. all medical services, including ancillary services for medically-related care;

2. scheduled personal services, including barber/beauty services;

3. scheduled personal errands; and

4. social/recreational opportunities.

B. The ARCP shall ensure and document that any vehicle used in transporting residents, whether such vehicles are operated by a staff member or any other person acting on behalf of the provider, is inspected and licensed in accordance with state law. The ARCP shall also have current commercial liability insurance.

C. When transportation services are provided by the ARCP, whether directly or by third party contract the provider shall:

1. document and ensure that drivers have a valid driver's license;

2. document and ensure that drivers have a valid chauffer's license or commercial driver's license with passenger endorsement upon hire, if applicable.

D. When transportation services are provided by the ARCP, the ARCP shall:

1. ensure drivers are trained in assisting residents in accordance with the individual resident's needs;

2. obtain documentation to ensure a safe driving record from the Louisiana Department of Motor Vehicles (DMV) upon hire and annually; and

3. ensure drivers meet personnel and health qualifications of other staff and receive necessary and appropriate training to ensure competence to perform duties assigned.

E. Vehicles shall be handicapped accessible or otherwise equipped to meet the needs of residents served.

F. Verifications by the ARCP shall not be required if the ARCP utilizes a third party transportation company that is authorized by the department to participate as an NEMT provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1100 (June 2015).

§6849. Meals Provided by the ARCP

A. For meals that are prepared and/or served by the ARCP, the ARCP shall offer to residents who choose to participate, a minimum of three varied, palatable meals per day, seven days a week.

1. Foods shall be prepared and served in a way that assures that they are appetizing, attractive, and nutritious and that promotes socialization among the residents.

2. The ARCP is permitted to offer liberalized diets. The nutritionist or licensed dietician may recommend to the physician to temporarily abate dietary restrictions and liberalize the diet to improve the resident's food intake.

B. The ARCP shall make reasonable accommodations, as stated in the residents' PCSP to:

1. meet dietary requirements, including following medically prescribed diets; however, nothing herein shall be construed to prohibit the ARCP from offering liberalized diets as recommended by the nutritionist or licensed dietician;

2. meet religious and ethnic preferences;

3. meet the temporary need for meals delivered to the resident's living area;

4. meet residents' personal routines and preferences; and

5. ensure snacks, fruits and beverages are available to residents at all times.

C. Staff shall be available in the dining area to assist with meal service, meal set up and to give individual attention as needed.

1. Dietary staff shall not store personal items within the food preparation and storage areas.

2. The kitchen shall not be used for dining of residents or unauthorized personnel.

3. Dietary staff shall use good hygienic practices.

4. Dietary employees engaged in the handling, preparation and serving of food shall use effective hair restraints to prevent the contamination of food or food contact surfaces.

5. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact will transmit the disease.

6. Garbage and refuse shall be kept in durable, easily cleanable, covered containers that do not leak and do not absorb liquids.

7. Containers used in food preparation and utensil washing areas shall be kept covered when meal preparation is completed and when full.

D. If a licensed dietitian is not employed full-time, the ARCP shall designate a full-time person to serve as the dietary manager.

1. The dietary manager who oversees food preparation may also fulfill other staff roles in the ARCP.

2. The dietary manager shall have Servsafe® certification.

E. Serving times for meals prepared and/or served by the ARCP shall be posted.

F. The menus for meals prepared and/or served by the ARCP, at a minimum, shall be reviewed and approved by a nutritionist or licensed dietician to assure their nutritional appropriateness for the setting's residents.

1. Menus shall be planned and written at least one week in advance and dated as served. The current week's menu shall be posted in one or more prominent place(s) for the current week in order to facilitate resident's choices about whether they wish to join in the meals prepared and/or served by the ARCP.

2. The ARCP shall furnish medically prescribed diets to all residents for which it is designated in the service plan.

3. Records of all menus as serviced shall be kept on file for at least 30 days.

4. All substitutions made on the master menu shall be recorded in writing.

G. Medically prescribed diets, prepared and/or served by the ARCP, shall be documented in the resident's record. There shall be a procedure for the accurate transmittal of dietary orders to the dietary manager when the resident does

not receive the ordered diet or is unable to consume the diet, with action taken as appropriate.

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

I. All food preparation areas (excluding areas in residents units) shall be maintained in accordance with LAC Title 51 *Sanitary Code*. Pets are not allowed in food preparation and serving areas.

J. If food is prepared in a central kitchen and delivered to separate physical sites, provision shall be made for proper maintenance of food temperatures and a sanitary mode of transportation.

K. Refrigeration

1. The ARCP's refrigerator(s) shall be maintained at a temperature of 41 degrees Fahrenheit or below.

2. The ARCP shall maintain daily temperature logs for all refrigerators and freezers.

3. Food stored in the refrigerator shall be covered, labeled, and dated.

L. The water supply shall be adequate, of a safe sanitary quality and from an approved source. Clean sanitary drinking water shall be available and accessible in adequate amounts at all times.

M. The ice scoop for ice machines shall be maintained in a sanitary manner with the handle at no time coming in contact with the ice.

N. Poisonous and toxic materials shall be appropriately identified, labeled and placed in locked cabinets which are used for no other purpose.

O. Written reports of inspections by OPH shall be kept on file in the ARCP.

P. If meals are provided by a third party service, the ARCP retains the responsibility to ensure that all regulations of this part are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1101 (June 2015).

§6851. Specialized Dementia Care Programs

A. Scope and Purpose. The ARCP may establish a separate and distinct program to meet the needs of residents with Alzheimer's disease or a related disorder. The ARCP shall provide a program of individualized care based upon an assessment of the cognitive and functional abilities of residents who have been included in the program.

B. Any ARCP that offers such a program shall disclose this program to the department upon establishing the program or upon its discontinuance.

C. Policies and Procedures

1. An ARCP that advertises, promotes or markets itself as offering a specialized dementia care program shall have written policies and procedures for the program that are retained by the administrative staff and available to all staff, to members of the public, and to residents, including those participating in the program.

2. The ARCP shall have established criteria for inclusion in the specialized dementia care program.

3. Guidelines for inclusion shall be provided to the resident, his/her family, and his/her legal representative.

4. Door locking arrangements to create secured areas may be permitted where the clinical needs of the residents require specialized protective measures for their safety, provided that such locking arrangements are approved by the OSFM and satisfy the requirements established by the OSFM and in accordance with R.S. 40:1300.121 et seq.

a. If the services are provided in a secured area where special door locking arrangements are used, the ARCP shall comply with the requirements established for limited health care occupancies in accordance with the laws, rules and codes adopted by the OSFM.

b. The secured areas shall be designed and staffed to provide the care and services necessary for the resident's needs to be met.

c. There shall be sufficient staff to respond to emergency situations in the locked unit at all times.

d. PCSPs shall address the reasons for the resident being in the unit and how the ARCP is meeting the resident's needs.

e. There must be documentation in the resident's record to indicate the unit is the least restrictive environment possible, and placement in the unit is needed to facilitate meeting the resident's needs.

f. Inclusion in a program on the unit must be in compliance with R.S. 40:1299.53.

D. Staff Training. Training in the specialized care of residents who are diagnosed by a physician as having Alzheimer's disease, or a related disorder, shall be provided to all persons employed by the ARCP in accordance with the provisions established in §6867 of this Chapter.

E. Disclosure of Services. An ARCP that advertises or markets itself as offering a specialized dementia care program shall provide in writing the following to any member of the public seeking information about the program:

1. the form of care or treatment provided that distinguishes it as being especially applicable to or suitable for such persons;

2. the philosophy and mission reflecting the needs of residents living with dementia;

3. the criteria for inclusion in the program and for discontinuance of participation should that become appropriate;

4. the assessment, care planning and the processes for ensuring the care plan's responsiveness to the changes in the resident's condition;

5. the staffing patterns, training and continuing education;

6. the physical environment and design features appropriate to support the functioning of residents living with dementia;

7. the involvement of families and the availability of family support programs;

8. the activities that are specifically directed toward residents diagnosed with Alzheimer's or a related disorder including, but not limited to, those designed to maintain the resident's dignity and personal identity, enhance socialization and success, and accommodate the cognitive and functional ability of the resident;

9. the frequency of the activities that will be provided to such residents;

10. the safety policies and procedures and any security monitoring system that is specific to residents diagnosed with Alzheimer's or a related disorder including, but not limited to safety and supervision within the secured unit and within the secured exterior area; and

11. the program fees.

F. An ARCP that advertises or markets itself as having a specialized dementia care program shall provide a secured exterior area for residents to enjoy the outdoors in a safe and secure manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8 and R.S. 40:1300.121-125.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1102 (June 2015).

Subchapter E. Resident Protection

§6855. Resident Rights

A. ARCPs shall have a written policy on resident rights and shall post and distribute a copy of those rights. In addition to the basic civil and legal rights enjoyed by other adults, residents shall have the rights listed below. ARCP policies and procedures must be in compliance with these rights. Residents shall:

1. be encouraged in the exercise of their civil or legal rights, benefits or privileges guaranteed by the Constitution of the United States and the Constitution of the State of Louisiana including the right to be free of discrimination or segregation based upon race, sex, handicap, religion, creed, national background or ancestry with respect to residency;

2. be treated as individuals in a manner that supports their dignity;

3. be assured choice and privacy and the opportunity to act autonomously, take risks to enhance independence and share responsibility for decisions;

4. participate and have family participate, if desired, in the planning of activities and services;

5. receive care and services that are adequate, appropriate, and in compliance with contractual terms of residency, relevant federal and state laws, rules and regulations and shall include the right to refuse such care and services;

6. receive upon moving in, and during his or her stay, a written statement of the services provided by the ARCP and the charges for these services;

7. be free from mental, emotional, and physical abuse and neglect, from chemical or physical restraints, and from financial exploitation and misappropriation of property;

8. have records and other information about the resident kept confidential and released only with the written consent of the resident or resident's representative or as required by law;

9. expect and receive a prompt response regarding requests (service, information, etc.) from the director and/or staff;

10. have the choice to contract with a third-party provider for ancillary services for medically related care (e.g., physician, pharmacist, therapy, podiatry, hospice,) and other services necessary as long as the resident remains in compliance with the contractual terms of residency;

11. be free to receive visitors of their choice without restriction except where the residents share bedrooms or apartments:

a. where residents do share bedrooms or apartments, reasonable restrictions that provide for the health, safety, and privacy of other residents shall be allowed;

12. manage their personal funds unless this authority has been delegated to the ARCP or to a third party by the resident, the resident's legal representative, or an agency that has the authority to grant representative payee status or fiscal management authority to a third party;

13. be notified, along with their representative in writing by the ARCP when the ARCP's license status is modified, suspended, revoked or denied renewal and to be informed of the basis of the action;

14. have choices about participation in community activities and in preferred activities, whether they are part of the formal activities program or self-directed;

15. share a room with a spouse or other consenting adult if they so choose;

16. voice grievances and suggest changes in policies and services to staff, advocates or outside representatives without fear of restraint, interference, coercion, discrimination, or reprisal and the ARCP shall make prompt efforts to address grievances including with respect to the behavior of other residents;

17. remain in their personal living area unless a change in the area is related to resident preference or to conditions stipulated in their contract, or necessitated by situations or incidents that create hazardous conditions in the living area;

18. live in a physical environment which ensures their physical and emotional security and well-being;

19. bring service animals into the ARCP;

20. bring pets into the ARCP if allowed by the ARCP and kept in accordance with the policies of the ARCP;

21. contact their advocates as provided by law;

22. be fully informed of all residents' rights and all rules governing resident conduct and responsibilities;

23. be informed of how to lodge a complaint with the Health Standards Section, the Office of Civil Rights, the Americans with Disabilities Act, the Office of the State Ombudsman, and the Advocacy Center. Contact information including telephone numbers and addresses for these entities shall be posted in a prominent location which is easily accessible to residents; and

24. have the right to privacy in his/her apartment or room(s), including the right to have:

a. a closed apartment or room door(s); and

b. the ARCP personnel knock before entering the apartment or room(s) and not enter without the resident's consent, except in case of an emergency or unless medically contraindicated.

B. Publicity. No resident shall be photographed or recorded without the resident's prior informed, written consent.

1. Such consent cannot be made a condition for joining, remaining in, or participating fully in the activities of the ARCP.

2. Consent agreements shall clearly notify the resident of his/her rights under this regulation and shall specify precisely what use is to be made of the photograph or recordings. Residents are free to revoke such agreements at any time, either orally or in writing.

3. All photographs and recordings shall be used in a way that respects the dignity and confidentiality of the resident. Recordings from security cameras placed in common areas of the building are not subject to publicity requirements for consent and shall not be used for publicity purposes.

C. Each resident shall be fully informed of their rights and responsibilities, as evidenced by written acknowledgment, prior to or at the time of occupancy and when changes occur. Each resident's file shall contain a copy of the written acknowledgment, which shall be signed and dated by the director and the resident and/or the resident's representative, if applicable.

D. The ARCP shall prominently post the grievance procedure, resident's rights, and abuse and neglect procedures in an area accessible to all residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1103 (June 2015).

§6857. Restraints

A. ARCPs are prohibited from the use of physical and chemical restraints. The ARCP shall establish and maintain a restraint free environment by developing individual approaches to the care of the resident as determined by resident assessments and PCSPs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1104 (June 2015).

§6859. Resident Representation and Grievance Procedures

A. Resident Association

1. The provider shall have a formal process and structure by which residents, in representative groups and/or as a whole, are given the opportunity to advise the director regarding resident services and life at the ARCP.

a. Any resident association requests, concerns or suggestions presented through this process shall be addressed by the director within a reasonable time frame, as necessitated by the concern, request or suggestion.

2. Staff may attend the residency association meetings only upon invitation made by the residents of the ARCP.

B. Grievance Procedure. A provider shall establish and have written grievance procedures to include, but not limited to:

1. a formal process to present grievances;

2. a formal appeals process for grievances;

3. a process to respond to residents and resident association requests and written grievances within seven days; and

4. the maintenance of a log to record grievances, investigation and disposition of grievances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1104 (June 2015).

§6861. Resident Personal Property and Funds

A. Personal Possessions. The ARCP may, at its discretion, offer safekeeping of valuable possessions. The ARCP shall have a written statement of its policy regarding the safekeeping of valuable possessions.

1. If the ARCP offers such a service, a copy of the written policy and procedures shall be given to a resident at the time of his/her occupancy.

2. The ARCP shall give the resident a receipt listing each item that the ARCP is holding in trust for the resident. A copy of the receipt shall be placed in the resident's record. The list shall be revised as items are added or removed.

B. Resident Funds

1. An ARCP may offer to safe keep residents' readily accessible personal funds up to $200 and/or assist with management of funds in excess of $200. The ARCP shall ensure that the resident's funds are readily available upon resident's request.

2. The residency agreement shall include the resident's rights regarding access to the funds, limits on incremental withdrawals, and the charges for the service, if any.

3. The ARCP shall provide a surety bond or otherwise provide assurance satisfactory to the secretary to assure the security of all personal funds entrusted to the ARCP.

4. If an ARCP offers the service of safekeeping readily accessible personal funds up to $200, and if a resident wishes to entrust funds, the ARCP shall:

a. obtain written authorization from the resident and/or the resident's representative, if applicable, as to safekeeping of funds;

b. provide each resident with a receipt listing the amount of money the ARCP is holding in trust for the resident;

c. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the resident for each transaction; and

d. afford the resident the right to examine the account during routine business hours.

5. If an ARCP offers the service of assisting with management of funds in excess of $200, the following shall apply.

a. The ARCP shall obtain written authorization to manage the resident's funds from the resident and the representative if applicable.

b. The resident shall have access through quarterly statements and, upon request, financial records.

c. The ARCP shall keep funds received from the resident for management in an individual account in the name of the resident.

d. Unless otherwise provided by state law, upon the death of a resident, the ARCP shall provide the executor or director of the resident's estate, or the resident's representative, if applicable, with a complete accounting of all the resident's funds and personal property being held by the ARCP. The ARCP shall release the funds and property in accordance with all applicable state laws.

6. If ARCP staff is named as representative payee by Social Security or the Railroad Retirement Board or as fiduciary by the US Department of Veterans Affairs, in addition to meeting the requirements of those agencies, the ARCP shall hold, safeguard, manage and account for the personal funds of the resident as follows.

a. The ARCP shall deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) separate from the ARCP's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there shall be a separate accounting for each resident's share.

b. The ARCP shall maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest bearing account, or petty cash fund.

c. The ARCP shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the ARCP on the resident's behalf.

i. The system shall preclude any comingling of resident funds with ARCP funds or with the funds of any person other than another resident.

ii. The individual financial record shall be available through quarterly statements and on request to resident and/or the resident's representative, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1104 (June 2015).

Subchapter F. Requirements Related to Staff, Record-Keeping and Incident Reports

§6863. General Provisions

A. The ARCP shall have qualified staff sufficient in number to meet the scheduled and unscheduled needs of residents and to respond in emergency situations.

B. Sufficient direct care staff shall be employed or contracted to ensure provision of personal assistance as required by the resident's PCSP.

C. Additional staff shall be employed as necessary to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment and grounds.

D. A staff member trained in the use of cardio pulmonary resuscitation (CPR) and first aid shall be on duty at all times.

E. Staff shall have sufficient communication and language skills to enable them to perform their duties and interact effectively with residents and staff.

F. The ARCP shall maintain a current work schedule for all employees showing actual coverage for each 24-hour day.

G. Criminal history checks and offers of employment shall be completed in accordance with R.S. 40:1203.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1105 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1976 (October 2017).

§6865. Staffing Requirements

A. At a minimum the following staff positions are required. For ARCPs level 2 through 4, one person may occupy more than one position in the ARCP but shall not be in this position on the same shift. In a level 1 ARCP, one person may occupy more than one staff position on the same shift.

1. Director. Each ARCP shall have a qualified director who is responsible for the day-to-day management, supervision, and operation of the ARCP and who shall be on-site no less than 20 hours per week.

a. During periods of temporary absence of the director, there shall be a responsible staff person designated to be in charge 24 hours per day, seven days per week that has the knowledge and responsibility to handle any situation that may occur.

b. The director shall be at least 21 years of age and have the responsibility and authority to carry out the policies of the provider.

c. Director Qualifications

i. For levels 1 and 2, the director shall meet one of the following criteria upon date of hire:

(a). have at least an associate's degree from an accredited college plus one year of experience in the fields of health, social services, geriatrics, management or administration; or

(b). in lieu of an associate's degree from an accredited college three years of experience in health, social services, geriatrics, management, administration; or

(c). a bachelor's degree in geriatrics, social services, nursing, health care administration or related field.

ii. For levels 3 and 4, the director shall meet one of the following criteria upon date of hire:

(a). a bachelor's degree plus two years of administrative experience in the fields of health, social services, geriatrics, management or administration;

(b). in lieu of a bachelor's degree, six years of administrative experience in health, social services, geriatrics, management or administration;

(c). a master's degree in geriatrics, health care, human service related field, management or administration; or

(d). be a licensed nursing facility administrator.

iii. Additionally, for level 4 ARCPs the director shall have successfully completed an adult residential care/assisted living director certification/training program consisting of, at a minimum, 12 hours of training that has been approved by any one of the following organizations:

(a). Louisiana Board of Examiners of Nursing Facility Administrators;

(b). Louisiana Assisted Living Association (LALA);

(c). LeadingAge Gulf States;

(d). Louisiana Nursing Home Association (LNHA); or

(e). any of the national assisted living associations, including the:

(i). National Center for Assisted Living (NCAL);

(ii). Assisted Living Federation of America (ALFA); or

(iii). LeadingAge.

iv. Training shall begin within six months and completed within 12 months of being appointed director.

v. Two years of experience as an assisted living director may be substituted in lieu of the certification requirements.

vi. Documentation of the director's qualifications shall be maintained on file at the ARCP.

2. Designated Recreational/Activity Staff. There shall be an individual designated to organize and oversee the recreational and social programs of the ARCP.

3. Direct Care Staff

a. The ARCP shall demonstrate that sufficient and trained direct care staff is scheduled and on-site to meet the 24-hour scheduled and unscheduled needs of the residents.

b. The ARCP shall be staffed with direct care staff to properly safeguard the health, safety and welfare of clients.

c. The ARCP shall employ direct care staff to ensure the provision of ARCP services as required by the PCSP.

d. Staff shall not work simultaneously at more than one ARCP on the same shift.

e. A direct care staff person who is not in the ARCP, but who is scheduled on the shift as on call shall not be included as direct care staff on any shift.

f. The ARCP shall maintain a current work schedule for all employees indicating adequate coverage for each 24-hour day.

B. Nursing Staff

1. In ARCPs that offer staff medication administration and level 4 ARCPs, the ARCP shall provide a sufficient number of RNs and LPNs to provide services to all residents in accordance with each resident's PCSP 24 hours per day.

2. Nursing Director

a. Level 4 ARCPs shall employ or contract with at least one RN who shall serve as the nursing director and who shall manage the nursing services. The nursing director need not be physically present at all times at the ARCP; however, the nursing director or his or her designee shall be on call and readily accessible to the ARCP 24 hours a day.

b. The nursing director, in conjunction with the resident's physician, shall be responsible for the preparation, coordination and implementation of the health care services section of the resident's PCSP.

c. The nursing director shall review and oversee all LPNs and direct care personnel with respect to the performance of health related services.

d. The nursing director shall be licensed by, and in good standing with, the Louisiana State Board of Nursing, and shall comply with all applicable licensing requirements.

3. Licensed Practical Nurses (LPNs). LPNs employed by or contracted with shall be licensed by, and in good standing with, the Louisiana State Board of Practical Nursing, and shall comply with all applicable nursing requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1105 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1977 (October 2017).

§6867. Staff Training

A. All staff shall receive the necessary and appropriate training to assure competence to perform the duties that are assigned to them.

1. All staff shall receive any specialized training required by law or regulation to meet resident's needs.

2. The ARCP shall maintain documentation that orientation and annual training has been provided for all current employees.

3. Orientation shall be completed within 14 days of hire and shall include, in addition to the topics listed in §6867.B, the following topics:

a. the ARCP's policies and procedures; and

b. general overview of the job specific requirements.

B. The following training topics shall be covered in orientation and annually thereafter for all staff and ARCP contracted providers having direct contact with residents:

1. residents' rights;

2. procedures and requirements concerning the reporting of abuse, neglect, exploitation, misappropriation and critical incidents;

3. building safety and procedures to be followed in the event of any emergency situation including instructions in the use of fire-fighting equipment and resident evacuation procedures including safe operation of fire extinguishers and evacuation of residents from the building;

4. basic sanitation and food safety practices;

5. requirements for reporting changes in resident's health conditions; and

6. infection control.

C. Training for Direct Care Staff

1. In addition to the topics listed in §6867.A.3 and §6867.B, orientation for direct care staff shall include an evaluation to ensure competence to provide ADL and IADL assistance. A new employee shall not be assigned to carry out a resident's PCSP until competency has been demonstrated and documented.

2. In addition to the required dementia training in §6867.F, direct care staff shall receive 12 hours of annual training which shall be recorded and maintained in the employee personnel file.

3. Annual training shall address the special needs of individual residents and address areas of weakness as determined by the direct care staff performance reviews.

4. All direct care staff shall receive certification in cardiac pulmonary resuscitation and adult first aid within the first 90 days of employment. The ARCP shall maintain the documentation of current certification in the staff's personnel file.

5. The requirements of §6867.C.1 may qualify as the first year's annual training requirements. However, normal supervision shall not be considered to meet this requirement on an annual basis.

D. Continuing Education for Directors

1. All directors shall obtain 12 continuing education units per year that have been approved by any one of the following organizations:

a. Louisiana Assisted Living Association (LALA);

b. Louisiana Board of Examiners of Nursing Facility Administrators;

c. LeadingAge Gulf States;

d. Louisiana Nursing Home Association (LNHA); or

e. any of the national assisted living associations, including:

i. National Center for Assisted Living (NCAL);

ii. Argentum (formerly ALFA); or

iii. LeadingAge;

2. Topics shall include, but not be limited to:

a. person-centered care;

b. specialty training in the population served;

c. supervisory/management techniques; and

d. geriatrics.

E. Third-Party Providers. A general orientation and review of ARCP policies and procedures is required to be provided to third-party providers entering the building to serve residents.

F. Dementia Training

1. All employees shall be trained in the care of persons diagnosed with dementia and dementia-related practices that include or that are informed by evidence-based care practices. New employees must receive such training within 90 days from the date of hire.

2. All employees who provide care to residents in a specialized dementia care Program shall meet the following training requirements.

a. Employees who provide direct face-to-face care to residents shall be required to obtain at least eight hours of dementia-specific training within 90 days of employment and eight hours of dementia-specific training annually. The training shall include the following topics:

i. an overview of Alzheimer's disease and other forms of dementia;

ii. communicating with persons with dementia;

iii. behavior management;

iv. promoting independence in activities of daily living; and

v. understanding and dealing with family issues.

b. Employees who have regular contact with residents, but who do not provide direct face-to-face care, shall be required to obtain at least four hours of dementia-specific training within 90 days of employment and two hours of dementia training annually. This training shall include the following topics:

i. an overview of dementias; and

ii. communicating with persons with dementia.

c. Employees who have only incidental contact with residents shall receive general written information provided by the ARCP on interacting with residents with dementia.

3. Employees who do not provide care to residents in a special dementia care program shall meet the following training requirements.

a. Employees who provide direct face-to-face care to residents shall be required to obtain at least two hours of dementia-specific training annually. This training shall include the following topics:

i. an overview of Alzheimer's disease and related dementias; and

ii. communicating with persons with dementia.

b. All other employees shall receive general written information provided by the ARCP on interacting with residents with dementia.

4. Any dementia-specific training received in a nursing or nursing assistant program approved by the department or its designee may be used to fulfill the training hours required pursuant to this Section.

5. ARCPs may offer a complete training curriculum themselves, or they may contract with another organization, entity, or individual to provide the training.

6. The dementia-specific training curriculum shall be approved by the department or its designee. To obtain training curriculum approval, the organization, entity, or individual shall submit the following information to the department or its designee:

a. a copy of the curriculum;

b. the name of the training coordinator and his/her qualifications;

c. a list of all instructors;

d. the location of the training; and

e. whether or not the training will be web-based.

7. A provider, organization, entity, or individual shall submit any content changes to an approved training curriculum to the department, or its designee, for review and approval.

a. Continuing education undertaken by the ARCP does not require the department’s approval.

8. If a provider, organization, entity, or individual, with an approved curriculum, ceases to provide training, the department shall be notified in writing within 30 days of cessation of training. Prior to resuming the training program, the provider, organization, entity, or individual shall reapply to the department for approval to resume the program.

9. Disqualification of Training Programs and Sanctions. The department may disqualify a training curriculum offered by a provider, organization, entity, or individual that has demonstrated substantial noncompliance with training requirements including, but not limited to:

a. the qualifications of training coordinators; or

b. training curriculum requirements.

10. Compliance with Training Requirements

a. The review of compliance with training requirements will include, at a minimum, a review of:

i. the documented use of an approved training curriculum; and

ii. the provider’s adherence to established training requirements.

b. The department may impose applicable sanctions for failure to adhere to the training requirements outlined in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1106 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1977 (October 2017).

§6869. Record Keeping

A. Administrative Records. The ARCP shall have an administrative record that includes:

1. the articles of incorporation or certified copies thereof, if incorporated, by-laws, operating agreements, or partnership documents, if applicable;

2. the written policies and procedures approved annually by the owner/governing body that address the requirements listed in this Subchapter;

3. the minutes of formal governing body meetings;

4. the organizational chart of the ARCP;

5. all leases, contracts, and purchase of service agreements to which the ARCP is a party, which includes all appropriate credentials;

6. insurance policies; and

7. copies of incident/accident reports.

B. Personnel Records. An ARCP shall maintain a personnel record for each employee. At a minimum, this file shall contain the following:

1. the application for employment, including the resume of education, training, and experience, if applicable;

2. a criminal history check, prior to an offer of employment, in accordance with state law;

3. evidence of applicable professional or paraprofessional credentials/certifications according to state law, rule or regulation;

4. documentation of any state or federally required medical examinations or medical testing;

5. employee's hire and termination dates;

6. documentation of orientation and annual training of staff;

7. documentation of a valid driver's license, documentation of a valid chauffer's or commercial driver's license with passenger endorsement, if applicable, and Louisiana DMV record for any employee that transports residents;

8. documentation of reference checks; and

9. annual performance evaluations. An employee's annual performance evaluation shall include his/her interaction with residents, family, and other providers.

C. Resident Records. An ARCP shall maintain a separate record for each resident. Such record shall be current and complete and shall be maintained in the ARCP in which the resident resides and readily available to ARCP staff and department staff. Each record shall contain the information below including but not limited to:

1. resident's name, marital status, date of birth, sex, Social Security number, and previous home address;

2. date of initial residency and date of termination of residency;

3. location of new residence following move-out;

4. name, address and telephone number of the resident's representative;

5. names, addresses, and telephone numbers of individuals to be notified in case of accident, death, or other emergency;

6. name, address, and telephone number of a physician to be called in an emergency;

7. ability to ambulate;

8. resident's plan/authorization for routine and emergency medical care;

9. the pre-residency assessment and service agreement;

10. assessment and any special problems or precautions;

11. individual PCSP, updates, and quarterly reviews;

12. continuing record of any illness, injury, or medical or dental care when it impacts the resident's ability to function without assistance with ADLs and IADLs or impacts the services the resident requires, including but not limited to all orders received from licensed medical practitioners;

13. a record of all personal property and funds which the resident has entrusted to the ARCP;

14. written and signed acknowledgment that the resident has been informed and received verbal explanation and copies of his/her rights, the house rules, written procedures for safekeeping of his/her valuable personal possessions, written statement explaining his/her rights regarding personal funds, and the right to examine his/her record;

15. advance directives and requirements for assistance in emergency evacuation; and

16. documentation of any third party services provided and documentation of any notifications provided to the resident's representative regarding services.

D. Maintenance and Storage of Records. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of in accordance with state laws. An ARCP shall have sufficient space, facilities, and supplies for providing effective storage of

records. The ARCP shall maintain the resident's records in the following manner.

1. Each resident and/or resident's legal representative, if applicable, upon written or oral request, shall have the right to inspect and/or copy his or her records during normal business hours in accordance with state and federal law.

a. After receipt of his/her records for inspection, the ARCP shall provide, upon request and two working days' notice, at a cost consistent with the provisions of applicable state law, photocopies of the records or any portions thereof.

2. The ARCP shall not disclose any resident records maintained by the ARCP to any person or agency other than the ARCP personnel, law enforcement, the department, or the attorney general's office, except upon expressed written consent of the resident or his or her legal representative, or when disclosure is required by state or federal law or regulations.

3. The ARCP shall maintain the original records in an accessible manner for a period of five years following a resident's death or vacating the ARCP.

4. The original resident records, while the resident maintains legal residence at the ARCP, shall be kept on the ARCP premises at all times, unless removed pursuant to subpoena.

5. In the event of a change of ownership, the resident records shall remain with the ARCP.

6. An ARCP which is closing shall notify the department of the plan for the disposition of residents' records in writing within 30 days prior to closure. The plan shall include where the records will be stored and the name, address and phone number of the person responsible for the resident and personnel records.

7. If the ARCP closes, the ARCP owner(s) shall store the resident records for five years from the date of closure within the state of Louisiana.

E. Confidentiality and Security of Records

1. The ARCP shall have written procedures for the maintenance and security of records specifying:

a. who shall supervise the maintenance of records;

b. who shall have custody of records; and

c. to whom records may be released. Release shall be made in accordance with any and all federal and state laws.

2. The ARCP shall have a written procedure for protecting clinical record information against loss, destruction, or unauthorized use.

3. The ARCP shall ensure the confidentiality of all resident records, including information in a computerized record system, except when release is required by transfer to another health care institution, law, third-party payment contractor, or the resident. Information from, or copies of, records may be released only to authorized individuals, and the ARCP shall ensure that unauthorized individuals cannot gain access to or alter resident records.

4. Employees of the ARCP shall not disclose or knowingly permit the disclosure of any information concerning the resident or his/her family, directly or indirectly, to any unauthorized person.

5. The ARCP shall obtain the resident's, and if applicable, the resident's representative's written, informed permission prior to releasing any information from which the resident or his/her family might be identified, except to the department. Identification information may be given to appropriate authorities in case of an emergency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1107 (June 2015).

§6871. Incident and Accident Reports

A. An ARCP shall have written procedures for the reporting and documentation of accidents, incidents and other situations or circumstances affecting the health, safety or well-being of a resident or residents. The procedures shall include:

1. a provision that the director or his/her designee shall be immediately verbally notified of accidents, incidents and other situations or circumstances affecting the health, safety or well-being of a resident or residents; and

2. a provision that staff shall be trained on the reporting requirements.

B. An ARCP shall report to HSS any incidents suspected of involving:

1. abuse;

2. neglect;

3. misappropriation of personal property regardless of monetary value; or

4. injuries of unknown origin. Injuries of unknown origin are defined as:

a. the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; or

b. the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).

C. The initial report of the incident or accident is due within 24 hours of occurrence or discovery of the incident.

D. After submission of the initial 24-hour report, a final report shall be submitted within five business days regardless of the outcome.

E. Report Contents. The information contained in the incident report shall include, but is not limited to the following:

1. circumstances under which the incident occurred;

2. date and time the incident occurred;

3. where the incident occurred (bathroom, apartment, room, street, lawn, etc.);

4. immediate treatment and follow-up care;

5. name and address of witnesses;

6. date and time family or representative was notified;

7. symptoms of pain and injury discussed with the physician; and

8. signatures of the director, or designee, and the staff person completing the report.

F. When an incident results in death of a resident, involves abuse or neglect of a resident, or entails any serious threat to the resident's health, safety or well-being, an ARCP director or designee shall:

1. immediately report verbally to the director and submit a preliminary written report within 24 hours of the incident to the department;

2. notify HSS and any other appropriate authorities, according to state law and submit a written notification to the above agencies within 24 hours of the suspected incident;

3. immediately notify the family or the resident's representative and submit a written notification within 24 hours;

4. immediately notify the appropriate law enforcement authority in accordance with state law;

5. take appropriate corrective action to prevent future incidents and provide follow-up written report to all the above persons and agencies as per reporting requirements; and

6. document its compliance with all of the above procedures for each incident and keep such documentation (including any written reports or notifications) in the resident's file. A separate copy of all such documentation shall be kept in the provider's administrative file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1108 (June 2015).

Subchapter G. Emergency Preparedness

§6875. Emergency Preparedness Plan

A. The ARCP shall have an emergency preparedness plan designed to manage the consequences of all hazards, declared disasters or other emergencies that have the potential to disrupt the ARCP's ability to provide care and treatment and/or threatens the lives or safety of the residents. The ARCP shall follow and execute its emergency preparedness plan in the event or occurrence of a disaster or emergency.

1. Emergency events include, but are not limited to hurricanes, floods, fires, chemical or biological hazards, power outages, tornados, tropical storms and severe weather.

B. The ARCP will work in concert with the local parish Office of Emergency Preparedness (OEP) in developing plans.

C. Upon the department's request, an ARCP shall present its plan for review. At a minimum, the plan shall include and address the elements listed below.

1. The plan shall be individualized and site specific. All information contained in the plan shall be current and correct. The ARCP's plan shall follow all current applicable laws, standards, rules or regulations.

2. Upon request, the plan shall be made available to representatives of the following offices:

a. OSFM;

b. OPH; and

c. local Office of Homeland Security.

3. The plan shall contain census information, including transportation needs for current census and available capacity.

4. The plan shall contain a clearly labeled and legible master floor plan(s) that indicates the following:

a. the areas in the ARCP, either in the resident's apartment or the other areas of the ARCP, that are to be used by residents as shelter or safe zones during emergencies;

b. the location of emergency power outlets, if available (if none are powered or all are powered, this shall be stated as such on the plan); and

c. the locations of posted, accessible, emergency information.

5. The plan shall provide for floor plans or diagrams to be posted and those plans or diagrams shall clearly indicate:

a. that specific room or apartment's location, the fire exits, the fire evacuation routes, locations of alarm boxes and fire extinguishers, and written fire evacuation procedures shall be included on one plan; and

b. a separate floor plan or diagram with safe zones or sheltering areas for non-fire emergencies shall indicate areas of building, apartments, or rooms that are designated as safe or sheltering areas.

6. The plan shall include a detailed list of what will be powered by emergency generator(s), if the ARCP has a generator.

7. The plan shall be viable and promote the health, safety and welfare of the residents.

8. The plan shall include a procedure for monitoring weather warnings and watches and evacuation orders from local and state emergency preparedness officials. This procedure will include:

a. who will monitor;

b. what equipment will be used; and

c. procedures for notifying the director or responsible persons.

9. The plan shall provide for the delivery of essential care and services to meet the needs of the residents during emergencies, who are housed in the ARCP or by the ARCP at another location, during an emergency.

10. The plan shall contain information about staffing when the ARCP is sheltering in place or when there is an evacuation of the ARCP. Planning shall include documentation of staff that have agreed to work during an emergency and contact information for such staff. The plan shall include provisions for adequate, qualified staff as well as provisions for the assignment of responsibilities and duties to staff.

11. The plan shall include procedures to notify each resident's family or responsible representative whether the ARCP is sheltering in place or evacuating to another site. The plan shall include which staff is responsible for providing this notification. If the ARCP evacuates, notification shall include:

a. the date and approximate time that the ARCP is evacuating;

b. the place or location to which the ARCP is evacuating, including the:

i. name;

ii. address; and

iii. telephone number.

12. The plan shall include the procedure or method whereby each ARCP resident has a manner of identification that is provided to them to be attached to his/her person. Residents shall be instructed to keep the identification on their person at all times in the event of sheltering in place or evacuation. The following minimum information shall be included with the resident:

a. current and active diagnosis;

b. medications, including dosage and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin or responsible person and contact information.

13. The plan shall include an evaluation of the building and necessary systems to determine the ability to withstand wind, flood, and other local hazards that may affect the ARCP. If applicable, the plan shall also include an evaluation of each generator's fuel source(s), including refueling plans and fuel consumption.

14. The plan shall include an evaluation of the ARCP's surroundings to determine lay-down hazards, objects that could fall on the ARCP, and hazardous materials in or around the ARCP, such as:

a. trees;

b. towers;

c. storage tanks;

d. other buildings;

e. pipe lines;

f. chemicals;

g. fuels; or

h. biologics.

15. For ARCPs that are geographically located south of Interstate 10 or Interstate 12, the plan shall include the determinations of when the ARCP will shelter in place and when the ARCP will evacuate for a storm or hurricane and the conditions that guide these determinations.

16. If the ARCP shelters in place, the ARCP's plan shall include provisions for seven days of necessary supplies to be provided by the ARCP prior to the emergency event, to include:

a. drinking water or fluids;

b. non-perishable food; and

c. other provisions as needed to meet the contractual obligations and current level of care requirements of each resident.

17. The plan shall include a posted communications plan for contacting emergency services and monitoring emergency broadcasts and whose duty and responsibility this will be. The communications plan will include a secondary plan in the event primary communications fail.

18. The plan shall include how the ARCP will notify the local Office of Emergency Preparedness and the department when the decision is made to shelter in place or evacuate and whose responsibility it is to provide this notification.

D. The ARCP shall have transportation or arrangements for transportation for evacuation, hospitalization, or any other services which are appropriate and to meet the contractual obligations and current level of care requirements of each resident.

1. Transportation or arrangements for transportation shall be adequate for the current census and meet the ambulatory needs of the residents.

2. Transportation or arrangements for transportation shall be for the evacuation from and return to the ARCP or as needed to meet the contractual obligations or current level of care requirements of each resident.

E. The ARCP director, or designee, shall make the decision to evacuate or shelter in place after reviewing all available and required information on the storm, the ARCP, the ARCP's surroundings, and in consultation with the local office of Emergency Preparedness. In making the decision to shelter in place or evacuate, the ARCP shall consider the following:

1. under what conditions the ARCP will shelter in place;

2. under what conditions the ARCP will close or evacuate; and

3. when will these decisions be made.

F. The ARCP accepts all responsibility for the health and well-being of all residents that shelter with the ARCP before, during, and after the storm.

G. The ARCP shall have a plan for an on-going safety program to include:

1. inspection of the ARCP for possible hazards with documentation;

2. monitoring of safety equipment and maintenance or repair when needed and/or according to the recommendations of the equipment manufacturer, with documentation;

3. investigation and documentation of all accidents or emergencies;

4. fire control and evacuation planning with documentation of all emergency drills; and

5. all aspects of the ARCP's plan, planning, and drills which shall meet the requirements of the OSFM.

H. The ARCP shall inform the resident and/or the resident's representative of the ARCP's emergency plan and ongoing safety plan and the actions to be taken. Current emergency preparedness plan information shall be available for review by the resident or the resident's representative.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1109 (June 2015).

§6877. Emergency Plan Activation, Review and Summary

A. Following an event or occurrence of a disaster or emergency, whether the ARCP shelters in place or evacuates, upon request by the department the ARCP shall submit a written summary attesting how the ARCP's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths.

B. The ARCP's emergency plan(s) shall be activated at least annually, either in response to an emergency or in a planned drill. All staff shall be trained and have knowledge of the emergency plan.

C. All ARCPs must conduct egress and relocation drills in accordance with the requirements of the OSFM and the applicable edition of the NFPA 101 Life Safety Code published by the NFPA.

1. All staff shall participate in at least one drill annually.

2. Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

D. In addition to the exercises for emergencies due to fire, the ARCP plan shall be activated at least once per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disasters. The activation(s) shall include an exercise for shelter-in-place and an exercise for evacuation. The ARCP shall document the exercise for shelter-in-place and the exercise for evacuation.

E. The ARCP's performance during the activation of the plan shall be evaluated annually by the ARCP and the findings shall be documented in the plan. Records shall be kept to document the evacuation times and participation. Such records shall be maintained at the ARCP and shall be readily available to the OSFM upon request.

F. The plan shall be revised if indicated by the ARCP's performance during the emergency event or the planned drill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1111 (June 2015).

§6879. Notification

A. The emergency preparedness plan shall specify the following:

1. list of all persons, agencies, authorities to be notified and routinely updated contact information;

2. process of notification;

3. verification or documentation of attempted notification; and

4. back-up communication plans and procedures.

B. An ARCP shall immediately notify the HSS program desk and other appropriate agencies of any fire, disaster or other emergency that may present a danger to residents or require their evacuation from the ARCP.

C. In the event that an ARCP evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state, local or parish Office of Homeland Security Emergency Preparedness (OHSEP), the ARCP must immediately give notice to the HSS and Governor's Office of Homeland Security Emergency Preparedness (GOHSEP) by facsimile or e-mail of the following:

1. the date and approximate time of the evacuation; and

2. the locations of where the residents have been placed, whether this location is a host site for one or more of the ARCP residents.

D. In the event that an ARCP evacuates, temporarily relocates or temporarily ceases operations at its licensed location for any reason other than an evacuation order, the ARCP must immediately give notice to the HSS by facsimile or e-mail of the following:

1. the date and approximate time of the evacuation; and

2. the location of where the residents have been placed, whether this location is a host site for one or more of the ARCP residents.

E. If there are any deviations or changes made to the locations of the residents that was given to the HSS and the local OEP, then both HSS and the local OEP shall be notified of the changes within 48 hours of their occurrence.

F. Effective immediately upon notification of an emergency declared by the Secretary, all ARCPs licensed in Louisiana shall file an electronic report with the ESF-8 Portal and its applications during a declared emergency, disaster, or a public health emergency.

1. The electronic report shall be filed as prescribed by the department throughout the duration of the disaster or emergency event.

2. The electronic report shall include but not be limited to the following:

a. status of operation;

b. availability of beds;

c. generator status, if applicable;

d. evacuation destination(s)and status;

e. shelter in place status;

f. current census;

g. emergency evacuation transportation needs categorized by the following types:

i. red—high risk patients that need to be transported by advanced life support ambulance due to dependency on mechanical or electrical life sustaining devices or very critical medical condition;

ii. yellow—residents who are not dependent on mechanical or electrical life sustaining devices, but cannot be transported using normal means (buses, vans, cars), may need to be transported by an ambulance; however, in the event of inaccessibility of medical transport, buses, vans or cars may be used as a last resort; or

iii. green—residents who need no specialized transportation may be transported by car, van, bus or wheelchair accessible transportation; and

h. any other information as requested by the department.

3. There shall be a plan and procedures to file the report if primary communications fail.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1111 (June 2015).

§6881. Authority to Re-open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation

A. The following applies to any ARCP that evacuates, temporarily relocates or temporarily ceases operation at its licensed location due to an emergency.

1. The ARCP must immediately give written notice to HSS by hand delivery, facsimile or e-mail of the following information:

a. the date and approximate time of the evacuation;

b. the sheltering host site(s) to which the ARCP is evacuating; and

c. a list of residents being evacuated, which shall indicate the evacuation site for each resident.

2. Within 48 hours, the ARCP must notify HSS of any deviations from the intended sheltering host site(s) and must provide HSS with a list of all residents and their locations.

3. If there was no damage to the licensed location due to the emergency event, and there was no power outage of more than 48 hours at the licensed location due to the emergency event, the ARCP may reopen at its licensed location and shall notify HSS within 24 hours of reopening. For all other evacuations, temporary relocations, or temporary cessation of operations due to an emergency event, an ARCP must submit to HSS a written request to reopen, prior to reopening at the licensed location. The request to reopen shall include:

a. a damage report;

b. the extent and duration of any power outages;

c. the re-entry census;

d. staffing availability;

e. access to emergency or hospital services; and

f. availability and/or access to food, water, medications and supplies.

B. Upon receipt of a reopening request, the department shall review and determine if reopening will be approved. The department may request additional information from the ARCP as necessary to make determinations regarding reopening.

C. After review of all documentation, in order to assure that the ARCP is in compliance with the licensing standards including, but not limited to, the structural soundness of the building, the sanitation code, staffing requirements and the execution of emergency plans, the department shall issue a notice of one of the following determinations:

1. approval of reopening without survey;

2. surveys required before approval to reopen will be granted. Surveys may include OPH, Fire Marshall and Health Standards; or

3. denial of reopening.

D. The HSS, in coordination with state and parish OHSEP, will determine the ARCP's access to the community service infrastructure, such as hospitals, transportation, physicians, professional services and necessary supplies.

E. The HSS will give priority to reopening surveys.

F. Upon request by the department, the ARCP shall submit a written summary attesting how the ARCP's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed;

5. a list of all injuries and deaths of residents that occurred during execution of the plan, evacuation and temporary relocation including the date, time, causes and circumstances of the injuries and deaths; and

6. a summary of all request for assistance made and any assistance received from the local, state, or federal government.

G. Sheltering in Place. If an ARCP shelters in place at its licensed location during an emergency event, the following will apply.

1. The ARCP must immediately give written notice to the HSS by hand delivery, facsimile or e-mail that the ARCP will shelter in place.

2. Upon request by the department, the ARCP shall submit a written summary attesting how the ARCP's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed;

e. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths; and

f. a summary of all request for assistance made and any assistance received from the local, state, or federal government.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1112 (June 2015).

Subchapter H. Physical Environment

§6885. General Requirements and Authority

A. The standards in this Subchapter shall apply to any ARCP constructed after the effective date of this rule, alterations, additions or substantial rehabilitation to an existing ARCP, or adaptation of an existing building to create an ARCP. Cosmetic changes to the ARCP such as painting, flooring replacement or minor repairs shall not be considered an alteration or substantial rehabilitation.

B. An ARCP shall submit architectural plans and construction documents to the OSFM. The regulations and codes governing new ARCPs also apply if and when the ARCP proposes to begin operation in a building not previously and continuously used as an ARCP licensed under these regulations.

C. Design Criteria. The project shall be designed in accordance with the following criteria:

1. the requirements of the OSFM;

2. Part XIV (Plumbing) of the *Sanitary Code* (LAC 51), state of Louisiana; and

3. the current department licensing regulations for adult residential care providers.

D. Life Safety Code Occupancy Requirements. Any ARCP that provides services to four or more residents who are not capable of taking action for self-preservation under emergency conditions without the assistance of others shall meet the construction requirements established for limited care health care occupancies and codes adopted by the OSFM. All level 4 ARCPs shall meet limited care health care occupancies and codes adopted by the OSFM.

E. During power outages or other emergencies, level 4 ARCPs shall have the ability to generate power for emergency lighting, designated power outlets and temperature control.

F. Waivers. The secretary may, within his or her sole discretion, grant waivers to physical environment requirements insofar as they do not conflict with the requirements of the OSFM or OPH. Requests for waivers are considered on the following basis.

1. The ARCP must demonstrate how resident health and safety and the maintenance of a homelike environment are not compromised.

2. No waiver shall be approved that results in an ARCP that is not physically distinct from any residential care facility, nursing home or hospital.

3. No waiver shall be approved which results in a living environment that does not provide all required physical features and/or does not provide sufficient space to permit residents to carry out, with or without assistance, all the functions necessary for independent living.

4. The ARCP shall demonstrate its ability to completely fulfill all other requirements of the service.

5. The department shall make a written determination of the request.

6. Waivers are not transferable in an CHOW and are subject to review or revocation upon any change in circumstances to the waiver.

G. All ARCPs licensed under these regulations shall be designed and constructed to substantially comply with pertinent local and state laws, codes, ordinances and standards. All new construction shall be in accordance with Louisiana *Uniform Construction Code* in effect at the time of original licensure.

H. Practices that create an increased risk of fire are prohibited. This includes, but is not limited to:

1. space heaters;

2. the accumulation or storage within the ARCP of combustible materials such as rags, paper items, gasoline, kerosene, paint or paint thinners; or

3. the use of extension cords or multi-plug adapters for electrical outlets, except ARCPs may utilize transient voltage surge protectors or surge suppressors with microprocessor electronic equipment such as computers or CD/DVD recorders or players. Any transient voltage surge protectors or surge suppressors shall have a maximum UL rating of 330v and shall have a functioning protection indicator light. ARCPs may not use transient voltage surge protectors or surge suppressors that do not function completely or for which the protection indicator light does not work.

I. Safety Standards for Smoking

1. Adult residential care providers may elect to prohibit smoking in the ARCP or on the grounds or both. If an ARCP elects to permit smoking in the ARCP or on the grounds, the ARCP shall include the following minimal provisions, and the ARCP shall ensure the following.

a. In ARCPs equipped with sprinkler systems, the ARCP may designate a smoking area or areas within the ARCP. The designated area or areas shall have a ventilation system that is separate from the ventilation system for non-smoking areas of the ARCP. ARCPs lacking a sprinkler system are prohibited from designating smoking areas within the ARCP.

b. Smoking shall be prohibited in any room or compartment where flammable liquids, combustible gases or oxygen is used or stored, and any general use/common areas of the ARCP. Such areas shall be posted with “no smoking” signs.

c. Smoking by residents assessed as not capable of doing so without assistance shall be prohibited unless the resident is under direct supervision.

d. Ashtrays of noncombustible material and safe design shall be placed in all areas where smoking is permitted.

e. Metal containers with self-closing cover devices into which ashtrays may be emptied shall be placed in all areas where smoking is permitted.

J. Kitchen/Food Service

1. Each ARCP shall comply with all applicable regulations relating to food service for sanitation, safety and health as set forth by state, parish and local health departments.

2. The ARCP shall have a central or a warming kitchen.

3. The kitchen of an ACRP shall be in compliance with the requirements of Part XXIII of the Louisiana *Sanitary Code* (LAC 51).

4. Level 3 and 4 ARCPs may opt out of having a central kitchen if meals are prepared in an off-site location.

a. ARCPs opting out shall have a kitchen area to hold, warm and serve food prepared at the off-site location. This kitchen area shall meet the Louisiana *Sanitary Code* requirements for food safety and handling.

b. Meals and snacks provided by the ARCP but not prepared on-site shall be obtained from or provided by an entity that meets the standards of state and local health regulations concerning the preparation and serving of food.

c. Opting out does not exempt ARCPs from meeting dining room space that is separate and distinct as referenced above in physical separation standards.

5. In ARCPs that have commercial kitchens with automatic extinguishers in the range hood, the manufacturer’s recommendations regarding portable fire extinguishers shall be followed.

6. The kitchen and food preparation area shall be well lit, ventilated, and located apart from other areas to prevent food contamination in accordance with the state *Sanitary Code*.

7. An adequate supply of eating utensils (e.g., cups, saucers, plates, glasses, bowls, and flatware) will be maintained in the ARCP's kitchen to meet the needs of the communal dining program. Eating utensils shall be free of chips or cracks.

8. An adequate number of pots and pans shall be provided for preparing meals.

9. Each ARCP shall have adequate storage space. All storage space shall be constructed and maintained to prevent the invasion of rodents, insects, sewage, water leakage or any other contamination. Shelving shall be of sufficient height from the floor to allow cleaning of the area underneath the bottom shelf. All items shall be stored in accordance with state *Sanitary Code*.

10. Food waste shall be placed in garbage cans with airtight fitting lids and bag liners. Garbage cans shall be emptied daily.

K. Laundry

1. Each ARCP shall have laundering facilities unless commercial laundries are used.

a. The laundry shall be located in a specifically designed area that is physically separate and distinct from residents' rooms and from areas used for dining and food preparation and service.

b. There shall be adequate rooms and spaces for sorting, processing and storage of soiled material.

c. Laundry rooms shall not open directly into a resident's personal living area or food service area.

2. Domestic washers and dryers for the use by residents may be provided in resident areas provided they are installed and maintained in such a manner that they do not cause a sanitation problem, offensive odors, or fire hazard.

3. Supplies and equipment used for housekeeping and laundry will be stored in a separate locked room. All hazardous chemicals will be stored in compliance with OPH requirements.

L. Lighting

1. All in-door areas of an ARCP shall be well lighted to ensure residents' safety and to accommodate need.

2. Night-lights for corridors, emergency situations and the exterior shall be provided as needed for security and safety.

3. All rooms shall have working light switches at the entrance to each room.

4. Light fixtures in resident general use or common areas shall be equipped with covers to prevent glare and hazards to the residents.

M. HVAC/Ventilation

1. The ARCP shall provide safe HVAC systems capable of maintaining a temperature range of 71-81 degrees Fahrenheit.

2. Filters for heaters and air conditioners shall be provided as needed and maintained in accordance with manufacturer's specifications.

N. If the ARCP uses live-in staff, staff shall be provided with adequate, separate living space with a private bathroom. This private bathroom is not to be counted as available to residents.

O. An ARCP shall have space that is distinct from residents' living areas to accommodate administrative and record-keeping functions.

P. An ARCP shall have a designated space to allow private discussions with individual residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1113 (June 2015).

§6887. Physical Appearance and Conditions

A. The ARCP shall be constructed, equipped, and maintained in good repair and free of hazards.

1. Potentially hazardous areas include, but are not limited to:

a. steep grades;

b. cliffs;

c. open pits;

d. swimming pools;

e. high voltage boosters; or

f. high speed roads.

2. Potentially hazardous areas shall be fenced off or have natural barriers to protect residents.

B. An accessible outdoor recreation area is required and shall be made available to all residents and include walkways suitable for walking and benches for resting. Lighting of the area shall be equal to a minimum of five foot-candles.

C. ARCPs shall have an entry and exit drive to and from the main building entrance that will allow for picking up and dropping off residents and for mail deliveries. ARCPs licensed after the effective date of this Rule shall have a covered area at the entrance to the building to afford residents protection from the weather.

D. If the ARCP maintains a generator on the grounds of the ARCP, it shall be fenced off or have natural barriers to protect residents.

E. Waste Removal and Pest Control

1. Garbage and rubbish that is stored outside shall be stored securely in covered containers and shall be removed on a regular basis.

2. Trash collection receptacles and incinerators shall be separate from outdoor recreational space and located as to avoid being a nuisance to neighbors.

3. The ARCP shall have an effective pest control program through a pest control contract.

F. Signage. The ARCP's address shall be displayed so as to be easily visible from the street.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1114 (June 2015).

§6889. Resident Dining and Common Areas

A. The ARCP shall provide common areas to allow residents the opportunity for socialization. Common areas shall not be confined to a single room.

B. The ARCP shall meet the following requirements for resident dining and common areas.

1. The common areas shall be maintained to provide a clean, safe and attractive environment for the residents.

2. Each ARCP shall have dining room and common areas easily accessible to all residents.

3. Dining rooms and common areas shall be available for use by residents at appropriate times to provide periods of social diversion and individual or group activities.

4. Common areas and dining rooms shall not be used as bedrooms.

C. Square Footage. Square footage requirements for common areas and dining room(s) are as follows.

1. Common areas shall be separate from the dining room with a combined total square footage of at least 60 square feet per resident as based on licensed capacity. Common areas do not include corridors and lobby areas for the purposes of calculation.

2. The ARCP shall have at least 20 square feet of designated dining space per resident if dining will be conducted in one seating. If dining will be conducted in two seatings, 10 square feet per resident will be required. ARCPs will document their dining seating plan, and maintain the documentation for review by the department.

D. Residents of the ARCP shall have access to the outdoors for recreational use. The parking lot shall not double as recreational space.

E. If the ARCP accepts residents that have dementia or cognitive impairments that make it unsafe for them to leave the building or grounds without supervision, an enclosed area shall be provided adjacent to the ARCP so that such residents may go outside safely.

F. With the exception of level 1 ARCPs, the ARCP shall provide public restrooms of sufficient number and location to serve residents and visitors. Public restrooms shall be located close enough to common areas to allow residents to participate comfortably in activities and social opportunities.

G. For every 40 residents, there shall be, at a minimum, one dedicated telephone available for use in common areas when a telephone line is not provided in each apartment.

1. The telephone shall allow unlimited local calling without charge.

2. Long distance calling shall be possible at the expense of the resident or the resident's representative via personal calling card, pre-paid telephone card, or similar methods.

3. The telephone shall be located away from frequently used areas so that residents shall be able to make telephone calls in an at least auditory privacy.

H. In ARCPs housing residents in more than one building, covered walkways with accessible ramps are required for buildings that house residents and areas intended for resident use, such as laundry facilities, dining rooms or common areas.

I. An ARCP shall not share common living, or dining space with another entity licensed to care for individuals on a 24-hour basis.

J. Space used for administration, sleeping, or passage shall not be considered as dining or common areas.

K. Adult Residential Care Providers in Shared Businesses

1. Physical and Programmatic Separation. If more than one business occupies the same building, premises, or physical location, the ARCP shall be both physically and programmatically distinct from the business to which it is attached or of which it is a part. ARCPs shall comply with R.S. 40:2007.

2. Entrance. If more than one business occupies the same building, premises, or physical location, the ARCP shall have its own entrance. This separate entrance shall not be accessed solely through another business or health care provider. This separate entrance shall have appropriate signage and shall be clearly identifiable as belonging to the ARCP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1115 (June 2015).

§6891. Resident Personal Space

A. Level 1 ARCP Bedroom Requirements

1. A level 1 ARCP shall ensure that each single occupancy bedroom space has a floor area of at least 100 net square feet and that each multiple occupancy bedroom space has a floor area of at least 70 net square feet for each

resident. Bathrooms and closets/wardrobes shall not be included in the calculation of square footage.

2. There shall be no more than two residents per bedroom. All shared living arrangements shall be agreed to in writing by both parties.

3. A room where access is through a bathroom or another bedroom shall not be approved or used as a resident's bedroom.

4. Privacy of residents shall be maintained in residents' personal space.

B. Level 2 ARCP Bedroom Requirements

1. A level 2 ARCP shall ensure that each single occupancy bedroom space has a floor area of at least 100 net square feet and that each multiple occupancy bedroom space has a floor area of at least 70 net square feet for each resident. Bathrooms and closets/wardrobes shall not be included in the calculation of square footage.

2. There shall be no more than two residents per bedroom. All shared living arrangements shall be agreed to in writing by both parties.

3. A room where access is through a bathroom or another bedroom shall not be approved or used as a resident's bedroom.

4. Privacy of residents shall be maintained in resident's personal space.

C. Requirements for Resident Bathrooms in Level 1 and 2 ARCPs

1. There shall be at least one bathroom for every four residents.

2. Bathrooms shall be equipped with one toilet, bathtub or shower, and a washbasin.

3. Grab bars and non-skid surfacing or strips shall be installed in all showers and bath areas.

4. Bathrooms shall have floors and walls of impermeable, cleanable, and easily sanitized materials.

5. Resident bathrooms shall not be utilized for storage or purposes other than those indicated by this Subsection.

6. Hot and cold-water faucets shall be easily identifiable and be equipped with scald control.

a. Hot water temperatures shall not exceed 120 degrees Fahrenheit.

7. Each bathroom shall be supplied with toilet paper, soap and towels.

8. Mirrors shall be provided and secured to the wall at convenient heights to allow residents to meet basic personal hygiene and grooming needs.

9. Bathrooms shall be located so that they open into the hallway, common area, or directly into the bedroom. If the bathroom opens directly into a bedroom, it shall be for the use of the occupants of that bedroom only.

D. Requirements for Resident Apartments in levels 3 and 4

1. All apartments in levels 3 and 4 shall be independent and shall contain at a minimum the following areas:

a. a bedroom/sleeping area that can be distinguished by sight from other areas in the apartment;

b. a bathroom;

c. a kitchenette that can be distinguished by sight from other areas in the apartment;

d. a dining/living area; and

e. a closet/wardrobe.

2. Square Footage in Level 3 and 4 ARCPs

a. Efficiency/studio apartments shall have a minimum of 250 net square feet of floor space, excluding bathrooms and closets and/or wardrobes.

b. Resident apartments with separate bedrooms shall be at minimum 190 square feet in living area excluding bathrooms and 100 square feet for each bedroom excluding closets and/or wardrobes.

3. Privacy of residents shall be maintained in all apartments.

4. Each apartment shall have an individual lockable entrance and exit. All apartments shall be accessible by means of a master key or similar system that is available at all times in the ARCP and for use by designated staff.

5. No apartment shall be occupied by more than two residents regardless of square footage. All shared living arrangements shall be agreed to in writing by both residents.

a. It is recognized that there may be more individuals in an ARCP due to the resident and a spouse or partner sharing a living unit than is listed as the total licensed capacity.

6. Each apartment shall contain an outside window. Skylights are not acceptable to meet this requirement.

7. In new ARCPs licensed after the effective date of these regulations, the ARCP shall provide HVAC thermostats that can be individually controlled by the resident, with a locking mechanism provided, if required, to prevent harm to a resident.

8. Each apartment shall have a call system, either wired or wireless, monitored 24 hours a day by the ARCP staff.

9. Each apartment shall be equipped for telephone and television cable or central television antenna system.

10. Each apartment shall have access to common areas and dining room(s).

11. Kitchenettes

a. For each apartment, the ARCP shall provide, at a minimum, a small refrigerator, a wall cabinet for food

storage, a small bar-type sink, and a counter with workspace and electrical outlets, a small cooking appliance, for example, a microwave or a two-burner cook top.

b. If the resident's assessment indicates that having a cooking appliance in the apartment endangers the resident, no cooking appliance shall be provided or allowed in the apartment or the cooking appliance may be disconnected.

12. Bathrooms. Each apartment shall have a separate and complete bathroom with a toilet, bathtub or shower, and sink. The bathrooms shall be ADA accessible.

a. Entrance to a bathroom from one bedroom shall not be through another bedroom.

b. Grab bars and non-skid surfacing or strips shall be installed in all showers and bath areas.

c. Bathrooms shall have floors and walls of impermeable, cleanable, and easily sanitized materials.

d. Resident bathrooms shall not be utilized for storage or purposes other than those indicated by this Subsection.

e. Hot and cold-water faucets shall be easily identifiable and be equipped with scald control.

i. Hot water temperatures shall not exceed 120 degrees Fahrenheit.

f. Each bathroom shall be equipped with an emergency call system that is monitored 24 hours a day by the ARCP staff.

13. Storage. The ARCP shall provide adequate portable or permanent closet(s) in the apartment for clothing and personal belongings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1115 (June 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1977 (October 2017).

§6893. Furnishings and Equipment

A. Common Areas

1. Furniture for shared living rooms and sitting areas shall include comfortable chairs, tables, and lamps.

2. All furnishings and equipment shall be durable, clean, and appropriate to its function. Furnishings shall be tested in accordance with the provisions of the applicable edition of the *NFPA 101 Life Safety Code*.

3. Windows shall be kept clean and in good repair and supplied with curtains, shades or drapes. Each window that can be opened shall have a screen that is clean and in good repair.

4. All fans located within seven feet of the floor shall be protected by screen guards.

5. Throw or scatter rugs, or bath rugs or mats shall have a non-skid backing.

6. Wastepaper baskets and trash containers used in the common areas shall be metal or approved washable plastic baskets.

B. Furnishings and Supplies

1. Each Facility shall strive to maintain a residential environment and encourage residents to use their own furnishings and supplies. However, if the resident does not bring their own furniture, the ARCP shall assist in planning and making arrangements for obtaining:

a. a bed, including a frame and a clean mattress and pillow;

b. basic furnishings, such as a private dresser or similar storage area for personal belongings that is readily accessible to the resident;

c. a closet, permanent or portable, to store clothing and aids to physical functioning, if any, which is readily accessible to the resident;

d. a minimum of two chairs;

e. blankets and linens appropriate in number and type for the season and the individual resident's comfort;

f. towels and washcloths; and

g. provisions for dining in the living unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1116 (June 2015).

Chapter 69. Juvenile Detention Centers

§6901. Definitions

Admitting Officer—a peace office, probation officer, and/or person designated and authorized by the court to detain children in a detention facility.

Detention—the provision of temporary care to children under physically restricting circumstances pending a court hearing, disposition or the execution of a court order.

Intake—the process by which a juvenile is admitted to detention pursuant to Section 6907 of these standards.

Jail—a secure facility designed for the care, custody and control of adult offenders.

Juvenile/Child—a person less than 17 years of age. In delinquency proceedings "juvenile/child" also means a person under 21 years of age, who committed a delinquent act before attaining the age of 17 years.

Juvenile Detention Center—a specially designed facility providing care to children under circumstances which are physically restricting.

May or Should—indicates that the rule, regulation or standard is permissive.

Parents—either parent if they are married and living together. If one parent is dead, or if the parents are divorced, legally separated, separated in fact, or unmarried, it means a parent or person having legal custody of the child. If no parent has legal or actual custody, it means the person, institution, agency, or association of persons having legal or actual custody.

Shall or Must—indicates that the rule, regulation or standard is mandatory.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6903. General Provisions

A. These licensing standards apply to all juvenile detention centers. There is an annual licensing fee based on capacity.

B. The detention administrator shall issue written policies, procedures, and directives to implement and supplement all aspects of these standards. The detention administrator shall insure that:

1. detention staff are knowledgeable of applicable provisions of these detention standards;

2. all rules for children detained are posted where accessible and/or otherwise made known to each child in an understandable manner;

3. relevant detention facility rules and information are made available to parents of children detained.

C. There shall be a written statement that describes the philosophy, goals or purposes of the facility, which is reviewed at least annually and updated if necessary.

D. There shall be a written plan that provides for continuing operations in the event of a work stoppage or other job action. Copies of this plan shall be available to all supervisory personnel, who are required to familiarize themselves with it.

E. Written policy and procedure shall provide that juveniles are not subject to discrimination based on race, national origin, color, creed, sex, or physical handicap.

F. The facility administration shall have a grievance procedure for employees which has been approved by the governing authority.

G. There shall be a written resident grievance procedure, which is made to all detained juveniles.

H. The agency operating a detention facility shall be a legal entity or part of a legal entity. If the agency is a nonprofit organization, it shall be incorporated in the governmental jurisdiction where located and in accordance with the legal requirements of that jurisdiction. If the agency is from the public sector, it shall have the authority to establish and operate a detention center.

I. Written policy and procedure shall provide for regular meetings and case conferences between the staff of probation agencies, shelter facilities, the court, the local law enforcement agency, and detention facility staff to develop and maintain sound interagency policies and procedures.

J. Policy and procedure shall provide that the facility administrator cooperate with the interstate compact administrator in the return of juveniles charged with juvenile offenses to the requesting state, pursuant to the provisions of the Interstate Compact on Juveniles.

K. Insurance coverage shall be provided for the facility which include coverage for the physical plant, equipment, and personal and property injury to employees, volunteers, residents, and third parties.

L. The legal entity administering a facility shall have a policy to protect all employees whose duties include the care, treatment or supervision of juveniles from financial loss arising out of any claim or judgment occurring as a result of alleged negligence which results in personal injury to a juvenile, provided that, the acts complained of were within the scope of employment and did not result from the willful and wanton act or gross negligence of employees.

M. The facility administration shall not have a policy which categorically excludes employment of ex-offenders.

N. The facility administrator shall be appointed by the chief executive officer or governing board of the parent agency.

O. The qualifications, authority, tenure, and responsibilities of the facility administrator shall be specified by the parent agency.

P. The term of the facility administrator shall be continuous and may be terminated only by the appointing authority for good cause and subsequent to a formal and open hearing on specific charges, if requested.

Q. In the case of death of any detained child, the facility administrator or his designated representative shall immediately notify the coroner.

R. It shall be the duty of the Department of Health and Human Resources, through its duly authorized agents, to visit and inspect, without previous notice, each center at least annually.

1. Licensing personnel may enter any facility at any time both for licensure and to investigate complaints. They shall be immediately admitted to such place upon request for such admittance and may confer with any child or employee privately and without interference.

2. Follow-up visits and inspections will be made as needed. The purpose of these visits is to determine if all rules and regulations of the department are strictly observed and followed by all persons connected with the facility.

S. No child or employee shall be punished or threatened with punishment for talking to licensing personnel.

T. After each licensing inspection an exit interview will be held by the licensing personnel with the administrator and/or other appropriate facility personnel. A written report listing deficiencies, if any, shall be mailed to the facility as soon as possible, specifying a reasonable time-frame in which the facility shall correct any deficiencies.

U. Subsequently, if the license is refused, suspended or revoked because a facility is not suitable, is not properly managed, or does not meet minimum requirements for licensure, the procedure is as follows:

1. The secretary, Department of Health and Human Resources, or his designee, by registered or certified letter, shall advise the facility administrator of the reasons for refusal, suspension, or revocation, and its rights of appeal. The facility administrator shall, in turn, immediately notify his immediate supervisor(s).

2. Within 30 days after receipt of such notice, the facility administrator may request in writing a hearing in order to appeal the decision.

3. The secretary or his designee shall set a hearing to be held within 30 days after receipt of such request. The hearing shall be held in the immediate vicinity of the center requesting appeal.

4. The secretary or his representative shall conduct the hearing. Within 10 days after the hearing, he shall advise the appellant by registered or certified letter of his decision, either confirming or reversing the original decision. If the license is refused, suspended or revoked, the facility shall be given 30 days to meet those standards delineated by the licensing agency.

5. If the facility is unable to meet the standards within this time-frame, funding received from the Department of Health and Human Resources shall be discontinued. A copy of this refusal, suspension, or revocation shall be made available to the district attorney.

6. Notwithstanding any other sections of this appeal procedure, if the secretary finds that public health, safety, or welfare requires emergency action, summary suspension of licensure and funding may be ordered pending proceedings for revocation, suspension, refusal of license, or other action. Such findings shall be in writing, shall be delivered to the facility administrator by registered mail, and may be incorporated in the original notice specified in Section 1 or in any subsequent notices or decisions rendered pursuant to this appeal procedure.

V. Nothing contained in the standards and requirements hereby fixed shall be construed to prohibit city, parish, or city and parish agency operating a local detention facility from adopting standards and requirements governing it own employees and facilities, provided such standards and requirements exceed and do not conflict with these standards and requirements. Nor shall these regulations be construed as the authority to violate any state or local fire safety standards, building standards, health and safety codes, or other applicable codes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6905. Admission Criteria

A. Only peace officers, probation officers, and/or persons designated by the court, who are specialized in juvenile training and the Code of Juvenile Procedure, should be authorized to detain children in a detention center. There should be a policy by which the facility administrator or a person designated by said administrator would refuse an admission if the admission does not meet the criteria for admission pursuant to these standards and the Code of Juvenile Procedure. An intake or admission form for each child presented for admission shall be completed and signed by the admitting officer, stating the following information:

1. date;

2. full name, address, telephone number;

3. birthdate, age;

4. race, sex;

5. father's name, address, and telephone number;

6. mother's name, address, and telephone number;

7. name, address, and telephone number of person with whom the child is living;

8. person(s) notified of detention and by whom;

9. a plain and concise statement of the facts and circumstances showing a basis for juvenile jurisdiction;

10. court of jurisdiction;

11. signature of admitting officer and agency;

12. signature of detention employee receiving child;

B. When signatures of both admitting officer and detention employee receiving the child have been affixed to the admission form, the detention center shall assume custody of the child.

C. Only children who are alleged to be delinquent or held in contempt of court in accordance with the Code of Juvenile Procedure, Article 34, Paragraph C and Article 83, Paragraph C, shall be detained in a detention center. Detention care should be used only when there is reason to believe that:

1. the child will commit injury to the persons or property of others or cause injury to himself or be subject to injury by others; or,

2. the child will run away or be taken away as to be unavailable for proceedings of the court or its officers; or,

3. the child has no parent, guardians, custodian, or other personable to provide adequate supervision or care or take him/her to further appointments with the court or law enforcement agencies.

D. No child shall be admitted if intoxicated, visibly under the influence of drugs, or shows evidence of being ill, injured, or psychotic, until examined by a physician. A written statement from the physician stating that the child can be detained without endangering himself or others shall accompany the child to the detention facility after said examination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6907. Intake Procedures

A.1. Pursuant to Article 35, Code of Juvenile Procedure, juvenile detention centers shall maintain a permanent record of certain information as to each child admitted. The record shall include:

a. the child's name and address;

b. the reason for the child's being taken into custody;

c. the date and time of child's entry into the center;

d. the name of the officer bringing the child to the center and the department of the officer.

2. The record in which such information is kept shall not be open for public inspection. Peace officers, probation officers, counsel representing the child, the district attorney, authorized officers of the court, and the Department of Health and Human Resources licensing personnel shall have access to the records. The records shall be kept in chronological order. Entries shall be made upon admission of each child.

B. At the time of admission, all money and personal property other than that which the child is allowed to keep pursuant to local policies shall be listed in writing in the presence of the child and the list shall be signed by the child and the facility admitting employee. The list shall be retained after signing and the monies and belongings shall be placed in a safe and secure place. At the time of release the belongings shall be returned and the list shall be signed as having been returned to the child by both the child and the releasing employee in the presence of the person receiving the child. All weapons and other illegal articles shall be turned over to the admitting officer and receipt of the same shall be signed by him, the child, and the detention employee receiving the child.

C. Upon admission, each child shall be given a shower and inspected by staff for bruises, lice, venereal disease, etc. A physician shall be consulted immediately if there is cause to believe the child is ill or injured. If extenuating circumstances arise, and a child cannot be showered immediately, he/she shall be kept separate from the other children until such time as a shower can be administered.

D. Upon admission, each child shall be issued clean clothing. If the policy of the family is not to provide clothing, the child's clothing shall be washed immediately and be given back to him to wear.

E. Necessary clean linen shall be issued upon admission and clean linens shall be issued at least once weekly. If the child is a bed wetter, then clean linens shall be issued at least daily.

F. Upon admission, each child shall be given a copy of the rules and regulations of the facility and appropriate staff shall discuss and answer any questions the child might have.

G. At the time of admission to the facility, juveniles shall be informed in writing of the procedures for gaining access to medical services.

H. After admission, a record shall be maintained for each child. Records shall include, but not be limited to:

1. intake form;

2. court order, if applicable;

3. height, weight;

4. color of eyes and hair;

5. religion;

6. family physician, if any;

7. prescribed medication and proper use;

8. physical defects, handicaps, or allergic reactions;

9. name of school and grade level;

10. admitting employee's observation of physical conditions of each child at admission;

11. whether the child is on probation and the name of probation officer, if applicable.

I. Upon admission, the detention personnel shall notify the parents of the detention if they have not already been notified.

J. Upon admission, each child shall be afforded the opportunity to make a telephone call to his parents/guardian or attorney, which may be local or, at his own expense, a long distance or collect call.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6909. Records

A. Each juvenile center shall maintain permanent records of all children detained pursuant to Article 35, Code of Juvenile Procedure. The record shall include:

1. the child's name and address;

2. the reason for the child's being taken into custody;

3. the date and time of the child's entry into the juvenile detention center;

4. the name of the officer bringing the child to the detention center.

B. The record shall also include:

1. the date and time of the child's release;

2. the name of the person to whom released.

C. Other written records shall be maintained regarding instances of an action taken regarding death, illness, accident, injury, discipline and control, and other records as specified in these standards.

D. The operating authority responsible for and providing the services of a detention facility may require such other records and reports as necessary.

E. Records of a detention facility shall not be open for public inspection. The records shall be available to the Department of Health and Human Resources licensing personnel.

F. All case records maintained in the facility shall be marked "Confidential" and kept in locked files which are also marked "Confidential".

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6911. Child Supervision and Care

A. Daily Routine

1. Activities for each day shall be scheduled in advance. Each day should be a structured one with specified times for work, school recreation, meals and other activities.

2. The daily schedule shall include a time for sleep which shall be no less than eight hours. Sleep schedules shall not be planned for the convenience of staff but shall meet the needs of the children.

B. Personal Hygiene

1. Every child shall be required to maintain him/herself in a clean manner and the staff of the facility shall see that all necessary and desirable supplies are available to accomplish this.

2. Children shall be required to bathe or shower daily except for medical reasons, in which case they are to "sponge" bathe. Towels, washcloths, soap, and warm water shall be provided.

3. Shampoo, deodorant, toothbrushes, toothpaste, combs, or brushes, and other personal hygiene products shall be available at all times and children shall be allowed access to these on a reasonable basis.

4. Clean underwear shall be made available daily. Clean and presentable outerwear shall be made available as needed but no less than every other day; every day is preferable.

5. Children shall be allowed to shave, under close supervision on an as-needed basis.

6. Hair shall not be cut against a child's wishes.

C. Medical and Other Services

1. A written plan to provide immediate medical and/or dental attention in case of illness or injury shall be developed and each staff member responsible for care of children shall be thoroughly familiar with it. The written plan shall include:

a. arrangements for the emergency evacuation of the residents from the facility;

b. arrangements for the use of an emergency medical vehicle;

c. arrangements for the use of one or more designated hospital emergency rooms or other appropriate health facilities;

d. arrangements for emergency on-call physician and dental services when the emergency health facility is not located in a nearby community;

e. arrangements for a report surrounding the circumstances of the emergency to be made by the staff member who was present and forwarded to the administrator who shall keep same as part of the child's record.

2. A physician licensed in the state shall be responsible for the facility's medical services pursuant to written agreement between the facility and a physician or qualified medical authority.

3. The physician shall have no restrictions imposed upon him or her by the facility administration regarding the practice of medicine.

4. Data concerning health history and vital signs shall be collected by medically trained or qualified medical personnel. Collection of all other health appraisal data shall be performed only by qualified medical personnel. Review of the results of the medical examination, tests, and identification of problems, shall be done by a physician or designated qualified medical personnel. All health appraisal data shall be recorded on the health data forms approved by the responsible physician.

5. Juveniles' medical complaints shall be monitored and responded to daily by medically trained personnel. Appropriate triage by qualified medical personnel shall follow.

6. Where sick call is not conducted by a physician, a physician shall be available at least weekly to respond to juveniles' complaints regarding service which they did or did not receive from other health personnel.

7. A medical examination by a physician or a medical assessment by a registered nurse should be provided for any child who remains in custody for longer than 72 hours.

8. In any case where there is reason to believe a detained female is pregnant, a physician shall be consulted as soon as possible and his directions followed.

9. All child care staff members shall be trained in first aid and lifesaving techniques to use in case of respiratory arrest, choking, epileptic seizures, injury or similar medical emergency. At least one such trained staff member shall be on duty at all times. Standard first aid supplies shall be kept available.

10. Staff members shall have training from the responsible physician and the official responsible for the facility and shall be accountable for administering prescribed medications on time and according to the physician's instructions. A record of the administration of medications issued shall be maintained in a manner and on a form approved by the responsible physician.

11. Children with contagious diseases should not be kept in detention unless there is no other alternative and shall not be allowed contact with other children while in the contagious stage.

12. In any case of serious injury or illness requiring the services of a physician, all reasonable efforts shall be made to notify the parents/ guardians and administrator.

13. Children experiencing difficulty because of emotional stress shall be given the same consideration for appropriate help as those suffering from physical problems and shall be afforded access to mental health counseling and crisis intervention in accordance with their needs.

14. Transportation shall be available for use in emergencies.

15. Written policy and procedure shall govern the transportation of juveniles outside the facility and from one jurisdiction to another.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6913. Food/Nutrition

A. A child shall receive no fewer than three nutritionally balanced meals in a 24 hour period; these three meals shall meet the minimum standard requirements as set by the Unites States Department of Agriculture. A consulting nutritionist should be available.

B. Regular meals shall not be withheld for any reason.

C. Children requiring special diets for health and religious reasons shall be accommodated.

D. Children shall not be forced to eat any given food item.

E. There shall be a single menu for staff and juveniles.

F. Written policy and procedures shall require that accurate records are maintained of all meals served for a period of at least three months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6915. Education

A. A program of academic instruction shall be provided by teachers certified by the Louisiana Department of Education. They should be certified in special education. Children shall be required to attend except for medical or disciplinary reasons.

B. Teachers should be employed by the local board of education but should be considered as part of the detention staff and shall be included in staff meetings and staff development programs.

C. The school day and curriculum shall be compatible with the local school system and with the child's present level of achievement.

D. The regular academic program shall be operated concurrently with the regular academic year of the local school system. Operation of the academic program on a 12 month basis is preferred.

E. A wide variety of books, learning materials, visual aids, and other educational resources of an appropriate interest and learning level shall be provided.

F. The child's own school should be notified immediately of the child's detention and shall be requested to send a summary of the child's achievement and special problems. Also, the detention teacher should report back to the school regarding the child's educational progress and related problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6917. Recreation

A. A child shall be provided at least a daily recreation hour outside unless prohibited by inclement weather or there is sufficient reason to believe the child is an escape risk. Recreation shall be provided indoors in the absence of outdoor recreation.

B. Children with physical disabilities, injuries, or ailments shall not be required to participate in recreational activities that would lead to aggravation of the particular condition.

C. Athletic equipment, games, books, arts and crafts materials, and other recreational resources appropriate to the age and interest group detained shall be provided in sufficient quantity.

D. In addition to structured daily provisions of recreation and exercise, periodic periods of rest and relaxation shall be incorporated into the day's schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6919. Religion

A. No child shall be deprived of the opportunity of religious counseling by a representative of his faith.

B. No child shall be required to attend religious services; no disciplinary action shall be taken toward a child who refuses to attend such services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6921. Work

A. Children may be required to participate in cleaning duties in areas used by them.

B. Children shall not be allowed to clean areas not used by them, to perform personal services to staff, not be used to replace employed staff.

C. Children shall be allowed to work in the area of food preparation.

D. Under no circumstances shall a child be removed from detention in order to perform work in any other area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6923. Discipline

A. Written rules of conduct prohibited within the facility and a schedule of appropriate disciplinary action to be taken for infractions shall be developed for each detention facility. They shall be made available for the detained children to read and for inspection by appropriate persons who have the responsibility for monitoring the facility. All staff members with authority to discipline the detained children shall be required to strictly adhere to these regulations.

B. Written policy and procedure shall insure that prior to privilege suspension the juvenile has the reason for the restriction explained to him/ her, and is afforded an opportunity to explain the behavior leading to suspension.

C. Each disciplinary action which results in a loss of privileges for a juvenile shall be recorded preferably in a log, and in the affected child's record. Such record shall be monitored by the administrator.

D. Corporal punishment, defined as slapping, kicking, hitting, arm twisting, hair pulling or and other act intended to cause physical pain to the child, shall not be used. Only the minimum force needed to subdue a child who is out of control shall be used.

E. Isolation, defined as removal from peer contact by sight and sound, shall be used only when other alternatives have failed, when he/she is a threat to him/herself or others, when the child continually refuses to obey reasonable rules, or upon return from escape.

1. Room confinement by staff members should be for the minimum amount of time to effect control or a change of attitude and in no case shall be for more than 24 hours including sleeping time, in a 48 hour period, and only then when severe discipline appears to be warranted. The detention home administrator may extend the isolation period in extreme circumstance.

2. If the child is in an emotional state, he/she shall be observed at least each half hour. In other instances when isolation is used, a child shall be observed at least every hour. A record of the staff member's observation shall be kept.

3. Any room used for isolation shall be lighted, safe, and comfortable with a means for outside communication in case of need.

F. Under no condition shall a child be deprived of any necessities, such as meals, sleep, bedding, medical attention, bathroom accessibility, or clothes for purposes of discipline.

G. Under no condition shall a staff member be allowed to use violent, profane, threatening, or abusive language toward a detained child.

H. No child shall have any authority over other children.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6925. Visitation

A. Under no condition shall the child's attorney, probation officer, social worker, or other involved professional be denied the right to visit the child except as prohibited by court order.

B. Each detention facility shall develop written visitation policies which allow for reasonable visiting times for parents/guardians and clergy. These shall be made available to the child and parents/guardians as soon as possible after admission.

1. Attorneys, probation officers, social workers, or other involved professionals shall not be confined to these hours, though they may be requested to visit at such times that will not interfere with meals or sleep.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6927. Correspondence

A. Under no condition shall a child be denied mail from his/her parents or guardians, attorney, social worker, or other

professional. Such incoming mail shall not be opened by any employee except in the presence of the child receiving the mail to determine the presence of contraband; nor shall the employee read such mail unless requested to do so by the child.

B. Children shall be provided writing materials and postage for purposes of correspondence to parents or guardians, attorney, probation officer, social worker, or other involved professionals, member of clergy, public officials, and jurisdictional judges. Such outgoing mail shall not be read or censored by an employee. Mail may be examined for contraband.

C. An opportunity to write letters as provided in Subsection B above, shall be provided on a reasonable basis.

D. Children should be allowed to send and receive personal correspondence from friends and relatives on a reasonable basis. This correspondence may be read by the detention administrator or his designee, but may not be withheld except for security reasons. The child shall be notified if outgoing mail is withheld and the reason. In any case, written policy and procedure shall require that incoming and outgoing mail shall not be held for more than 24 hours. Postage for personal correspondence may be provided by the detention center.

E. All cash sent to juveniles shall be retained for the juveniles and held for them in accordance with procedures of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6929. Safety

A. Children shall not have access to any sharp or dangerous instrument such a razors, knives, scissors, tools, and other instruments except as they may be used for a specific purpose. When not in use they shall be kept under lock in an area inaccessible to children.

B. Drugs and medication shall be kept under double lock and key.

C. Cleaning supplies, poisons, and any other substance that could be inhaled or ingested to the detriment of the child shall be kept in an area inaccessible to the child.

D. Every precaution shall be used to eliminate any potential hazard which may place any child or staff member in danger of injury.

E. A plan of evacuation in case of fire, flood, or other disaster shall be developed and posted. This should be done in cooperation with local agencies such as fire department and civil defense agencies. Staff members shall periodically practice evacuation drills at least quarterly.

F. As required in the Life Safety Code, Articles 10-3141 and 10-3142:

1. reliable means shall be provided to permit the prompt release of juveniles confined in locked sections, spaces, or rooms in the event of fire or other emergency;

2. prompt release from secure areas shall be guaranteed on a 24 hour basis by sufficient personnel with ready access to keys.

G. Alternative plans in case of loss of electricity shall be developed and staff members shall be made aware of these.

H. Emergency equipment shall be tested at least quarterly for effectiveness and be repaired or replaced if necessary.

I. The population using housing or living units shall not exceed the designated or rated capacity of the facility.

J. All detention facilities shall comply with appropriate health, sanitation, fire, safety and any other such codes, rules or regulations as set by the state or local governments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6931. Personnel

A. Staff Composition

1. There shall be a competent staff of administrative, supervisory, and maintenance personnel sufficient in number to provide for safety and constant supervision of all children under care.

2. All personnel in direct contact with juveniles, regardless of the nature of their jobs, should be carefully selected with regard to their emotional maturity, personal qualifications suitable for working with disturbed children and youth, and special training and skills required for the position.

3. As defined in local statutes, a criminal record check shall be conducted on all new employees to ascertain whether there are criminal acts which have a specific relationship to job performance.

4. All personnel shall be required to pass a complete physical examination conducted by a licensed physician prior to employment.

a. All applicants must be found to be physically fit to perform detention duties by a licensed physician and no person shall be hired who has a communicable disease until he is free from disease.

b. Any employee found to be suffering from a communicable disease shall be temporarily relieved from duty until he provides certification form a licensed physician that he is free from the disease.

5. Staff Child Ratio

a. During waking hours there shall be a minimum ratio of one staff person per each eight children.

b. During sleeping hours there shall be a minimum ratio of one person per each 16 children.

c. The staff included in these ratios may include paid child-care and program staff, but shall not include maintenance, janitorial, clerical, food service, laundry workers, and other similar support classifications.

6. Whenever children are detained there shall be a sufficient number of employees present, awake and on duty, for the purpose of supervising the activities of children and to insure their presence and safety.

7. A female staff member shall always be on duty when and where girls are detained and shall always accompany male staff entering girls' quarters; a male staff member shall always be on duty when and where males are detained and shall always accompany female staff entering boys' quarters.

8. Each facility shall establish a regular work week for all employees.

9. No child-care or support staff shall live in the detention facility.

10. There shall be on duty at all times an adult, who, by definition of job or delegated authority, is responsible for the administration of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6933. Qualifications of Staff

A. None of the personnel provisions in this standard shall be interpreted to disqualify any person now employed on regular basis in any juvenile detention center upon the effective date of ratification of these standards.

1. Detention Director. Any person whose full-time employment is that of administrative responsibility for daily operation of the facility:

a. this position shall be filled by a person having a minimum of a baccalaureate degree in one of the social, behavioral, or administrative sciences or a related field from an accredited college or university, and when possible, by a person with graduate training;

b. the detention director shall also have not less than three years of experience, including experience working with juveniles and/or staff supervision and administration of a detention program.

2. Assistant Director. This position shall be filled by a person having a minimum of a baccalaureate degree in one of the social, behavioral, or administrative sciences or a related field from an accredited college or university. This person shall have a minimum of two years experience working with juveniles and/or staff supervision and administration of a detention program. This position is optional.

3. Program Supervisors. All personnel whose full-time employment consists of developing, implementing, and supervising detention programs. These positions shall be filled by persons with a minimum of:

a. a high school education supplemented by a combination of three years of college and experience working with children or teenage groups; or,

b. completion of a two-year certificate or associate degree in a behavioral science from an accredited community college, or other college. This position is optional.

4. Child-Care Staff. All personnel whose full-time employment consists of providing daily programs to children: This position shall be filled by persons having a minimum of high school education and an expressed interest and ability to interact with children and youths in a positive manner.

5. All Other Staff. Should have training, experience, and competency in job role being performed plus a demonstrated interest and ability to interact with children and youths in a positive manner.

a. Job descriptions shall be provided in written form stating distinguishing features of the work, examples of the work, knowledge and skills, education and experience required.

b. Written policy shall outline experience and education substitutes for position qualifications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6935. Regulations

A. The duties, responsibilities, and authority of established positions in a detention facility shall be clearly defined in writing.

B. The facility shall comply with all governmental regulatory requirements relating to employment and personnel practices.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6937. Training

A. The agency shall provide at least 40 hours of orientation for all new direct child-care staff prior to job assignment. The orientation shall provide training which relates to the specific job function for which the employee was hired as well as relating to the needs of the children.

B. A minimum of 15 hours of continuing training shall be offered to and required of all staff each year. This training shall be job-related.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6939. Volunteers

A. Written policy and procedure shall specify the lines of authority, responsibility, and accountability for the volunteer service program, if applicable.

B. There shall be a staff member who is responsible for administering the volunteer services program.

C. Volunteers who serve in a detention center shall be carefully screened by the agency.

D. The agency administration or the parent agency shall provide against liability or tort claims in the form of insurance, signed waivers, or other legal provisions, valid in the jurisdiction in which the program is located.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6941. Physical Plant

A. Site selection for new construction of juvenile detention centers.

1. The site selected for a juvenile detention center shall meet all requirements and/or have the approval of the Department of Health and Human Resources, local zoning boards, parish and municipal governing bodies or commissions, and other responsible local bodies.

2. The site selected shall serve a geographic region combining the maximum detainable population (juvenile delinquents) with the minimal amount of travel time for courts, attorneys, law enforcement officials, and families of the detained juveniles.

3. The site shall permit ready accessibility to the juvenile courts, law enforcement, and legal services.

4. The site location shall be reasonably accessible to parents and family members by available public transportation.

5. The site location shall be reasonably accessible to emergency medical, fire, and law enforcement services.

6. The site locale shall be reasonably accessible to support services such as trash pick-up, laundry services, and food delivery.

7. A site shall be selected that is serviced by an existing road or highway from the existing transportation network.

8. A site shall be selected that will be, or is already provided power, water, telephone, and other utility services by the appropriate utility companies.

9. The site should be located so that there is a maximum travel time of 60 minutes to the detention center from a majority of the home communities of the juvenile detained.

10. The site selected should avoid a depressed area, industrial tract or general shopping section.

11. The site shall avoid proximity to a jail or adult correctional facility or contiguity to any building except the juvenile court.

12. The site shall be large enough to provide an outdoor recreation area for the maximum capacity of children.

13. The site shall be located so as to prevent juveniles from seeing or being seen by passers-by except at a remote distance.

14. The site shall permit adequate space for staff and visitor parking.

15. The site located shall take into consideration future development options. Specifically, it shall:

a. assure privacy against future encroachment by new construction on adjacent properties;

b. permit possible future expansion of detention or erection of juvenile court facilities.

16. Community involvement in site-selection should be encouraged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6943. Design

A. Design should be single-story buildings, not institutional or jail-like in appearance, and providing necessary security. All areas used by children, such as sleeping, eating and other activity areas, shall be restricted to the ground level.

B. The facility should be designed to include features of visibility and control, flexibility in use of rooms, ease of maintenance, ease of communication with children, and a bright and cheerful setting.

C. The design shall include separate specific areas for administering education, intake, storage, inside recreation, interviewing or counseling, health care, dining, cooking, visiting, showering, and sleeping.

D. The sleeping area shall not be designed as cells or dormitories.

1. A single occupancy room without wash basin and toilet shall be at least 70 square feet, finished dimensions.

2. A double occupancy room without wash basin and toilet shall be at least 80 square feet, finished dimensions.

3. A double occupancy room with wash basin and toilet shall be at least 80 square feet, finished dimensions.

4. A single occupancy room with wash basin and toilet within the room is preferred.

E. The design shall include a secure outside recreation area with appropriate recreational equipment, good visual supervision, and minimum of 1000 square feet per rated bed capacity.

1. There should be adequate paved area for basketball, volleyball and similar games, and a large grass area for softball, football, etc.

2. Facilities constructed prior to the adoption of these standards shall provide a minimum of 36,000 square feet of secure, outdoor recreation area.

F. The facility shall be so constructed as to prevent passing contraband through or over a fence or wall.

G. Facility construction shall provide for the removal of architectural barriers to physically handicapped persons.

H. Both building and grounds shall be designed to form an attractive addition to the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6945. Construction

A. All materials used in construction of detention centers shall meet the requirements of the state building code, life safety code and other applicable codes.

B. All construction materials used shall be fire-resistive.

C. The exterior walls and roof shall be reinforced concrete, masonry, or other similar hard-surface materials.

D. The interior wall in areas used by children shall be reinforced concrete, cement masonry or brick or other hard-surface material. Wall surfaces should have a hard, washable surface.

E. The floors shall consist of concrete, finished or smooth, and/or terrazzo and/or quarry tile and/or (in areas other than sleeping quarters) a durable, easily cleaned floor tile.

F. The ceiling shall consist of reinforced concrete, either finished or smooth, and/or steel or other similar hard surface materials.

G. Glass used in construction shall be heavy safety or high tempered glass, Plexiglas, or Lexan and shall be properly installed.

1. All windows in sleeping room shall be institutional security/type sash with mesh detention screens of the best obtainable quality, mounted flush with inside wall. Such screens should withstand a pressure of at least 800 pounds per square inch.

2. All windows which open should be operated by a removable crank.

H. Exterior doors shall be security-type doors and shall be keyed to both sides. The number of exits, width and location of exit doors and swing of exit doors shall be in accordance with the state building code.

I. Sleeping rooms shall have solid hardwood doors, solid wood doors securely covered with metal and attractively finished, or flush-type 14-guage hollow metal doors filled with sound-deadening insulation.

1. All sleeping room doors shall be equipped with one-quarter inch tempered or very heavy safety glass panels at least ten inches square.

2. Doors shall be hinged to a metal frame set securely in the wall with sound-insulating strips on the jamb.

3. Hinge pins of doors shall be tamperproof and non-removable.

4. Doors to sleeping rooms should be arranged alternately so that they are not across the corridor from each other.

J. Each sleeping room should be equipped with a wash basin, a toilet, and provisions for drinking water.

1. Sturdy fixtures, of a noninstitutional design, and securely fastened to floor and/or wall shall be used.

2. Tamperproof, push-button type faucets with limited flow should be used.

K. There should be no exposed plumbing, and traps and shut-off valves should be accessible behind locked doors outside the sleeping room.

L. The facility should be constructed with floor drains in all living and activity areas, and should be equipped with emergency water shut-off valves.

1. Drains should be so constructed as to reduce the problem of stoppage and permit stoppage to be pushed through without clogging.

2. All flow drains should be provided with tamperproof grills.

M. Sufficient light shall be provided by institutional-type fixtures with indestructible lenses or protective lens covers. Fixtures, switches, and conduits should be tamperproof.

1. Lighting in an individual room should be sufficient to permit easy reading by a person with normal vision.

2. All light switches for sleeping rooms should be located in the corridor next to the door of each room. Switches may be provided for central as well as individual control outside each room.

3. Night lighting shall be incorporated into the primary illuminating fixture or provided in separate installation.

N. Separate and adequate showers shall be provided for both sexes, with not less than one shower for each five children.

1. The interior should be so constructed and arranged to give maximum visual control.

2. All hot water, for showers and basins alike, shall be thermostatically controlled.

3. At least one wash basin shall be provided for each five children.

4. At least one bathtub shall be provided.

O. A minimum of one toilet for each five children shall be provided in each living unit.

P. A minimum of one toilet shall be provided in the day area that allows reasonable accessibility to youths. Separate facilities should be provided for each sex.

Q. There shall be a drinking fountain accessible to residents and staff.

R. An adequate laundry facility shall be available.

S. An adequate facility for food preparation and serving shall be available..

T. An adequate system of heating, ventilation, and air conditioning shall be provided. Component parts shall be inaccessible to children, and exposed vents shall be tamperproof. The system shall be installed with consideration for the safety and security of children and staff.

U. Educational, Dining, and Activity Areas

1. A combination activity area shall be provided to include not less than 100 square feet of inside area per rated capacity.

2. At least 30 square feet of clear space per rated capacity shall be provided in the day room on each living unit.

3. Open and unprotected glass expanses should not be included in the construction of these areas.

4. A room shall be provided for educational purposes.

V. Administrative/Professional Services Areas

1. There shall be at least one control center for admissions, discharges, day and night security, visitor control, and principal administration of the facility. The control center shall provide for visual supervision over an interview room and visiting area and shall be located within the security perimeter completely separate from juvenile living quarters.

2. Separate, secure areas shall be available for health care programs, interviewing, counseling, and visiting, although one single room may be equipped as a multipurpose room to provide two or more of the above needs.

3. The interview and visiting rooms should allow privacy, yet permit visual supervision by the staff.

W. Service and Maintenance Areas

1. Separate areas for mechanical equipment shall be provided in a location inaccessible to the children.

2. Adequate and properly located storage shall be provided for janitorial supplies, food/kitchen supplies and equipment, arts and crafts materials, office supplies, and other supplies required for the maintenance of the facility.

3. Storage space for personal clothing shall be provided.

4. A separate locked cabinet/safe for money and other valuables shall be provided.

5. A minimum allowance of 100 cubic feet of space per child shall be provided for storage.

6. All service and maintenance areas shall be provided with locking devices and shall be inaccessible to the children.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

§6947. Security

A. All areas in which detained children will be present shall be secure. The entire facility, including space not generally used by children, should be secure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51, 46:1401-1424.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987).

Chapter 72. Forensic Supervised Transitional Residential and Aftercare Facilities Licensing Standards

Subchapter A. General Provisions

§7201. Introduction

A. These rules and regulations contain the minimum licensure standards for forensic supervised transitional residential and aftercare (FSTRA) facilities, pursuant to R.S. 28:31-28:37. These licensing regulations contain core requirements as well as module specific requirements, depending upon the services provided by the forensic supervised transitional residential and aftercare facility. The modules to be licensed under a FSTRA license are:

1. secure community supervised transitional/residential facility; and

2. secure forensic facility.

B. A forensic supervised transitional residential and aftercare facility serves clients referred by state forensic hospitals or state forensic inpatient psychiatric units operated by the Department of Health, including persons who are court ordered and persons who are on court ordered

conditional release status. A FSTRA facility shall operate 7 days per week, 24 hours a day.

C. The care and services to be provided through arrangement or by the facility shall include, but are not limited to, the following:

1. behavioral health services;
2. nutritional services;
3. medication management;
4. assistance with independent living skills;
5. recreational services; and
6. transportation services.

D. Key administrative personnel shall include the administrator, physician/psychiatrist and the registered nurse supervisor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:51 (January 2017).

§7203. Definitions

Activities of Daily Living (*ADLs*)—the functions or tasks which are performed by an individual in a typical day, either independently or with supervision/assistance. Activities of daily living may include, but are not limited to, bathing, dressing, eating, grooming, walking, transferring and/or toileting.

Administrator—the person responsible for the on-site, daily implementation and supervision of the overall facility's operation commensurate with the authority conferred by the governing body.

Assistance with Activities of Daily Living—services that provide assistance with activities of daily living. Such assistance may be the actual performance of the task for the individual, or may provide hands-on assist with the performance of the tasks, or may be supervision and prompting to allow the individual to self-perform such tasks.

Behavior Management—techniques, measures, interventions and procedures applied in a systematic fashion to promote positive behavioral or functional change which fosters the client's self-control, and to prevent or interrupt a client's behavior which threatens harm to the client or others.

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

Department—the Louisiana Department of Health (LDH).

Division of Administrative Law (*DAL*)—the administrative law tribunal authorized by law to hear and decide the administrative appeals for the department.

Forensic Clients—persons transitioned from a forensic facility established pursuant to R.S. 28:25.1(A) or (B).

Forensic Psychiatrist—a physician, currently licensed to practice medicine in Louisiana, who:

1. signs the order admitting the individual to the FSTRA facility;
2. maintains overall responsibility for the client's medical management; and
3. is readily available for consultation and collaboration with the FSTRA facility staff.

Forensic Supervised Transitional Residential and Aftercare Facility—a facility that provides supervised transitional residential and aftercare services to forensic clients, including persons who are court ordered or who are on court ordered conditional release status. A forensic supervised transitional residential and aftercare facility shall provide clients, referred by state operated forensic facilities/hospitals and under court order or court ordered forensic conditional release, with individualized services to develop daily living skills and to prepare for vocational adjustment and reentry into the community.

Health Standards Section (*HSS*)—the licensing and certification section of the Louisiana Department of Health.

Instrumental Activities of Daily Living (*IADLs*)—the functions or tasks that are not necessary for fundamental functioning but assist an individual to be able to live in a community setting. These are activities such as light house-keeping, food preparation and storage, grocery shopping, laundry, reminders to take medication, scheduling medical appointments, arranging transportation to medical appointments and accompanying the client to medical appointments.

Licensee—the person, partnership, company, corporation, association, organization, professional entity or other entity to whom a license is granted by the licensing agency and upon whom rests the ultimate responsibility and authority for the conduct of and services provided by the FSTRA facility.

Non-Operational—the FSTRA facility is not open for continuous business operation 24 hours a day, 7 days per week as stated on the licensing application and business location signage.

Secure Community Supervised Transitional/Residential Facility—a secure residential facility within the community that provides individualized services to persons who are under a court order or court ordered forensic conditional release and who are referred by a state forensic hospital or state forensic psychiatric unit. These services enable such persons to develop daily living skills and to prepare for vocational adjustment and reentry into the community.

Secure Forensic Facility—a secure residential facility located on the grounds of a state owned/operated hospital that provides individualized services, including personal care services and medication administration, to persons who are under a court order or court ordered forensic conditional release and who are referred by a state forensic hospital or state forensic psychiatric unit. These services prepare such persons for transition to a less restrictive environment before transitioning to the community.

Therapeutic—process of intervention, in accordance with the treatment plan, that has the desirable effect of modifying or redirecting a client's behavior and/or emotional state in a positive or beneficial manner.

Treatment Plan—a comprehensive plan developed by the facility for each client that includes the services each client needs. It shall include the provision of medical/psychiatric, nursing and psychosocial services.

Unit—an integral, separate, segregated living space utilized only by either male, or by female clients, and who reside in that space of the licensed facility. Living spaces include the client's sleeping quarters and bathroom facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:51 (January 2017).

§7205. Licensing Requirements

A. Any person or entity applying for a FSTRA license shall meet all of the core licensing requirements contained in this Subchapter as well as module specific requirements, unless otherwise specifically noted herein.

B. All facilities providing forensic supervised transitional residential and aftercare services shall be licensed by the department. A FSTRA facility shall not be established, opened, operated, managed, maintained or conducted in this state without a license issued by the Department of Health. Each facility shall be separately licensed.

C. The Department of Health is the only licensing authority for FSTRA facilities in the state of Louisiana. It shall be unlawful to operate a FSTRA facility without possessing a current, valid license issued by the department.

D. Each FSTRA license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the facility to which it is issued and only for the specific geographic address of that facility;

3. be valid for one year from the date of issuance, unless revoked, suspended or modified prior to that date, or unless a provisional license is issued;

4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the facility;

5. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

E. In order for the FSTRA facility to be considered operational and retain licensed status, the facility shall meet the following conditions.

1. When clients are present, the facility shall provide 24 hours a day, 7 days per week supervision and the care and services sufficient to meet the needs of the clients, including but not limited to:

a. at least three direct care staff persons during the day and two awake staff during the night;

b. at least two direct care staff persons in each building and/or unit; and

c. a functional security system on all points of ingress and egress with 24-hour, 7 days per week continuous monitoring by awake staff.

2. There shall be staff employed and available to be assigned to provide care and services to each client during all operational hours consistent with the behavioral health needs of each client.

3. The facility shall have provided services to at least two clients in the preceding 12-month period in order to be eligible to renew its license.

F. The licensed FSTRA facility shall abide by and adhere to any state law, rules, policy, procedure, manual, or memorandums pertaining to such facilities.

G. A separately licensed FSTRA facility shall not use a name which is substantially the same as the name of another such facility licensed by the department, unless the facility is under common ownership with other FSTRA facilities.

H. No branches, satellite locations or offsite campuses will be authorized for a FSTRA facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:52 (January 2017).

§7207. Initial Licensing Application Process

A. An initial application for licensing as a FSTRA facility shall be obtained from the department. A completed initial license application packet for a facility shall be submitted to and approved by the department prior to an applicant providing services. An applicant shall submit a completed initial licensing packet to the department, which shall include:

1. a completed facility licensure application and the non-refundable licensing fee as established by statute;

2. a copy of the approval letter of the architectural facility plans from the Office of the State Fire Marshal and any other office/entity designated by the department to review and approve the facility's architectural plans;

3. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal;

4. a copy of the health inspection report with approval of occupancy from the Office of Public Health;

5. a copy of the statewide criminal background checks on the following persons:

a. all individual owners with a 5 percent or more ownership interest in the FSTRA facility entity;

b. facility administrators; and

c. members of the facility's board of directors, if applicable;

6. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;

i. any state agency operating a FSTRA facility, or any entity operating a facility pursuant to a cooperative endeavor agreement (CEA) with a state agency, shall be exempted from the line of credit requirement;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

7. if applicable, clinical laboratory improvement amendments (CLIA) certificate or CLIA certificate of waiver;

8. a letter-sized floor sketch or drawing of the premises to be licensed; and

9. any other documentation or information required by the department for licensure.

B. If the initial licensing packet is incomplete when submitted, the applicant will be notified of the missing information and will have 90 days from receipt of the notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a facility shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application packet has been approved by the department, notification of such approval shall be forwarded to the applicant. Within 90 days of receipt of the approval of the application, the applicant shall notify the department that the facility is ready and is requesting an initial licensing survey. If an applicant fails to notify the department within 90 days, the initial licensing application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming a licensed facility shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

D. When issued, the initial forensic supervised transitional residential and aftercare facility license shall specify the capacity of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:52 (January 2017).

§7209. Types of Licenses

A. The department shall have the authority to issue the following types of licenses.

1. Full Initial License. The department shall issue a full license to the facility when the initial licensing survey finds that the facility is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees. The license shall be valid until the expiration date shown on the license unless the license is modified, revoked, or suspended.

2. Provisional Initial License. The department shall issue a provisional initial license to the facility when the initial licensing survey finds that the facility is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the individuals receiving services. The provisional license shall be valid for a period not to exceed six months.

3. Full Renewal License. The department shall issue a full renewal license to an existing licensed facility which is in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license unless the license is modified, revoked, or suspended.

B. The department, in its sole discretion, may issue a provisional license to an existing licensed facility for a period not to exceed six months for the following reasons.

1. The existing facility has more than five deficient practices or deficiencies cited during any one survey.

2. The existing facility has more than three validated complaints in one licensed year period.

3. The existing facility has been issued a deficiency that involved placing a client at risk for serious harm or death.

4. The existing facility has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey.

5. The existing facility is not in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

C. When the department issues a provisional license to an existing licensed facility, the department shall conduct an on-site follow-up survey at the facility prior to the expiration of the provisional license, and shall issue written notice of the results of the follow-up survey.

1. If the on-site follow-up survey determines that the facility has corrected the deficient practices and has maintained compliance during the period of the provisional

license, the department may issue a full license for the remainder of the year until the anniversary date of the facility license.

2. If the on-site follow-up survey determines that the facility has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional license shall expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee, if no timely informal reconsideration or administrative appeal of the deficiencies cited is filed pursuant to this Chapter.

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

D. When the department issues a provisional license as a result of the initial licensing survey, the facility shall submit a plan of correction to the department for approval, and shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct an on-site follow-up survey at the facility prior to the expiration of the provisional license and shall issue written notice to the facility of the results of the follow-up survey.

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

2. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional license shall expire and the facility shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee and any applicable facility need review approval for licensure.

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

E. The license for a facility shall be valid for one year from the date of issuance, unless revoked, suspended or modified prior to that time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:53 (January 2017).

§7211. Licensing Surveys

A. Prior to the initial license being issued to the facility, an initial licensing survey shall be conducted on-site at the facility to assure compliance with licensing standards. The facility shall not provide services until the initial licensing survey has been performed and the facility found in compliance with the licensing standards. The initial licensing survey shall be an announced survey.

B. In the event that the initial licensing survey finds that the facility is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the facility.

C. In the event that the initial licensing survey finds that the facility is noncompliant with any licensing laws or regulations, or any other required statutes, laws, ordinances, rules or regulations, that present a potential threat to the health, safety, or welfare of clients, the department shall deny the initial license.

D. Once an initial license has been issued, the department shall conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

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

1. An acceptable plan of correction may be required from a facility for any survey where deficiencies have been cited.

2. If deficiencies have been cited, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

a. civil monetary penalties;

b. directed plans of correction;

c. license revocations; and

d. denial of license renewal.

F. LDH surveyors and staff shall be:

1. given access to all areas of the facility and all relevant files during any licensing or other survey; and

2. allowed to interview any facility staff, or client as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:54 (January 2017).

§7213. Changes in Licensee Information or Personnel

A. A facility license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any change regarding the facility name, “doing business as” name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the occurrence. Any change regarding the facility name or “doing business as” name requires a change to the facility license and the required fee for the reissuance of an amended license.

C. Any change regarding the facility's key administrative personnel shall be reported in writing to the department within five days of the change.

1. Key administrative personnel include the administrator, physician/psychiatrist and the registered nurse supervisor.

2. The facility's notice to the department shall include the individual's:

a. name;

b. facility address;

c. hire date; and

d. qualifications.

D. A change of ownership (CHOW) of the facility shall be reported in writing to the department within five days of the change of ownership.

1. The license of a facility is not transferable or assignable. The license of a facility cannot be sold.

2. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

3. A facility that is under license suspension, revocation, denial of license renewal or provisional licensure shall not undergo a CHOW.

E. Any request for a duplicate license shall be accompanied by the required fee.

F. A facility that intends to change the physical address of its geographic location is required to have plan review approval, Office of State Fire Marshall approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the facility relocation.

1. Written notice of intent to relocate shall be submitted to the licensing section of the department when plan review request is submitted to the department for approval.

2. The relocation of the facility's physical address results in a new anniversary date and the full licensing fee shall be paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:54 (January 2017).

§7215. Renewal of License

A. License Renewal Application. The facility shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. a copy of the current on-site inspection with approval for occupancy from the Office of the State Fire Marshal;

3. a copy of the current on-site inspection report with approval of occupancy from the Office of Public Health;

4. proof of financial viability, comprised of the following:

a. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000; any state agency operating a FSTRA facility, or any entity operating a FSTRA facility pursuant to a CEA with a state entity, shall be exempt from the line of credit requirement;

b. general and professional liability insurance of at least $300,000; and

c. worker's compensation insurance;

5. the license renewal fee; and

6. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit a completed license renewal application packet prior to the expiration of the current license will result in the voluntary non-renewal of the FSTRA license.

D. The renewal of a license or the denial of a renewal application does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:55 (January 2017).

§7217. Denial of License, Revocation of License, Denial of License Renewal

A. In accordance with the provisions of the Administrative Procedure Act, the department may:

1. deny an application for a license;

2. deny a license renewal; or

3. revoke a license.

B. Denial of an Initial License

1. The department shall deny an initial license when the initial licensing survey finds that the facility is noncompliant with any licensing laws or regulations or with any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety, or welfare of the clients who will be served by the facility.

2. The department may deny an initial license for any of the reasons in this Chapter that a license may be revoked or denied renewal.

C. Voluntary Non-Renewal of a License

1. If a facility fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the facility.

2. If a facility fails to timely renew its license, the facility shall immediately cease and desist providing services, unless the facility is actively treating clients, in which case the facility shall comply with the following:

a. immediately provide written notice to the department of the number of clients receiving treatment at the facility;

b. immediately provide written notice to the prescribing physician and to the client or legal representative of the following:

i. notice of voluntary non-renewal;

ii. notice of closure; and

iii. plans for orderly transition of the client(s);

c. discharge and transition of each client within 15 days of voluntary non-renewal; and

d. notify the department of the location where records will be stored and the contact person for the records.

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

D. Revocation of License or Denial of License Renewal. A facility license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the FSTRA facility licensing laws, rules and regulations or with other required statutes, laws, ordinances, rules or regulations;

2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the department, the Attorney General's office, any regulatory agency or any law enforcement agency;

3. failure to uphold clients' rights whereby deficient practices result in harm, injury, or death of a client;

4. negligent failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

5. failure to notify the proper authorities, as required by federal or state law, rules or regulations, of all suspected cases of:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

6. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, client records or facility records;

d. matters under investigation by the department or the Office of the Attorney General; or

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to department employees or to law enforcement agencies;

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

9. fraudulent operation of a facility by the owner, administrator, manager, member, officer or director;

10. an owner, officer, member, manager, administrator, director or person designated to manage or supervise client care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court. For purposes of these provisions, conviction of a felony includes a felony relating to any of the following:

a. violence, abuse, or negligence of a person;

b. misappropriation of property belonging to another person;

c. cruelty, exploitation, or sexual battery of a person with disabilities;

d. a drug offense;

e. crimes of sexual nature;

f. a firearm or deadly weapon;

g. fraud or misappropriation of federal or state funds, including Medicare or Medicaid funds;

11. failure to comply with all reporting requirements in a timely manner as required by the department;

12. failure to allow or refusal to allow the department to conduct an investigation or survey, or to interview provider staff or clients;

13. failure to allow or refusal to allow access to facility or client records by authorized departmental personnel; or

14. failure to maintain all required elements of the proof of financial viability without interruption.

E. If an existing facility has been issued a notice of license revocation or suspension and the facility's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect in any manner the license revocation.

F. If a facility license is revoked or renewal is denied, any owner, officer, member, director, manager or administrator of such facility may be prohibited from opening, managing, directing, operating or owning another FSTRA facility for a period of two years from the date of the final disposition of the revocation or denial action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:55 (January 2017).

§7219. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal

A. Notice of a license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. A facility has a right to an informal reconsideration of the license denial, license revocation or denial of license renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the facility.

1. The facility shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation or denial of license renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the facility will receive written notification of the date of the informal reconsideration.

4. The facility shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or denial of license renewal shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The facility will be notified in writing of the results of the informal reconsideration.

C. A facility has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the facility.

1. The facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the results of the informal reconsideration of the license denial, license revocation, or denial of license renewal. The facility may forego its rights to an informal reconsideration, and if so, the facility shall request the administrative appeal within 30 calendar days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law (DAL).

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL, the administrative appeal of the license revocation or denial of license renewal shall be suspensive, and the facility shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

a. If the secretary of the department determines that the violations of the facility pose an imminent or immediate threat to the health, welfare, or safety of a client, the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal. The facility shall be notified of this determination in writing.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation or denial of license renewal shall not be a basis for the administrative appeal.

D. If a timely administrative appeal has been filed by the facility on a license denial, denial of license renewal or license revocation, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

1. If the final agency decision is to reverse the license denial, the denial of license renewal or the license revocation, the facility's license will be re-instated or granted upon the payment of any licensing or other fees due

to the department and the payment of any outstanding sanctions due to the department.

2. If the final agency decision is to affirm the denial of license renewal or the license revocation, the facility shall discharge any and all clients receiving services. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where its records will be stored.

E. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional license to a new facility. A facility that has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license to an existing facility is not considered to be a denial of license, a denial of license renewal, or a license revocation.

F. A facility with a provisional initial license or an existing facility with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an informal reconsideration and the right to an administrative appeal regarding the deficiencies cited at the follow-up survey.

1. The facility has five calendar days from the receipt of the department's notice of the results of the follow-up survey to submit a written request for informal reconsideration of the follow-up survey findings.

2. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

3. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

4. The facility has 15 calendar days from the receipt of the department's notice of the results of the follow-up survey to submit a written request for an administrative appeal.

G. A facility with a provisional license that expires under the provisions of this Chapter shall cease providing services and discharge clients unless the DAL issues a stay of the expiration.

1. A stay may be granted by the DAL upon application by the provider at the time the administrative appeal is filed and only:

a. after a contradictory hearing; and

b. upon a showing that there is no potential harm to the clients being served by the facility.

H. If a timely administrative appeal has been filed by a facility with a provisional license that has expired under the provisions of this Chapter, the DAL shall conduct the hearing in accordance with the Administrative Procedure Act.

1. If the final agency decision is to remove all deficiencies, the facility's license will be reinstated upon the payment of any licensing or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final agency decision is to uphold the deficiencies and affirm the expiration of the provisional license, the facility shall discharge all clients receiving services. Within 10 days of the final agency decision, the facility shall notify the department's licensing section in writing of the secure and confidential location of where records will be stored.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:56 (January 2017).

§7221. Complaint Surveys

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

B. Complaint surveys shall be unannounced surveys.

C. A follow-up survey may be conducted for any complaint survey where deficiencies have been cited to ensure correction of the deficient practices. If the department determines that other action, such as license revocation, is appropriate, a follow-up survey may not be required. The facility will be notified of any action.

D. The department may issue appropriate sanctions, including but not limited to, civil monetary penalties, directed plans of correction, and license revocations for deficiencies and non-compliance with any complaint survey.

E. LDH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. LDH surveyors and staff shall be allowed to interview any facility staff, client, or participant, as necessary or required to conduct the survey.

F. A facility which has been cited with violations or deficiencies on a complaint survey has the right to request an informal reconsideration of the validity of the violations or deficiencies. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 10 calendar days of the facility's receipt of the notice of the violations or deficiencies.

G. A complainant shall have the right to request an informal reconsideration of the findings of the complaint survey or investigation. The written request for an informal reconsideration shall be submitted to the department's Health Standards Section. The department must receive the written request within 30 calendar days of the complainant's receipt of the results of the complaint survey or investigation.

H. An informal reconsideration for a complaint survey or investigation shall be conducted by the department as an administrative review. The facility or complainant shall submit all documentation or information for review for the informal reconsideration, and the department shall consider

all documentation or information submitted. There is no right to appear in person at the informal reconsideration of a complaint survey or investigation. The facility's correction of the violation or deficiency shall not be the basis for the reconsideration. The facility and/or the complainant shall be notified in writing of the results of the informal reconsideration.

I. Except as provided pursuant to R.S. 40:2009.13 et seq., the informal reconsideration shall constitute final action by the department regarding the complaint survey or investigation, and there shall be no right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:57 (January 2017).

§7223. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to a facility shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

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

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

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

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

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:58 (January 2017).

§7225. Cessation of Business

A. A cessation of business or closure is deemed to be effective the date on which the facility stops providing services to the community or residents.

1. Except as provided in §7227 and §7228 of this Chapter, a license shall be immediately null and void if a FSTRA ceases to operate.

B. A cessation of business is considered to be a voluntary action on the part of the facility. As such, there is no right to an informal reconsideration and no right to an administrative appeal of a cessation of business or closure.

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

D. A facility that intends to close or cease operations shall comply with the following procedures:

1. give 30 days' advance written notice to the:

a. department;

b. forensic psychiatrist; and

c. ordering court of any conditional release client(s); and

2. provide for an orderly discharge and transition of all clients admitted to the facility.

E. In addition to the 30 days' advance written notice, the facility shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

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

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

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

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

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

G. Once the facility has ceased doing business, the facility shall not provide services until the facility has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:58 (January 2017).

§7227. Temporary Inactivation of a License Due to a Declared Disaster or Emergency

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

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

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

b. the facility intends to resume operation as a FSTRA facility in the same service area;

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

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

e. provides a list of all clients and to where each client has been discharged or transferred;

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

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

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

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

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

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

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

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

2. The facility resumes operating as a FSTRA in the same service area within one year.

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

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

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:58 (January 2017).

§7228. Inactivation of License due to Non-Declared Emergency or Disaster

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

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

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

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

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

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

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

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

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

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

C. Upon the FSTRA's receipt of the department's approval of request to inactivate the FSTRA's license, the FSTRA shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility to OSFM and OPH as required.

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

1. Exception. If the FSTRA requires an extension of this timeframe due to circumstances beyond the FSTRA's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the FSTRA's active efforts to complete construction or repairs and the reasons for request for extension of the FSTRA's inactive license. Any approvals for extension are at the sole discretion of the department.

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

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

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

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

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

NOTE: The licensed bed capacity of the reinstated license shall not exceed the licensed bed capacity of the FSTRA at the time of the request to temporarily inactivate the license.

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

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

I. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the FSTRA license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:59 (January 2017).

§7229. Temporary Inactivation of Licensed FSTRA Beds Due to Major Alterations

A. A FSTRA which is undergoing major alterations to its physical plant may request a temporary inactivation of a certain number of licensed beds providing that:

1. The FSTRA submits a written request to the licensing agency of the department seeking temporary inactivation of a certain number of its licensed bed capacity. Such written request shall include the following:

a. that the FSTRA has experienced or will experience a temporary interruption in the provisions of services to its licensed bed capacity as a result of major alterations;

b. an attestation that the renovations are the sole causal factor in the request for temporary inactivation of a certain number of its licensed beds;

c. the anticipated start date of the temporary inactivation of a certain number of licensed beds;

d. the anticipated end date of the temporary inactivation of a certain number of licensed beds; and

e. the number of licensed beds requested to be inactivated temporarily;

2. the FSTRA ensures the health, safety and welfare of each client during the major alterations; and

3. the FSTRA continues to provide, and each client continues to receive, the necessary care and services to attain or maintain the client's highest practicable physical, mental, and psychosocial well-being, in accordance with each client's comprehensive assessment and plan of care.

B. Upon receiving a completed written request for temporary inactivation of a certain number of the licensed bed capacity of a FSTRA, the department shall issue a notice of temporary inactivation of a certain number of the FSTRA's licensed beds.

C. No change of ownership in the FSTRA shall occur until such FSTRA has completed the major alterations and has resumed operating at prior approved licensed bed capacity.

D. Upon completion of the major alterations and receiving a completed written request to reinstate the number of licensed beds of a FSTRA, the department may conduct a physical environment survey. If the FSTRA meets the requirements for licensure and the requirements under this Subsection, the department may issue a notice of reinstatement of the FSTRA's licensed bed capacity.

NOTE: The licensed bed capacity after major alterations are completed shall not exceed the licensed bed capacity of the FSTRA at the time of the request to temporarily inactivate a certain number of its licensed bed capacity prior to renovations.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:60 (January 2017).

Subchapter B. Administration and Organization

§7231. Governing Body

A. A FSTRA shall have an identifiable governing body with responsibility for, and authority over, the policies and activities of the program/facility.

B. A FSTRA shall have documents identifying the following information regarding the governing body:

1. names and addresses of all members;

2. terms of membership;

3. officers of the governing body; and

4. terms of office of any officers.

C. When the governing body of a FSTRA is comprised of more than one person, the governing body shall hold formal meetings at least twice a year. There shall be written minutes of all formal meetings and bylaws specifying frequency of meetings and quorum requirements.

D. When the governing body is composed of only one person, this person shall assume all responsibilities of the governing body.

E. Responsibilities of a Governing Body. The governing body of a FSTRA shall:

1. ensure the FSTRA's compliance and conformity with the facility's charter or other organizational documents;

2. ensure the FSTRA's continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;

3. ensure that the FSTRA is adequately funded and fiscally sound;

4. review and approve the FSTRA's annual budget;

5. designate a person to act as administrator and delegate sufficient authority to this person to manage the facility (a sole owner may be the administrator);

6. formulate and annually review, in consultation with the administrator, written policies concerning the FSTRA's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

7. annually evaluate the administrator's performance (if a sole owner is not acting as administrator);

8. have the authority to dismiss the administrator (if a sole owner is not acting as administrator);

9. meet with designated representatives of the department whenever required to do so;

10. inform designated representatives of the department prior to initiating any substantial changes in the services provided by the FSTRA; and

11. notify the Health Standards Section in writing at least 30 days prior to any change in ownership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:60 (January 2017).

§7233. Policy and Procedures

A. The FSTRA shall establish procedures to assure written communication among staff to ensure safety and continuity of services to all clients.

B. Direct care employees shall have access to information concerning clients that is necessary for effective performance of the employee's assigned tasks.

C. Confidentiality and Security of Files. A FSTRA shall have written procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of records and to whom records may be released.

D. The FSTRA shall allow designated representatives of the department, in the performance of their mandated duties, to inspect all aspects of the FSTRA's practices which impact clients and to interview any staff member or client relevant or as required for any survey or investigation.

1. The FSTRA shall make any information or records that the facility is required to have and any information reasonably related to assessment of compliance with these requirements available to the department.

2. The client's rights shall not be considered abridged by this requirement.

E. Procedures shall address the following.

1. Confidentiality of Records

a. The FSTRA shall maintain the confidentiality of all clients' records. Employees of the facility shall not disclose or knowingly permit the disclosure of any information concerning the client or his/her family, directly, or indirectly, to any unauthorized person.

b. The FSTRA may use material from records for teaching and research purposes, if names are deleted and other identifying information is disguised or deleted.

2. Release of Information

a. A FSTRA shall obtain the client's or legal representative's written, informed permission prior to releasing any information from which the client or his/her family might be identified, except to the department.

b. Identifying information may be given to appropriate authorities in cases of an emergency.

c. The FSTRA shall have a procedure by which representatives or family of clients is given an opportunity to receive information about the individual client in care of the facility.

3. Publicity

a. The FSTRA shall have written policies and procedures regarding the photographing and audio or audiovisual recordings of clients.

b. No client shall be photographed or recorded without the client's prior informed, written consent. Such consent cannot be made a condition for admission into, remaining in, or participating fully in the activities of the facility.

i. Consent agreements shall clearly notify the client of his/her rights under this regulation, shall specify precisely what use is to be made of the photograph or recordings, and are valid for a maximum of one year from the date of execution.

ii. Clients are free to revoke such agreements at any time, either orally or in writing.

c. All photographs and recordings shall be used in a way that respects the dignity and confidentiality of the client.

F. Personnel Policies. The FSTRA shall have written personnel policies that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members;

2. written job descriptions for each staff position including volunteers;

3. policies which provide for staff, either contracted or directly employed, to have a criminal background check, prior to offer of employment and, at least, annually thereafter. Such policy shall be defined in the facility's policy and procedures and in accordance with applicable state or federal laws;

4. policies which provide for staff, upon offer of employment, to have a health assessment, as defined in the facility's policy and procedures. Such policies shall apply for any staff, either contracted or directly employed.

a. these policies shall, at a minimum, require that the FSTRA's staff, either contracted or directly employed, have no evidence of active tuberculosis and be retested on a time schedule as mandated by the Office of Public Health. Test results dated within one year prior to the offer of employment are acceptable for initial employment;

5. policies which provide for any FSTRA staff, either contracted or directly employed, who provide transportation of clients, to have a driving history report upon hire and annually thereafter;

6. an employee grievance procedure;

7. abuse reporting procedures that require all employees to report any incidents of neglect, abuse or mistreatment whether that neglect abuse or mistreatment is done by another staff member, a family member, a client, or any other person;

a. these policies shall have, at a minimum, any reporting requirements to the facility administration, and to the department, as applicable; and

8. a written policy to prevent discrimination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:61 (January 2017).

Subchapter C. Admissions, Transfers and Discharges

§7235. Admissions

A. The facility shall have a clear and specific written description of admission policies and procedures. This written description shall include, but is not limited to the following:

1. the application process and the possible reasons for the rejection of an application;

2. types of clients suitable to the facility;

3. services offered and allowed in the facility; and

4. the facility's house rules.

B. Intake Evaluation

1. An intake evaluation shall take place on the first day of admission and shall include the client's:

a. demographic data;

b. family information; and

c. psychiatric and social background.

2. All of the facility's rules and regulations shall be reviewed with the client. A complete clothing inventory shall be completed and the client shall be assigned to a room.

C. Nursing Assessment

1. The licensed nurse shall complete a nursing assessment and review the client's medication(s). The client's medication administration records shall contain a detailed description of the client's:

a. medication;

b. dosage(s) of medication;

c. frequency medications should be taken; and

d. ability to self-administer medications.

D. Diagnostic Evaluation

1. The diagnostic evaluation shall include examination of the medical, psychosocial, social, behavioral and developmental aspects of the client's situation and reflect the need for services from a FSTRA.

2. Each medical evaluation shall include:

a. diagnoses;

b. summary of medical findings;

c. medical history;

d. mental and physical functional capacity;

e. prognosis; and

f. physician's recommendations.

E. An individualized plan of care for each client shall be developed upon admission and shall be revised to include recommended changes in the therapeutic plan. The plan to be followed in the event of emergency situations shall be specified in the plan of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:61 (January 2017).

§7237. Mandatory Transfers and Discharges

A. The administrator/director shall, in coordination with the client, forensic aftercare facility, Community Forensic Service, and state level forensic coordinator (as appropriate), assist in planning and implementing the mandatory transfer or discharge of the client when:

1. the treatment plan goals and objectives are substantially met and a crisis relapse/prevention plan is developed and support systems are in place that allow the client to reside safely in a less restrictive environment;

2. the client's physician certifies that the client's physical condition necessitates transfer to a medical facility or the client's psychiatric condition necessitates transfer to a higher level of care; or

3. the client's condition is such that he or she is:

a. a danger to self or others; or

b. is consistently disruptive to the peace and order of the facility, staff services, or other clients.

B. Emergency Discharge. The FSTRA shall immediately report to the Community Forensic Service, probation officer, state level forensic coordinator, and provider(s) of behavioral health services any program violations (i.e. illegal drugs, suspected or confirmed weapon possession or access, gross deterioration of behavior, or non-compliance with medication). The FSTRA in collaboration with the probation officer and community forensic staff, as appropriate, shall be responsible for the relocation of the client to an appropriate secure placement.

C. The facility shall initiate outpatient services for the client upon discharge and provide consultation to the client concerning where to obtain necessary medications, resources and follow-up outpatient behavioral health services.

D. Discharge Records

1. The following discharge information shall be recorded in the client's record:

a. date of discharge;

b. destination; and

c. reason(s) for leaving.

2. Discharge records shall be retained in a secured environment in accordance with the facility's policy and procedure for at least three years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:62 (January 2017).

Subchapter D. Participation Requirements

§7241. Assessment, Service Coordination, and Monitoring

A. Once the client is admitted, the facility shall conduct an assessment to determine the needs of the client. The assessment shall be kept in the client's record and shall at a minimum, include:

1. the client's interests, likes and dislikes;

2. review of physical health, psycho-social status, and cognitive status and the determination of services necessary to meet those needs;

3. a summary of the client's health needs, if any, including medication(s), treatment and special diet orders obtained from licensed professionals with responsibility for the client's physical or emotional health;

4. a written description of the activities of daily living and instrumental activities of daily living for which the client requires assistance, if any, obtained from the client or the client's physician;

5. recreational and social activities in accordance with the client's treatment plan;

6. a plan for handling special emergency evacuation needs, if any; and

7. additional information or documents pertinent to the client's treatment planning, such as guardianship papers, power of attorney, living wills, do not-resuscitate orders, or other relevant medical documents.

B. Within 30 days after admission, the facility, with input from the client, shall develop a service plan using information from the assessment.

C. The service plan shall be responsive to the client's needs and preferences. The service plan shall include:

1. the client's needs;

2. the scope, frequency, and duration of services and monitoring that will be provided to meet the client's needs;

3. staff/providers responsible for providing the services; and

4. a plan for the implementation towards the least restrictive settings.

D. The client's service plan shall be revised by the designated licensed facility staff when a client's needs or condition changes. The revised service plan shall be signed by the client and the designated facility staff.

E. The service plan shall be monitored on an ongoing basis by facility staff to determine its continued appropriateness and to identify when a client's condition or preferences have changed. A documented review of the service plan by the licensed professional staff shall be made at least every quarter. However, changes to the plan may be made at any time, as necessary.

F. All service plans and reviews shall be signed by the client and by the designated licensed facility staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:62 (January 2017).

§7243. Personal and Supportive Services

A. The facility shall provide adequate services and oversight/supervision, including adequate security measures, around the clock as needed for any client in accordance with the client's treatment plan.

B. Client Self-administration of Medications

1. The FSTRA shall have clear written policies and procedures on direct care staff assistance with client self-administration of medications.

2. The FSTRA shall assist clients in the self-administration of prescription and non-prescription medication(s) as agreed to in their contract or service plan and as allowed by applicable state statute and in accordance with the regulations of this Section.

3. Assistance with self-administration of medications shall be limited to the following.

a. The client may be reminded to take his/her medication(s) when such medications have been prescribed for a specific time of day, a specific number of times per day, specific intervals of time or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed.

b. The medication regimen, as indicated on the container, may be read to the client.

c. The dosage may be checked according to the container label.

d. The staff may open the medicine container (i.e. bottle, pill organizer, blister pak, etc.) and/or provide assistance with pouring medications if the client lacks the physical ability to open the container or pour his/her own medications and the client is cognitive of what the medication is, what the medication is for and the need for the medication.

i. Offering of liquids to a client who is familiar with his/her medications to assist that client in ingesting oral medications is allowed.

e. Assistance with self-administration of medications shall not include:

i. administering injections of any kind;

ii. administering any prescription medications including, but not limited to, eye drops, ear drops, nose drops, liquid medications, inhalers, suppositories, or enemas;

iii. prompting or reminding a resident that it is time to take a PRN, or as-needed medication;

iv. crushing or splitting medications;

v. placing medications in a feeding tube; or

vi. mixing medications with foods or liquids.

4. An employee that provides assistance with the self-administration of medications to a client shall have documented training on the policies and procedures for assistance with client self-administration of medications including the limitations of this assistance. This training shall be repeated and documented at least annually. Documentation shall include the signature of the employee initially and at least annually at time of training.

5. A competency evaluation shall be developed and conducted to ensure that each direct care staff person that assists a client with the self-administration of medications is able to demonstrate competency in the training areas pursuant to §7243.B.1-4.

a. Documentation of such competency evaluation of each direct care staff person shall be maintained and readily available in the facility's records.

6. Unlicensed employees shall not perform medication administration which is separate and apart from the

performance of assistance of a client with the self-administration of medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:63 (January 2017).

§7245. Nutrition

A. The facility shall provide three varied, palatable meals a day, seven days a week. Meals shall take into account clients' preferences and needs.

B. Menus shall be planned and written at least one week in advance and dated as served. The current week's menu shall be posted in one or more conspicuous places in the facility.

C. The facility shall provide medically prescribed diets as ordered by the client's physician. These menus shall be planned or approved by a licensed registered dietician (LRD) and shall include nourishing snacks. The LRD shall be available for consultation as needed and may be either contracted or directly employed by the facility.

D. The facility shall purchase and provide to the clients only food and drink of safe quality. The storage, preparation and serving techniques shall ensure that nutrients are retained and spoilage is prevented. Milk and milk products shall be Grade A and pasteurized.

E. Staff shall be available in the dining area to provide supervision as needed.

F. Written reports of inspections by the Department of Health, Office of Public Health, Sanitarian Services shall be kept on file in the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:63 (January 2017).

§7247. Transportation Requirements

A. The facility shall have the capacity to provide or to arrange transportation for the following:

1. transportation to behavioral health services (i.e., community mental health center or addictive disorder clinic); and

2. all other related medical appointments.

B. The facility shall:

1. have automotive liability insurance coverage and have proof of such continuous coverage for any vehicle that provides client transportation and which is owned/operated by the facility and staff, either contracted or directly employed;

2. conform to all applicable state laws and regulations pertaining to drivers, vehicles and insurance; and

3. provide for safety of clients by ensuring all transportation drivers have current driving records and current driver's licenses in good standing.

C. The number of occupants allowed in a car, bus, station wagon, van, or any other type of transportation shall not exceed the number of manufacturer's issued seat belts for passengers and the number of passengers for which the vehicle is designed.

D. Provisions shall be made to accommodate clients who use assistive devices for ambulation.

E. Each vehicle shall be maintained in safe, operating condition.

F. If the center contracts with a commercial proprietor for transportation, such shall be licensed to provide commercial transportation. All rules established for transportation furnished by the center shall be observed by the contracted commercial proprietor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:64 (January 2017).

Subchapter E. Client Protection

§7251. Client Rights

A. The facility shall have a written policy on clients' civil rights and the practices of the facility shall assure that no client of a facility shall be deprived of civil or legal rights, benefits or privileges guaranteed by law or the Constitution of the United States solely by reason of status as a client of a facility. A copy of these rights shall be posted conspicuously in the facility.

B. In addition to the basic rights enjoyed by other adults, the facility's written policy on rights shall assure that clients shall be afforded the rights enumerated in R.S. 28:171.

C. The client shall receive, upon admission and during his/her stay, a written statement of the services provided by the facility and the charges for these services.

D. The client shall be free from mental, emotional, and physical abuse and neglect and assured that no chemical restraints will be used.

E. The facility shall ensure that records and other information about the client are kept confidential and released only with a client's expressed written consent or in accordance with state law.

F. In accordance with facility policy and pursuant to R.S. 28:171, the facility shall ensure that the client:

1. receives a timely response to a request from the administrator/director and/or staff;

2. has access to private telephone communication;

3. is able to send and receive mail promptly and unopened;

4. is notified in writing by the facility when the facility's license status is suspended, revoked or limited, and to be informed of the basis of the licensing agency's action;

5. is allowed to select a health care provider and arrange for the services, at his/her own expense, which are not available through the facility as long as the client remains in compliance with the conditions of his/her admission to the facility;

6. is encouraged and assisted to exercise rights as a citizen;

7. is allowed to voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of restraint, interference, coercion, discrimination, or reprisal;

8. is fully informed of all client rights and all rules governing client conduct and responsibilities; and

9. is allowed to consult freely with counsel of their choice.

G. Each client shall be fully informed of these rights and of all rules and regulations governing client conduct and responsibilities, as evidenced by written acknowledgment, prior to or at the time of admission, and when changes occur.

1. Each client's file shall contain a copy of the written acknowledgment which shall be signed and dated by the director or his/her designee, the client and/or representative.

H. The facility shall establish and have written grievance procedures that include, but are not limited to:

1. a formal process to present grievances; and

2. a process to investigate and to respond to grievances in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:64 (January 2017).

Subchapter F. Facility Responsibilities

§7255. General Provisions

A. Facilities shall comply and show proof of compliance with all relevant standards, regulations and requirements established by state, local and municipal regulatory bodies. It is the facility's responsibility to secure the approvals from the following entities:

1. LDH, Health Standards Section;

2. Office of Public Health;

3. Office of State Fire Marshal;

4. city fire department, if applicable; and,

5. the applicable local governing authority (e.g., zoning, building department or permit office).

B. The administrator/director or person authorized to act on behalf of the administrator/director shall be accessible to facility staff or designated representatives of LDH at all times.

1. Updated electronic mail and/or telephonic contact information of key administrative personnel shall be provided to the department's Health Standards Section.

C. The facility shall have an administrative file that includes:

1. the Articles of Incorporation or certified copies thereof, if incorporated, or partnership documents, if applicable;

2. a current copy of the approved constitution and/or bylaws of the governing body;

3. a current roster of the governing body membership which includes the members' addresses;

4. written policies and procedures approved by the owner/governing body that address the following:

a. confidentiality and security of files;

b. publicity;

c. personnel;

d. client's rights;

e. grievance procedure;

f. safekeeping of personal possessions, if applicable;

g. clients' funds, if applicable;

h. emergency and evacuation procedures;

i. abuse and neglect;

j. critical incidents;

k. admissions and discharge procedures;

l. assistance with client self-administration of medication;

m. driver training, safety and responsibilities while transporting clients; and

n. policies related to client transportation; either contracted or provided by facility staff;

5. the minutes of formal governing body meetings;

6. an organizational chart of the FSTRA;

7. all leases, contracts and purchase-of-service agreements to which the FSTRA is a party, which includes all appropriate credentials;

8. insurance policies:

a. every facility shall maintain in force at all times a comprehensive general business insurance policy or policies in an amount adequate to cover all foreseeable occurrences. The insurance shall include coverage for any:

i. personal or professional negligence, malpractice or misconduct by facility owners or employees;

ii. injuries received by any client while being transported by facility staff or third-party contractors; and

iii. injuries sustained by any client while in the facility; and

9. incident/accident reports.

D. The facility shall maintain a personnel record for each employee. At a minimum, this file shall contain the following:

1. the application for employment and/or résumé of education, training, and experience;

2. evidence of a criminal history check prior to an offer of employment and annually thereafter, in accordance with state laws and regulations;

3. evidence of applicable professional credentials, licensing or certifications according to state law;

4. documentation of Tuberculosis test results and any other facility required medical examinations;

5. documentation of reference checks or employee screening in accordance with facility policy;

6. annual performance evaluation;

7. the employee's hire and termination dates;

8. documentation of orientation and annual training, including but not limited to safety and transportation of clients; and

9. documentation of a current, valid and unrestricted driver's license if driving or transporting clients.

E. The facility shall not release an employee's personnel record without the employee's written permission, except as required by state law.

F. The facility shall have a personnel record for each employee to be kept on the premises or at the corporate office. These records shall be made available and accessible to the survey staff within one hour of request by department surveyors.

1. All records shall be maintained in an accessible, standardized order and format, and shall be retained and disposed of in accordance with state laws.

2. A facility shall have sufficient space, facilities and supplies for providing effective record keeping services, either electronically or via paper documentation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:64 (January 2017).

§7257. Core Staffing Requirements

A. Each facility shall be staffed to properly safeguard the health, safety and welfare of the clients, as required by these regulations. At a minimum, the following staff positions are required; however, one person may occupy more than one position.

B. Consulting Forensic Psychiatrist

1. Each facility shall have a qualified physician, currently licensed to practice medicine in Louisiana, who:

a. signs the order admitting the individual to the facility;

b. maintains overall responsibility for the client's medical management; and

c. is readily available for consultation and collaboration with the facility staff.

2. The forensic psychiatrist may act as consultant by employment on staff, by contract, or by arrangement with state agency.

C. Administrator/Director

1. Each facility shall have a qualified administrator/director who is an on-site employee and is responsible for the day-to-day management, supervision and operation of the facility.

2. During periods of temporary absence of the administrator/director, there shall be a responsible staff person designated to be in charge that has the knowledge and responsibility to handle any situation that may occur.

3. There shall be a responsible staff person designated to be in charge on the premises of the facility 24 hours per day.

4. The administrator/director shall be at least 21 years of age and have the responsibility and authority to carry out the policies of the facility.

5. The administrator/director shall meet one of the following criteria upon date of hire:

a. possess a bachelor's degree from an accredited institution plus one year of administrative experience in the fields of health care, behavioral health services, or forensics;

b. possess an associate's degree from an accredited institution plus two years of administrative experience in the fields of health care, behavioral health services, or forensics; or

c. in lieu of a degree, possess six years of administrative experience in health care, behavioral health services, or forensics.

6. Documentation of the administrator/director's qualifications shall be maintained on file at the facility.

D. Nursing Services

1. The facility shall provide a sufficient number of nursing service personnel consisting of registered nurses, licensed practical nurses and other staff to provide nursing care to all clients in accordance with the client's treatment plan.

2. Registered Nurse (RN). The facility shall employ or contract with at least one RN who is responsible for the overall delivery and supervision of nursing services.

a. The RN shall be currently licensed by, and in good standing with, the state nursing board of Louisiana. No individual who is unlicensed may be employed, either directly or by contract, by the facility as an RN.

b. The RN shall:

i. be on-site or available by telephone during the day time hours of the facility;

ii. develop policies and procedures related to the delivery of nursing services; and

iii. provide medication management through administration, supervision, education and training.

3. Licensed Practical Nurse (LPN). The facility shall employ or contract with LPNs to meet the nursing needs of the clients.

a. The LPN shall be currently licensed by, and in good standing with, the state nursing board of Louisiana. No individual who is unlicensed may be employed, either directly or by contract, by the facility as a LPN.

b. LPNs may administer medication and deliver nursing services as provided by Louisiana law or applicable regulations.

E. Direct Care Staff

1. The facility shall ensure that an adequate number of trained direct care staff, either contracted or directly employed, is available to meet the needs of the clients in accordance with the client's scheduled and unscheduled needs.

2. Direct care staff may include care assistants, activities personnel, or other staff who provide direct care services to clients on a regular basis.

3. Direct care staff shall have the following qualifications:

a. a minimum of a high school diploma, eighteen years of age and six months of experience working with adults with a serious and persistent behavioral health diagnosis; or

b. two years of experience working with adults with a serious and persistent behavioral health diagnosis.

4. The facility shall have at least two direct care staff on site when there is at least one client at the facility.

5. The facility shall demonstrate that sufficient staff is scheduled and available (working) to meet the 24-hour scheduled and unscheduled needs of the clients. At a minimum, there shall be one direct care staff person on duty for every 15 clients.

6. The facility shall not share direct care staff with another licensed facility. (Staff cannot fill two staff positions on the same shift at different licensed facilities.)

F. The facility shall maintain a current work schedule for all employees, either contracted or directly employed, including relief workers, ensuring adequate coverage for each day and night shift.

G. Facility professional staff shall be licensed and/or certified by the appropriate state licensing or certification board(s) of Louisiana. The license and/or certification shall be current, unrestricted and in good standing.

H. Designated Recreational/Activity Staff. There shall be an individual designated to organize and oversee the recreational and social programs of the facility.

I. A facility shall provide, as needed, consultation(s) with a licensed registered dietician, either directly employed or contracted.

J. Direct Care Staff Orientation and Training

1. Prior to providing services to clients, the FSTRA shall provide a 20-hour documented orientation including, but not limited to the following:

a. the policies and procedures of the facility, including program components;

b. emergency and evacuation procedures;

c. training in proper fire and emergency safety procedures including:

i. CPR;

ii. the Heimlich maneuver;

iii. first aid;

iv. crisis management; and

v. risk reduction;

d. effective communication skills for forensic, behavioral health clients;

e. confidentiality and HIPAA requirements;

f. trainings and intervention programs as deemed appropriate and mutually agreed upon by Community Forensic Services and the state level forensic coordinator;

g. client's rights;

h. procedures and requirements regarding the reporting of abuse, neglect and critical incidents; and

i. transportation safety and responsibilities for staff that transport clients.

2. Orientation for direct care staff shall include an additional five days of supervised training. Training, at a minimum, shall include the following:

a. training in client care services (ADLs and IADLs) provided by the facility;

b. infection control to include blood borne pathogens;

c. crisis de-escalation and the management of aggressive behavior including acceptable and prohibited responses; and

d. any specialized training to meet clients' needs.

3. A new employee, either contracted or directly employed, shall not be given sole responsibility for the implementation of a client's program plan until this orientation and training is completed.

a. The new employee, either contracted or directly employed, shall sign a statement certifying that such training has occurred and this shall be maintained in the new employee's personnel file.

4. Orientation and five days of supervised training shall meet the first year's annual training requirements.

5. All direct care staff, either contracted or directly employed, shall receive certification in adult first aid and CPR within the first 30 days of employment.

a. Documentation of such certification shall be maintained in the personnel file of each direct care staff person.

K. Annual Training

1. A facility shall ensure that each direct care worker, contracted or directly employed, participates in and satisfactorily completes a minimum of 16 hours of training each year to ensure continuing competence.

NOTE: Orientation and normal supervision shall not be considered as meeting this requirement.

2. The facility shall document that direct care staff receives training on an annual basis in:

a. the facility's policies and procedures;

b. emergency and evacuation procedures;

c. client's rights;

d. the procedures and legal requirements concerning the reporting of abuse and critical incidents;

e. client care services (ADL'S & IADL'S);

f. infection control to include blood borne pathogens; and

g. any other areas that may require specialized training to meet clients' needs including but not limited to, driver safety in transporting clients.

3. All direct care staff, either contracted or directly employed, shall have documentation of current certification in adult first aid and CPR.

4. The administrator/director shall participate annually in at least 12 hours of continuing education in the field of behavioral health and specialized training in the population served and/or supervisory/management techniques.

5. Each employee shall sign a statement of understanding certifying that annual training has occurred.

L. A competency evaluation shall be developed and conducted to ensure that, at a minimum, each direct care staff person is able to demonstrate competencies in the training areas in §7257.I-J core staffing requirements.

1. Documentation of such competency evaluation of each direct care staff person shall be maintained and readily available in the agency's records.

M. An employee's annual performance evaluation shall include his/her interaction with clients, family, staff and other providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:65 (January 2017).

§7259. Client Records

A. The facility shall maintain a separate record for each client. Such records shall be current and complete and shall be maintained in the facility or in a central administrative location readily available to facility staff and to the department.

B. All records shall be maintained in an accessible, standardized order and format, either electronically and/or in paper form, and shall be retained and disposed of in accordance with state laws.

C. The facility shall have sufficient space, equipment, and supplies for providing effective record keeping services.

D. The facility shall have a secured storage area that ensures the safeguarding of all electronic or paper client records and that prevents loss from, including but not limited to, fire or water.

E. Each record shall contain at least the following information:

1. the client's identifying and personal information including:

a. the client's name;

b. date of birth;

c. sex;

d. Social Security number;

e. previous home address; and

f. marital status, if applicable;

2. dates of admission and discharge;

3. names, addresses, and telephone numbers of responsible persons to be notified in case of accident, death or other emergency;

4. name, address, and telephone number of a physician and dentist to be called in an emergency;

5. ambulatory status;

6. the client's plan/authorization for routine and emergency medical care, as required;

7. the client's written authorization for a representative and their name, address and telephone number, if applicable;

8. the pre-admission assessment by a forensic psychiatrist and admission agreement;

9. findings of the assessment and any special problems or precautions identified;

10. the service plan, updates, and quarterly reviews;

11. continuing record of any illness, injury or medical or dental care when it impacts the client's ability to function or the services he/she needs;

12. a record of all personal property and funds which the client has entrusted to the facility;

13. reports of any client complaints or grievances and the conclusion or disposition of these reports;

14. incident reports; and

15. written acknowledgments that the client has received clear verbal explanations and:

a. copies of his/her rights and the house rules;

b. written procedures for safekeeping of valuable personal possessions of clients; and

c. a written statement explaining the client's rights regarding personal funds and the right to examine his/her record.

F. All information and records obtained from or regarding clients shall be securely stored and kept confidential.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:67 (January 2017).

§7261. Abuse and Neglect

A. The facility shall have comprehensive written procedures concerning client abuse and neglect to include provisions for:

1. training and maintaining staff awareness of abuse prevention, current definitions of abuse and neglect, reporting requirements and applicable laws;

2. protecting clients from abuse inflicted by other clients, employees or third parties, including but not limited to, criminal prosecution of the offending person and his/her permanent removal from the facility;

3. ensuring that regulations stipulated in this rule for reporting any incidents involving abuse and neglect are followed;

4. ensuring that the administrator/director completes an investigation report within 10 working days; and

5. ensuring that the client is protected from potential harassment during such investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:67 (January 2017).

§7263. Critical Incidents

A. A facility shall have written procedures for the reporting and documentation of unusual incidents and other situations or circumstances affecting the health, safety or well-being of a client(s) (i.e. death by unnatural causes, injuries, fights or physical confrontations, situations requiring the use of passive physical restraints, suspected incidents of abuse or neglect). Critical incidents shall be defined by facility policy, approved by the facility's governing body and reviewed at least annually.

1. Such procedures shall ensure timely verbal reporting to the director or designee and a preliminary written report within 24 hours of the incident.

2. Copies of all critical incident reports shall be kept as part of the client's record and a separate copy shall be kept in the administrative file of the facility.

B. Incident/Accident Report. When an incident occurs, a detailed report of the incident shall be documented. At a minimum, the incident report shall provide documentation of the following:

1. the circumstances under which the incident occurred;

2. the date and time the incident occurred;

3. the location where the incident occurred (bathroom, bedroom, street, lawn, etc.);

4. immediate treatment and follow-up care;

5. the names and addresses of witnesses;

6. the date and time the family or representative was notified;

7. any symptoms of pain and injury discussed with the physician; and

8. the signatures of the staff completing the report, client, and administrator/director.

C. When an incident results in the death of a client, involves abuse or neglect of a client, or entails any serious threat to the client's health, safety or well-being, a facility shall:

1. immediately take appropriate corrective action to protect the client and to prevent further incidents;

2. report the incident verbally to the administrator within two hours of the time of the incident;

3. notify the appropriate law enforcement authority in accordance with state law, but no later than 24 hours after the time of the incident;

4. verbally notify the family or the client's representative as soon as possible but no later than two hours

after the time of the incident, with written notification to follow within 24 hours;

5. notify the Department of Health, Health Standards Section, and other appropriate authorities in accordance with state law, with written notification to the above agencies to follow within 24 hours of the time of the incident;

6. provide follow-up written reports to all of the persons and agencies identified in this §7261.C; and

7. document its compliance with all of the above procedures for each incident and shall keep such documentation (including any written reports or notifications) in the client's file. A separate copy of all such documentation shall be kept in the facility's administrative file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:68 (January 2017).

§7265. Personal Possessions

A. The facility may, at its discretion, offer to clients the service of safekeeping their valuable possessions. The facility shall have a written statement of its policy.

B. If the facility offers such a service, a copy of the written policy and procedures shall be given to a client at the time of his/her admission.

C. The facility shall give the client a receipt listing each item that it is holding in trust for the client. A copy of the receipt shall be placed in the client's record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:68 (January 2017).

§7267. Client Funds

A. The facility's admission agreement shall include the client's rights regarding personal funds and list the services offered and charges, if any.

B. The facility shall offer safekeeping and management of a client's funds. If a client chooses to entrust funds with the facility, the facility shall obtain written authorization from the client and/or his/her representative for the safekeeping and management of the funds.

C. The facility shall:

1. provide each client with an account statement on a quarterly basis with a receipt listing the amount of money the facility is holding in trust for the client;

2. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;

3. provide a list or account statement regarding personal funds upon request of the client;

4. maintain a copy of each quarterly account statement in the client's record;

5. keep the funds received from the client in a separate interest-bearing account; and

6. not commingle the clients' funds with the facility's operating account.

D. The facility shall develop, implement, and follow written policies and procedures to protect client funds.

E. Unless otherwise provided by state law, upon the death of a client, the facility shall provide the executor or administrator of the client's estate or the client's representative, as agreed upon in the admission agreement, with a complete account statement of the client's funds and personal property of the client being held by the facility.

F. A client with a personal fund account managed by an FSTRA facility may sign an account agreement acknowledging that any funds deposited into the personal account by, or on the client's behalf, are jointly owned by the client and his legal representative or next of kin. The account agreement shall state that:

1. the funds in the account shall be jointly owned with the right of survivorship;

2. the funds in the account shall be used by, for or on behalf of the client;

3. the client or the joint owner may deposit funds into the account; and

4. the client or joint owner may endorse any check, draft or other monetary instrument to the order of any joint owner, for deposit into the account.

G. If a valid account agreement has been executed by the client, upon the client's death, the facility shall transfer the funds in the client's personal fund account to the joint owner within 30 days of the client's death.

H. If a valid account agreement has not been executed, upon the client's death, the facility shall comply with the federal and state laws and regulations regarding the disbursement of funds in the account and the properties of the deceased. The facility shall abide by the procedures of the Louisiana Department of the Treasury and the Louisiana Uniform Unclaimed Property Act for the handling of funds of a deceased client that remain unclaimed.

I. The provisions of this Section shall have no effect on federal or state tax obligations or liabilities of the deceased client's estate. If there are other laws or regulations which conflict with these provisions, those laws or regulations will govern over and supersede the conflicting provisions.

J. A termination date of the account and the reason for termination shall be recorded on the client'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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:68 (January 2017).

§7269. Contraband

A. There shall be no contraband, illegal drugs, controlled dangerous substances or any medications that are not prescribed to a client, on the campus of the facility. Clients may be subjected to random periodic drug testing as a requirement for residency at the facility. A positive drug test shall be reported to the attending psychiatrist and the applicable court.

B. The facility shall have written policies defining contraband and procedures for staff to follow when contraband is discovered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:69 (January 2017).

Subchapter G. Safety and Emergency Preparedness

§7271. General Provisions

A. The facility shall have an emergency preparedness plan designed to manage the consequences of natural disasters or other emergencies that could disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the clients and/or the community it serves. The emergency preparedness plan shall be made available, upon request or if mandated to do so, to local, parish, regional and/or state emergency planning organizations, the department and the Office of the State Fire Marshal.

B. At a minimum, the emergency preparedness plan shall include:

1. identification of potential hazards that could necessitate an evacuation, including internal and external disasters such as a natural disaster, acts of bioterrorism, weapons of mass destruction, labor work stoppage or industrial or nuclear accidents;

2. emergency procedures for evacuation of the facility;

3. procedures in the case of interruption of utility services in a way that affects the health and safety of clients;

4. identification of the facility and an alternate facility to which evacuated clients would be relocated;

5. the estimated number of clients and staff that would require relocation in the event of an evacuation;

6. the system or procedure to ensure that medical charts accompany clients in the event of a client evacuation and that supplies, equipment, records and medications would be transported as part of an evacuation; and

7. the roles and responsibilities of staff members in implementing the disaster plan.

C. The facility shall conduct and document fire drills once per quarter, one drill per shift every 120 days, at varying times of the day. Each employee, either contracted or directly employed, shall participate in at least one drill annually.

D. The facility shall immediately notify the Health Standards Section and other appropriate agencies of any fire, disaster or other emergency that may present a danger to clients or require their evacuation from the facility.

E. The facility shall have access to 24-hour telephone service, and shall either post telephone numbers of emergency services, including the fire department, police department, medical services, poison control and ambulance services or show evidence of an alternate means of immediate access to these services.

F. General Safety Practices

1. The facility shall not maintain any firearm or chemical weapon in the living units of the facility.

2. The facility shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers labeled as to the contents. Such materials shall be maintained only as necessary and shall be used in a manner that ensures the safety of clients, staff and visitors.

3. The facility shall ensure that an appropriately equipped first aid kit is available in the living units and in all vehicles used to transport clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.
HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:69 (January 2017).

Subchapter H. Physical Environment

§7275. General Provisions

A. Location

1. The area to be licensed as a FSTRA facility shall meet all of the licensing regulations established for FSTRA facilities.

2. A facility that is located within any other facility shall be secure and have its own identifiable staff, space and storage. The facility shall have a separate entrance, separate dining area and separate common areas.

3. A facility that accepts both male and female clients shall not assign male and female clients to reside within the same unit of the licensed facility.

B. General Appearance and Conditions

1. Heating, cooling and ventilation systems shall permit comfortable conditions.

2. Furniture that is clean, safe and operable, where applicable, shall be available to facilitate usage by the number of clients in the facility.

3. The facility shall have sufficient space and equipment to accommodate the full range of program activities and services.

4. The facility shall be flexible and adaptable for large and small groups and individual activities and services.

5. There shall be sufficient office space to permit staff to work effectively and without interruption.

6. There shall be adequate storage space for program and operating supplies.

C. Interior Space

1. Floors and steps shall have a non-slippery surface and kept dry when in use by the clients.

2. Doorways and passageways shall be kept clear to allow free and unhindered passage.

3. The facility shall provide an appropriate controlled-egress system on all required exit doors and doors leading to other areas of the facility unless prior approval of an alternative method for prevention of client elopement from the facility has been obtained from the authority (Office of the State Fire Marshal) having jurisdiction over such matters.

4. All staff shall have a key to locked exit doors.

5. All operable windows shall be equipped with a mechanism to limit exterior openings to prevent elopement.

6. Windows used for ventilation to the outside and exterior doors used for ventilation shall be screened and in good repair.

7. The facility shall be constructed, equipped, and maintained in operating condition and kept free of hazards.

8. The facility shall have sufficient storage space for administration records, locked areas for medications, cleaning supplies (janitorial), food service (supplies) and lawn maintenance (equipment).

9. There shall be evidence of routine maintenance and cleaning programs in all areas of the facility.

10. The facility shall have an effective pest control program. Pest control services may be provided by maintenance personnel of the facility or by contract with a pest control company. If pest control chemicals are stored in the facility, they shall be kept in a locked location.

11. The facility shall have an area for the safe and secure maintenance and storage of medical records and other facility files, records and manuals.

D. Bedrooms

1. Single rooms shall contain at least 100 square feet and multi-bed rooms shall contain at least 80 square feet per bed, exclusive of fixed cabinets, fixtures, and equipment. An existing state owned or operated hospital that converts a building, unit or wing to a facility shall contain a minimum of 65 square feet per bed in a multi-bed room.

2. Any client room shall not contain more than four beds.

a. Beds shall be of solid construction, appropriate to the size and age of the client and have a clean, comfortable, non-toxic fire-retardant mattress that fits the bed.

b. Cots or other portable beds are to be used in emergencies only.

3. Rooms shall have at least a 7 1/2 foot ceiling height over the required area.

a. In a room with varying ceiling heights, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space.

4. There shall be at least three feet between beds.

5. There shall be sufficient and satisfactory separate storage space for clothing, toilet articles and other personal belongings of clients.

6. Doors to individual bedrooms shall not be equipped with locks or any other device that would prohibit the door from being opened from either side.

7. The facility shall not use any room that does not have a window as a bedroom space.

8. The facility shall provide sheets, pillows, bedspreads and blankets that are of good quality for each client. Linens that are torn or worn shall not be used.

9. Each client shall have his/her own dresser or other adequate storage space for private use and designated space for hanging clothing in proximity to the bedroom occupied by the client.

10. The facility shall not assign clients to a space that is not part of the licensed facility.

E. Bathrooms

1. The number of toilets and hand-washing facilities shall not be less than one designated, segregated male bathroom facility and one designated, segregated female bathroom facility per 13 clients.

a. Post promulgation of this rule, facilities seeking to change geographic location or new construction, and that have not received plan review approval, the number of toilets and hand-washing facilities shall be in accordance with current, applicable state laws, rules and regulations.

2. A bathroom facility shall have wash basins with hot and cold water, flush toilets, and bath or shower facilities with hot and cold water according to client care needs.

3. Bathrooms shall be so placed as to allow access without disturbing other clients during sleeping hours.

4. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene, unless clients are individually given such items.

a. Clients shall be provided individual items such as hair brushes and toothbrushes.

5. Tubs and showers shall have slip proof surfaces.

6. The facility shall have toilets and baths or showers that allow for individual privacy, unless the clients in care require assistance.

7. Toilets, wash basins and other plumbing or sanitary facilities in the facility shall, at all times, be maintained in operable condition and shall be kept free of any materials that might clog or otherwise impair their operation.

8. The facility shall have separate toilet facilities for staff.

F. Furnishings

1. The facility shall be sufficiently furnished to meet the needs of the clients. All furnishings and equipment shall be kept clean, safe and operable, where applicable.

2. Adequate furniture shall be available and shall be appropriate for use by the clients in terms of comfort and safety.

3. Furnishings shall include tables and chairs sufficient in number to serve all clients.

G. Kitchen

1. A facility that has a kitchen area shall meet all health and sanitation requirements and shall be of sufficient size to accommodate meal preparation for the proposed number of clients.

2. Kitchens used for meal preparations shall have the equipment necessary for the preparation, serving and storage and clean-up of all meals regularly served to all clients and staff. All equipment shall be maintained in proper working order.

3. The facility's refrigerator(s) shall be maintained at a temperature of 45 degrees Fahrenheit or below. Freezers shall be maintained at a temperature of 0 degrees Fahrenheit or below. Thermometers shall be provided for all refrigerators and freezers. The facility shall maintain logs of temperatures of the refrigerator and freezers. Abnormal temperatures shall be reported to management and arrangements made for repair/service. Documentation of such shall be maintained.

4. The facility shall ensure that all dishes, cups and glasses used by clients are free from chips, cracks or other defects and are in sufficient number to accommodate all clients.

5. If food is prepared in a central kitchen and delivered to the facility, provisions shall be made and approved by the Department of Health, Office of Public Health, Sanitarian Services for proper maintenance of food temperatures and a sanitary mode of transportation.

H. Medication Storage and Monitoring

1. The facility shall have policies and procedures for the storage, administration and disposal of both prescription and over-the-counter medications.

2. There shall be a designated secure area for the storage, preparation, and proper disposal of medications.

3. Medications that require refrigeration shall be stored in a separate secured refrigerator (not with food, beverages, etc.).

4. The facility shall have a process for monitoring the inventory and reconciliation of prescribed controlled substances by authorized licensed staff. The process shall include the reporting of lost or missing medications by designated licensed staff in accordance with the Louisiana State Board of Pharmacy and applicable state law.

5. Medications may be administered from a secured medication dispensing central area of the facility.

I. Laundry

1. The facility shall provide for laundry services, either on-site or at an off-site location that is adequate to meet the needs of the clients.

2. For any provision of laundry service, available on-site or contracted, the facility shall ensure and maintain procedures to prevent cross contamination of soiled laundry with clean laundry.

3. If on-site, laundry facilities shall be located in a specifically designated area and there shall be adequate rooms and spaces for sorting, processing, and storage of soiled material.

4. Laundry rooms shall not open directly into client common areas or food service areas.

5. Domestic washers and dryers that are for the exclusive use of clients may be located in client areas, provided they are installed in such a manner that they do not pose a sanitation problem or safety risk.

J. Water Supply

1. An adequate supply of water, under pressure, shall be provided at all times.

2. Clean sanitary drinking water shall be available and accessible in adequate supply at all times. Disposable cups, if used, shall be stored in such a way as to prevent contamination.

3. When a public water system is available, a connection shall be made thereto. If water from a source other than a public water supply is used, the supply shall meet the requirements set forth under the rules and regulations of the Office of Public Health (OPH).

4. The facility shall have a plan and policy for an alternative water supply in the event of interruption of water supply and for the prolonged loss of water.

K. All sewage shall be disposed of by means of either:

1. a public system where one is accessible within 300 feet; or

2. an approved sewage disposal system that is constructed and operated in conformance with the standards established for such systems by OPH.

L. Facility Exterior

1. The FSTRA shall maintain all areas of the facility that are accessible to the clients in good repair and free from any reasonably foreseeable hazard to health or safety.

2. All structures on the grounds of the facility shall be maintained in operating condition.

3. Garbage and rubbish stored outside shall be secured in noncombustible, covered containers and shall be removed on a regular basis.

4. Fences shall be in good repair and constructed in such a way as to provide safety and security.

5. Areas determined unsafe, including steep grades, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced or have natural barriers to protect clients.

6. Clients shall have access to safe, suitable outdoor recreational space.

7. The facility shall ensure that exterior areas are well lit at night.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:70 (January 2017).

Subchapter I. Secure Community Supervised Transitional/Residential Facility Module

§7279. General Provisions

A. Providers applying for the Secure Community Supervised Transitional/Residential (SCSTR) Facility module under the FSTRA facility license shall meet the core licensing requirement as well as the following module specific requirements.

B. A secure community supervised transitional/residential facility is a secure residential facility within the community that provides individualized services to develop daily living skills and to prepare for vocational adjustment and reentry into the community, to persons who are under a court-ordered forensic conditional release and who are referred by a state forensic hospital or a state forensic psychiatric unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:72 (January 2017).

§7281. Operational Requirements

A. Staff Requirements

1. When clients are present, the facility shall provide 24-hour, 7 day per week supervision and the care and services sufficient to meet the needs of the clients. Staffing shall consist of at least three direct care staff persons during the day, one of which shall be a licensed nurse and at least two awake staff during the night.

a. Requirements for the level of supervision provided and the specified time frame for day hours shall be defined by facility policy and approved by the facility governing body with documented annual review.

2. The facility shall have a licensed nurse on call when there are no licensed nurses on duty at the facility.

B. Admissions. The facility shall:

1. only accept clients referred by LDH state forensic facilities or those who are under a court-ordered forensic conditional release;

2. admit only those clients who have the ability to self-administer medications and provide for their own personal care needs;

3. admit male and female clients to reside in separate segregated and designated units of the licensed facility;

4. not admit more clients into care than the number specified on the facility's license; and

5. provide contact information, including the telephone number and mailing address, for the appropriate state protection and advocacy organization.

NOTE: the facility shall request from the HSS an increase in licensed bed capacity prior to accepting more clients than specified on the facility's license.

C. Assistance with Medication Self-Administration

1. The facility shall have clear written policies and procedures on medication self-administration.

2. The facility shall assist clients in the self-administration of prescriptions and non-prescription medication according to the client's service plan and as allowed by state laws and regulations. For assistance with self-administration, such clients shall have documented awareness of the medications to be taken.

3. Assistance with self-administration of medication shall be limited to the following:

a. the client may be reminded to take his/her medication;

b. the medication regimen, as indicated on the container, may be read to the client;

c. the dosage may be checked according to the container label;

d. staff may open the medicine container (i.e. bottle, mediset, blister pack, etc.) if the client lacks the ability to open the container; and

e. the client may be physically assisted in pouring or otherwise taking medications, so long as the client is

cognitive of what the medication is, what it is for, and the need for the medication.

4. An unlicensed employee that provides assistance with the self-administration of medications to a client shall have documented training on the policies and procedures for medication assistance including the limitations of this assistance. Documentation shall include the signature of the employee. This training shall be repeated at least annually.

a. A competency evaluation shall be developed and conducted to ensure that each direct care staff person that assists a client with the self-administration of medications is able to demonstrate competency in the training areas pursuant to §7281.C.1-4.

b. Documentation of such competency evaluation of each direct care staff person shall be maintained and readily available in the agency's records.

NOTE: Such training does not permit the unlicensed employee to perform medication administration which is separate and apart from the performance of assistance of a client with the self-administration of medications.

5. Medications shall be stored in a secure central location and not stored in the client's own room.

6. The facility may require the clients to come to a designated medication area to take their medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:72 (January 2017).

Subchapter J. Secure Forensic Facility Module

§7285. General Provisions

A. Providers applying for the secure forensic (SF) facility module under the FSTRA facility license shall meet the core licensing requirement as well as the following module specific requirements.

B. A secure forensic facility is a secure residential facility located on the grounds of a state owned or operated hospital that provides individualized services, including personal care services and medication administration, to persons who are under a court order or court ordered forensic conditional release and who are referred by a state forensic hospital or state forensic psychiatric unit, in order to prepare such persons for transition to a less restrictive environment before transitioning to the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:72 (January 2017).

§7287. Operational Requirements

A. The facility shall provide 24-hour, seven day per week supervision and the care and services sufficient to meet the needs of the clients. Staffing shall consist of at least three direct care staff persons during the day and two awake staff during the night. There shall be at least two direct care staff persons in each building and/or unit at all times when clients are present.

1. The facility shall have a RN on duty during the day shift to oversee the nursing services of the facility.

a. Requirements for the level of RN supervision provided and the specified time frame for day shift shall be defined by facility policy, approved by the governing body, reviewed and documented annually.

2. The facility shall have at least one licensed nurse on duty for each shift.

3. The facility shall provide for, either directly or through contract, a licensed medical doctor on call.

B. Admission

1. The facility shall:

a. admit clients who are under a court order or court ordered forensic conditional release and who are referred by a LDH state forensic facility;

b. not admit more clients into care than the number specified on the facility's license; and

c. provide contact information, including the phone number and mailing address, for the appropriate state protection and advocacy organization.

C. Client Services

1. The facility shall provide or coordinate, to the extent needed or desired by clients, the following services:

a. assistance provided by direct care staff, either employed or contracted, with activities of daily living and all instrumental activities of daily living;

b. medication administration by the licensed nurse;

c. opportunities for individual and group socialization;

d. services for clients who have behavior problems requiring ongoing staff support, therapeutic intervention, and supervision to ensure no danger or infringement of the rights of other clients or individuals;

e. household services essential for the health and comfort of clients (e.g. floor cleaning, dusting, bed making, etc.);

f. basic personal laundry services; and

g. a planned program of recreational activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 28:31-28:37.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:73 (January 2017).

Chapter 75. Licensing of Rural Health Clinics

Subchapter A. General Provisions

§7501. Definitions and Acronyms

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

CLIA—Clinical Laboratories Improvement Act—requires a waiver or certificate to assure quality of laboratory testing.

DHH—Louisiana Department of Health and Hospitals

Division of Research and Development—Office of Primary and Rural Health Care Unit in DHH.

HCFA—Health Care Financing Administration—federal regulatory agency for Medicaid, Medicare, and Child Health Insurance programs.

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

Midlevel Practitioner—a certified nurse midwife, a certified nurse practitioner, or physician assistant.

OMB—Office of Management and Budget of the Executive Office of the President of the United States.

OPH—Office of Public Health in the Department of Health and Hospitals.

OSFM—Louisiana Office of State Fire Marshal.

Primary Care—services normally provided in a physician's office to diagnose, treat, or prevent illness or injury; and includes professional services provided by licensed professionals such as assessment, examination, approved laboratory services, and treatment services listed in §7519.

Professional Services—documented on-site visits at the clinic or in locations other than the clinic, such as the patient's home, for the purpose of providing professional level skilled services. *Professional Services* include physical assessment, any of the waived clinical laboratory tests and treatment/education for the illness diagnosed when provided by a qualified professional as defined below.

Qualified Professionals—one of the following professionals qualified to provide services:

a. Physician—Doctor of Medicine (MD);

b. Advanced Practice Registered Nurse (APRN);

c. Licensed Physician's Assistant (PA);

d. Licensed Social Worker—Licensed Clinical Social Worker (LCSW);

e. Licensed Clinical Psychologist (LP).

Rural Area—a non-metropolitan statistical area, as defined by the federal Office of Management and Budget and the Census Bureau/Population and Housing Unit Counts, which has a shortage of physicians and other health care providers as determined by the Department of Health and Hospitals.

Rural Health Clinic (RHC)—an outpatient primary care clinic seeking or possessing certification by the Health Care Financing Administration (HCFA) as a rural health clinic, which provides diagnosis and treatment to the public by a qualified mid-level practitioner and a licensed physician.

Secretary—secretary of the Department of Health and Hospitals.

Standards of Practice—standards developed and issued by Louisiana professional practices boards that govern health care and allied health professions. Duties and delegation of duties by licensed/certified personnel shall be performed within the bounds of ethical and legal standards of practice. All patient care services must be provided in accordance with the orders of licensed and certified practitioners. Standards of practice pertinent to rural health clinic practice are listed in §7523 of this document.

Waiver or Variance—written permission granted by the HSS or DHH Secretary or his designee to a facility to operate out of compliance with a specific portion of the standards when it is determined that the health and safety of the patients will not be jeopardized.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:508 (March 2002).

§7503. Licensing

A. General Provisions. Rural Health Clinics shall:

1. operate in accordance with rules, regulations and standards contained in this document;

2. meet and maintain compliance with all current DHH minimum licensing standards;

3. maintain a sufficient number of qualified professional personnel to provide services appropriate to level of care and the number of patients served; and

4. maintain at least $500,000 of general liability insurance and $500,000 of professional liability insurance and provide to DHH proof of insurance upon request;

5. The rural health clinic license shall be posted within public view in a conspicuous place within the facility.

B. Initial Licensing

1. Policies

a. All applications shall be original documents submitted to HSS in accordance with current procedures.

b. Incomplete applications will be closed and discarded 90 days from date of original submission of data.

An application is not considered pending until the day a complete application has been received and approved.

c. Any misrepresentation or falsification of documentation will nullify the application and automatically restrict the applicant from participation in any programs licensed by HSS for at least one year.

d. Fees or payments for charges submitted to HSS shall be in the form of a company check, certified check or money order made payable to DHH and are non-refundable and non-transferable.

2. Procedures

a. Obtain a packet from HSS (packet is informational and current for approximately 90 days from date of purchase).

b. Complete and submit an original rural health clinic licensing application.

c. Submit the appropriate licensing fee.

d. Submit the following documentation:

i. all documentation pertinent to the proposed location from the Division of Research and Development, Office of Primary and Rural Health Care Unit and dated within 30 days prior to application;

ii. written approval of site/building plans by DHH planning review section;

iii. required jurisdictional approvalsXlocal, state, and federal such as zoning, Fire Marshal, and sanitation;

iv. letter of intent which shall include:

(a). proposed operational hours;

(b). proposed target population including clinic location, service area, and pertinent demographics;

(c). copy of site plan and sketch of the floor plan of the building;

(d). proposed date to begin operation;

(e). services to be provided;

(f). relationships and/or agreements with other entities (hospitals, emergency transportation, etc.);

(g). other licenses, contracts with state, such as Community Care, Kid Med, managed care, etc.;

v. appropriate CLIA approval prior to any initial survey.

3. Survey. Prior to issuing an initial license, DHH/HSS will make a comprehensive on-site assessment to determine the capability of the facility to provide primary care services. A facility shall be operational prior to survey and must have seen at least five patients at the time of survey.

C. Types of License

1. Full, Unrestricted. This license type indicates that the facility is in full compliance with licensing standards, and is valid for one year unless revoked, suspended, or denied. The license is non-transferable.

2. Provisional. This license type is issued for a specific length of time in order to designate that the facility is not in full compliance with licensing standards. A provisional license may be issued for the following reasons:

a. any repeat violation;

b. serious violation during any survey or on-site visit;

c. isolated incidence of non-compliance that has the potential for serious harm if not corrected immediately; or

d. determination that the facility has potential for serious violation or potential harm due to personnel turnovers, ownership changes, management changes, etc.

D. Informal Dispute Resolution. Following each survey, the provider will have one opportunity to question citations of deficient practice through an informal dispute resolution process. Notice is sent with each statement of deficiencies and provides instructions on how to request the informal dispute resolution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:508 (March 2002).

§7505. Denial, Revocation, or Non-Renewal of License

A. The Secretary of DHH may deny an application for a license, refuse to renew a license or revoke a license when an investigation reveals that the applicant or licensee is not in conformance with or in violation of the provisions of R.S. 40:2197, provided that in all such cases, the Secretary shall furnish the applicant or licensee 30 calendar days written notice specifying the reasons for the action.

B. A rural health clinic license may be denied, revoked, or non-renewed for any of, but not limited to, the following reasons:

1. failure to meet any of the minimum standards, rules and regulations as prescribed under R.S. 40:2197;

2. conviction of a felony, as shown by a certified copy of the applicant's record of the court of conviction, or if the applicant is a firm or corporation, on any of its members or officers, or of the person designated to manage or supervise the facility; or if the supervisor of the facility is not reputable; or if the staff or a member of the staff is temperamentally or otherwise unsuited for the care of the patients in the facility. For the purposes of this Paragraph, *conviction of a felony* means and includes:

a. conviction of a criminal offense related to that person's involvement in any program under Medicare or Medicaid, since the inception of those programs;

b. conviction of a felony relating to violence, abuse and/or neglect of a person;

c. conviction of a felony related to the misappropriation of property belonging to another person;

3. failure to comply with all federal, state and local laws;

4. failure of the facility to protect patients/persons in the community from harmful actions of the clinic employees, including but not limited to:

a. health;

b. safety;

c. coercion;

d. threat;

e. intimidation;

f. solicitation; and

g. harassment;

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

6. failure to employ qualified personnel;

7. failure to remain fully operational at all times for any reason other than a disaster;

8. failure to submit fees, including but not limited to, annual renewal fee at least 30 days prior to the license expiration date;

9. failure to allow entry to the rural health clinic or access to any requested records during any state or federal survey;

10. cruelty to patients.

C. Any involuntary termination, failure to renew, or voluntary termination of the facility's license to avoid adverse action will automatically prevent the facility, the facility owners, professional staff, administrative staff, family members and others as appropriate from applying for a RHC license, or from owning or working with a rural health clinic, for at least one year. Persons who own 5 percent or more of a facility are considered owners.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:508 (March 2002).

§7507. Changes/Reporting

A. Data Submission. Information requests will be sent to the clinic by various offices of DHH or its contractors. All requests must be answered promptly and must be current at time of renewal or license will not be issued.

1. Each facility shall notify DHH/HSS if facility contracts to provide services under another program such as Community Care, Kid Med, managed care, etc.

2. Failure to return requested information shall result in adverse action including, but not limited to, sanctions, and/or revocation of license.

B. Notifications. The rural health clinic must notify HSS at least fifteen days prior to any operational changes. A license is non-transferable; therefore, invalid for any other location or owner except as originally issued. Any break in the operation of the facility will invalidate the license.

1. Change of Ownership. The following information must be submitted:

a. certified copy of bill of sale;

b. application reflecting changes; and

c. letter of intent, narrative explanation of changes.

2. Change of Address(Location). Submit the following information:

a. same zip code:

i. letter for approval by DHH/HSS;

ii. fire marshal's approval;

iii. fee to re-issue license; and

iv. copy of current license;

b. different zip code-site approval letter in addition to above requirements.

3. Change in Services. The following information must be submitted:

a. letter to file listing current services; additional/deleted services;

b. copy of license;

c. professional and management staffing changes; and

d. use of a contract mid-level practitioner instead of the employee for any period of time greater than 30 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:509 (March 2002).

§7509. Annual Licensing Renewal

A. Department of Health and Hospital Responsibilities. It is the responsibility of DHH to:

1. send a letter of notification of license renewal to the facility approximately 45 days prior to expiration of the license;

2. conduct an annual survey to assure that the facility provides quality care and adheres to licensing requirements; and

3. make a determination and take appropriate action regarding licensing.

B. Rural Health Clinic Responsibilities. It is the responsibility of the RHC to:

1. notify DHH if the renewal letter is not received in a timely manner;

2. complete the licensing application and obtain and submit other required data; and

3. submit the appropriate license fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:509 (March 2002).

§7511. Notice and Appeal Procedures

A. Administrative Appeal. In accordance with the Administrative Procedure Act, the facility may request an administrative appeal when notice is received of denial of initial license, denial of a license renewal or revocation of the license. The request for the administrative appeal must be submitted in writing to the Department of Health and Hospitals, Office of the Secretary, within 30 days of receipt of the notice of the adverse action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:509 (March 2002).

§7513. Complaint Procedures

A. All complaints and appeals from complaints will be investigated by the HSS in accordance with Louisiana R.S. 40:2009.13 et. seq.

B. Deficiencies or violations noted during complaint investigations may result in adverse actions, sanctions, terminations, and/or require immediate or routine corrective action as determined by DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2197.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1848 (October 1999).

§7515. Voluntary Cessation of Business

A. Cessation of Business. If at any time the facility ceases to operate (regardless of length of time), the license shall be deemed invalid and shall be returned to DHH/HSS within five working days.

1. The agency owner is responsible for notifying DHH of the location of all records required to be maintained by the facility.

2. If the facility fails to surrender its license, the facility and its owners and administrative officers may be prohibited from operating for at least one year as a rural health clinic.

B. Expiration of License. Failure to renew a license prior to its expiration date shall result in non-renewal of the license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:509 (March 2002).

§7517. Personnel Qualifications/Responsibilities

A. Responsibility. The administration is responsible for assuring that:

1. all staff members are aware of their job responsibilities and are capable of performing assigned tasks;

2. a facility's staffing is adequate to produce the desired treatment outcomes and must reflect the volume of the patients, patient acuity, and number of services provided;

3. a facility develop and utilize a specific process to determine appropriate staffing levels.

B. Qualification. All personnel shall be licensed in accordance with their respective professions and be either board certified or board eligible as required by their respective certifying organizations. In addition, a facility shall be responsible for verifying and monitoring that professional certified personnel maintain continuous license/certification.

1. Physician Services. The physician shall provide on-site supervision of the mid-level practitioner(s) as required by the payment source and professional boards or at least every other week. All rural health clinic records and care provided by a mid-level practitioner(s) shall be assessed by a physician on a periodic basis or as the situation dictates to assure proper treatment and progress toward positive patient outcomes.

a. Medical Director. The medical director shall be credentialed to provide primary care. He/she is responsible for providing the medical direction for the clinic's activities, consultation for and supervision of the mid-level practitioner. The Medical Director, in conjunction with the mid-level practitioner, participates in the development and periodic review of the clinic's policies and services. He/She periodically reviews the patient records, issues medical orders and provides medical care services to the rural health clinic patients.

b. Other. Licensed physician credentialed to provide services provided as part of the rural health clinic services.

2. Mid-level Practitioner. The mid-level practitioner shall be appropriately licensed and credentialed as either an advanced practice registered nurse (family nurse practitioner) or physician's assistant. The mid-level practitioner(s) shall be required to maintain Advanced Cardiac Life Support (ACLS) certification to assure his/her proficiency in accepted standards of emergency care. If a facility has a current written agreement with an advanced life support provider, who can provide care within 10

minutes, then the mid-level practitioner and/or physician are exempt from this required certification.

a. Waivers will not be accepted for a mid-level practitioner.

b. Mid-level practitioners may be contracted to fulfill staffing requirements for 120 days each calendar year (January 1-December 31) with no accrual of days from year to year.

3. Support Staff. The facility should be adequately staffed to provide necessary support to the professionals. Additional staff may include pharmacists, administrators, managers, and clerical and medical records personnel.

C. Governing Body. All owners of a Rural Health Clinic shall be disclosed. Ownership of five percent or more constitutes ownership. In the case of a corporation, members of the board of directors must be identified and minutes of the board meetings shall be made available to DHH/HSS. The board shall meet at least once a year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:509 (March 2002).

§7519. Services

A. Preventive Services

1. Health. Community-wide immunization efforts; wellness/fitness programs; educational programs; and health screening shall be provided.

2. Dental. Educational information and a current list of local dental providers shall be available.

B. Diagnostic Services. The clinic must have the capacity to evaluate and make initial diagnoses on-site in order to refer the patient to the appropriate facility for treatment and/or more definitive diagnoses. RHCs shall, as a minimum, provide basic laboratory services essential to the immediate diagnosis and treatment of the patient. This includes:

1. chemical examinations of urine by stick or tablet method, or both (including urine ketones);

2. hemoglobin or hematocrit;

3. blood glucose;

4. examination of stool specimens for occult blood;

5. pregnancy tests; and

6. primary culturing for transmittal to a certified laboratory.

C. Treatment Services

1. Primary Care. The clinic shall provide primary care services, as defined in §7501 to all citizens of the community. Required primary care components include:

a. prevention of illness, education in wellness and preventive measures;

b. assessment and physical examination; and

c. diagnosis and treatment.

2. Emergency Care. The clinic shall maintain emergency equipment, medications and personnel to provide pre-hospital advanced cardiac life support until emergency transportation can arrive and assume care of those in need of services.

a. Facilities within ten minutes of Advanced Life Support (ALS) services may opt to have written agreement with a provider to provide services in lieu of certain equipment such as defibrillators and monitors, but must have equipment required for Basic Life Support.

b. All facilities shall have written agreement with emergency transportation provider to transport to the nearest hospital.

3. Contracted Treatment Services. Written agreements with full-service hospitals and credentialed practitioner(s) for specialty care must be current, clearly written, and reviewed annually. The facility retains responsibility for all medical care provided until the patient is referred to or admitted into another facility. Agreements must be signed and dated by all parties.

D. Miscellaneous Services

1. Family Services. The Rural Health Clinic shall maintain a current list of local/nearest support organizations and assist (whenever necessary) with accessing those entities. Examples of services that may be listed by the clinic shall include such organizations as the Public Health Unit, Office of Family Support, school clinics, hospices agencies, home health agencies, American Cancer Society, and services for substance abuse and mental illness.

2. Coordination of services for complex cases is the responsibility of the RHC professional staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:509 (March 2002).

§7521. Agency Operations

A. Municipals. A facility shall function as a community resource for all citizens of the service area and shall promote improvement of the health of the entire community by providing educational opportunities where feasible, resource lists for referrals, assistance with accessing other resources, wellness programs, and participation in community efforts to promote health and safety. A facility shall demonstrate the following.

1. Telemedicine Capacity/Resource. Computer access is recommended.

2. Emergency Preparedness. A facility shall:

a. maintain a disaster plan appropriate to region and community;

b. have facility protocols for medical and non-medical emergencies;

c. maintain emergency supplies to provide basic emergency care in the case of a disaster in the community; and

d. participate in the development of local community disaster plan.

B. Agreements. Written agreements shall be clearly worded, dated, reviewed and signed by all parties. All agreements shall be updated as needed to reflect any changes in relationships, provision of services, or other pertinent information.

C. Operation Hours. A facility shall provide:

1. primary care services at least 36 hours per week. For rural health clinics located in parishes designated as priority access, mobile units and RHC's with low caseloads, the Department may waive such requirement if:

a. the RHC demonstrates to the satisfaction of the Health Standards Section of DHH that by providing primary care services less than 36 hours per week, patients are not denied access to care;

b. the Department determines that a waiver of the requirement will not endanger the health or safety of patients needing RHC services; and

c. a waiver granted by the Department is subject to annual review;

2. on-call qualified professional assistance for 24 hours per day, seven days per week;

3. appropriately qualified professional staff on duty during all hours of operation. Failure to do so will result in immediate adverse action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:510 (March 2002).

§7523. Procedural Standards

A. The following processes are required for rural health clinics in Louisiana:

1. Access to Care. Rural health clinics shall:

a. be in compliance with R.S. 40:2007 if the RHC is located within another health care provider;

b. be located away from metropolitan areas;

c. provide services to all citizens of the community across all life cycles;

d. provide service delivery to accommodate the majority of residents of the community; and

e. provide professional coverage as required by §7517 and §7519.C.

2. Patient Assessment. Documentation of an assessment shall include:

a. comprehensive scope of information with updates as indicated by changes in the patient's status;

b. physical examination and medical history, that identifies the patient's condition and care needs, and an estimate of his/her continuing care needs;

c. indicators that identify the need for further assessment/treatment such as the signs/symptoms of substance abuse, which requires a substance abuse assessment be included as part of the mental status evaluation; and

d. pertinent and comprehensive information relative to the reason for the encounter.

3. Care Planning. The plan of care shall be based upon the needs documented in the assessment and may be generic if original assessment and physical examination indicates the patient is generally healthy. The plan of care shall be modified to reflect any changes in the patient's condition.

4. Continuity of Care. The clinic staff shall:

a. provide orderly and efficient transition between levels of care without duplication or disruption of services;

b. provide post-hospitalization care based on the hospital's discharge assessment, possibly a Uniform Needs Assessment Instrument (UNAI), but includes at least a description of the patient's functional status, nursing and/or other care requirements, and the availability of family/care givers;

c. update comprehensive care plan as indicated and provide clinic services as indicated in the plan of care;

d. coordinate care and treatment interventions by all relevant disciplines;

e. evaluate progress and adjust actual care as needed to achieve progress.

5. Infection Control. A facility shall maintain a written and dated effective infection control program that protects the patients and staff from infections and communicable diseases.

6. Information Management. A facility shall maintain a record keeping system to communicate and measure clinic performance to assure that patient needs are documented and met. This system shall include accurate documentation of a patient visit for quality assessment and performance improvement purposes. The facility shall ensure the integrity, effectiveness, confidentiality, and security of the facility's data system.

7. Clinical Protocols. Written clinical protocols shall be established between mid-level practitioner(s) and the physician and the treatment(s) of choice shall be easy to identify.

8. The facility must have a grievance process and must indicate who the patient can contact to express a grievance. Records of all grievances, steps taken to investigate, and results of interventions must be available to surveyors upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1846 (October 1999), amended LR 28:510 (March 2002).

§7525. Record Keeping

A. Medical Records

1. Identifying Information. The patient identification information such as name or ID number must appear on each page.

2. Entry Identification. Entries must be dated, signed, and credentials identified (MD, RN, etc.).

3. Contents. Each patient record must contain the following:

a. personal/biographical data including full name, age, sex, address, employer, home and work telephone numbers, and marital status;

b. next of kin or contact person;

c. pertinent medical history/information.

4. Storage. All medical records shall be protected from theft, fire, and unauthorized use. Open shelving may be utilized only when the patients/visitors do not have access to the storage area. Closed records must be maintained by the facility or its designee in accordance with the following:

a. a minimum of seven years from the date of last entry. After two years, records may be maintained electronically;

b. until the age of majority, plus seven years in the case of children or adolescents.

B. Facility Records. A facility must maintain records of credentials and other evidence that facility is in compliance with current standards of practice and licensing standards as listed below:

1. personnel records;

2. advisory board meeting minutes;

3. policies/procedures with annual approvals;

4. governing board meeting minutes; and

5. proof of hours worked for professional employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1850 (October 1999).

§7529. Quality Assurance

A. Definitions

Scope of Care/Services—a facility shall delineate their scope of practice to include:

a. the range of services provided, including conditions prevented, managed, or treated;

b. treatments and/or procedures provided;

c. patient populations served;

d. hours when care or services are provided; and,

e. types of professional disciplines and/or specialists providing services.

Evaluation—the review and assessment of the quality and appropriateness is an important aspect of care. The review and assessment is designed to identify problems and develop procedures to prevent and resolve the problems.

Important Aspects of Care—clinical activities that involve a high volume of patients, that entail a high degree of risk for patients, or that tend to produce problems for staff or the patients are deemed most important for purposes of monitoring and evaluation.

Monitoring—a process of surveillance, and/or auditing to identify systemic or localized problem area(s) where improvement may be indicated.

Performance Indicators—the measurement tool used to monitor and evaluate the facility's quality of management, clinical services, and support functions.

Pursuit of Opportunity to Further Improve Care—applies pro-active efforts to identify and implement improvements.

Quality Improvement—a management led and patient focused systematic method of improving systems and processes. Its basis is a statistical process control.

Quality of Patient Care—the degree to which patient care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes.

B. Process

1. Utilization Review. At least 10 percent of all encounters shall be reviewed quarterly by the medical director and/or physician member of the advisory board.

2. Internal Evaluation. Facility shall develop and conduct an annual internal evaluation process to provide necessary data to formulate a plan for continuous quality improvement/quality assurance.

3. Quality Assurance/Continuous Quality Improvement. The facility shall have ongoing programs to assure that the overall function of the clinic is in compliance with federal, state, and local laws, and is meeting the needs of the citizens of the area, as well as attaining the goals and objectives developed from the mission statement established by the facility.

4. Quality Improvement Program. The facility shall have a written quality improvement program that addresses at least the following elements:

a. facility philosophy/mission/goals/objectives/ scope of care/services;

b. personnel roles/responsibilities/physician supervision/nurse practitioner, credentialing/re-credentialing policy/procedures/annual review/evaluation and drug policy and procedures;

c. important aspects of care/quality of care studies;

d. performance indicators relative to, but not limited to, identified problem areas of the clinic or healthy outcomes;

e. monitoring and evaluation procedures/ documentation of findings;

f. patients' rights, responsibilities, grievance and appeal policies/procedures;

g. utilization review/medical records audit; and

h. patient satisfaction surveys.

5. Systemic Quality Improvements. A facility shall:

a. participate in a continuous effort to improve its performance;

b. focus on improving patient outcomes and patient satisfaction;

c. have objective measures to allow tracking of performance over time to ensure that improvements are sustained;

d. develop/adopt quality indicators that are predictive of desired outcomes or are outcomes that can be measured, analyzed and tracked;

e. identify its own measure of performance for the activities it identifies as priorities in quality assessment and performance improvement strategy;

f. conduct distinct successful improvement activities proportionately to the scope and complexity of the clinic operations;

g. immediately correct problems that are identified through its quality assessment and improvement program that actually or potentially affect the health and safety of the patients;

h. make an aggressive and continuous effort to improve overall performance of clinic and personnel; and

i. use the process of improvement (identification of patient care and service components; application of performance measures; and continuous use of a method of data collection and evaluation) to identify or trigger further opportunities for improvement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1851 (October 1999).

§7531. Patient's Rights and Responsibilities

A. The facility shall provide education to personnel regarding patient rights during orientation at least annually, and post a copy of the patient's rights in a conspicuous place.

1. Patients of Rural Health Clinics shall have the right to:

a. be treated equally and receive care without regard to age, sex, religion, race or creed;

b. receive care that is not determined by patient's ability to pay for service;

c. confidentiality of his/her clinical records;

d. be informed of all costs and expected payment from other resources;

e. be treated with respect for the individual patient's comfort, dignity and privacy;

f. be informed of his/her rights in advance of care being provided;

g. access information contained in his/her clinical records within a reasonable time frame;

h. make decisions regarding his/her care;

i. formulate advance directives and have staff/ practitioners to comply with those directives;

j. maintain personal privacy and receive care in a safe setting; and

k. be free from verbal or physical abuse or harassment from staff.

2. Patients of Rural Health Clinics are responsible for:

a. providing, to the extent possible, information needed by professional staff in caring for the patient;

b. following instructions and guidelines given by those providing health care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1852 (October 1999).

§7533. Advisory Committee

A. All members of the advisory committee shall be designated in writing and approved by the governing board. The advisory committee shall be composed of two medical professionals, and at least one consumer of services, not employed by the facility. However, facility staff should attend meetings.

1. Qualifications

a. Medical professionals may be any Louisiana licensed health care professional, including but not limited

to, medical doctor, registered nurse, board certified social worker, pharmacist, or physical therapist.

b. Consumers must be members of the local community, over 21 years of age, and not affiliated by employment, family, finance or contract with the facility or its owners.

2. Responsibilities. The Advisory Committee shall:

a. meet annually to review the facility's mission/philosophy, operations, finances, policies and planned activities to assure that the facility is improving access and health care to the community; and

b. provide suggestions regarding facility changes based upon community needs, growth, and support.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2197, 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 25:1846 (October 1999), amended LR 28:510 (March 2002).

§7535. Physical Environment

A. Occupancy. The facility shall have written approval from the appropriate agency to verify compliance with Office of the State Fire Marshal.

B. Safety. The following are fundamental to the effective management of a facility:

1. preventing, reporting and correcting threatening situations, equipment failures, and actual incidents that involve injury or damage to property;

2. proper safety management;

3. emergency preparedness;

4. proper storage and disposal of trash and medical waste;

5. proper temperature control, light and ventilation;

6. proper storage of drugs and cleaning material; and

7. clean and free of hazards;

a. bathrooms shall be vented to outside and have adequate soap, hand towels and hot water to promote infection control;

b. general appearance of facility shall be neat and clean;

8. exits shall not be obstructed and facility shall have:

a. a minimum of two exits spaced as widely apart as possible;

b. exit doors that are at least 34 inches wide but less than 48 inches;

c. exit corridors that are at least 44 inches wide and do not pass through a storage room, mechanical room, or kitchen;

d. clearly marked exits and exit pathways with exit signs and arrows;

e. adequate light at all times. If the facility is occupied at night, all exit signs must be internally lighted and corridors must have emergency light units;

f. doors which can be opened from inside the room or area without a key or special knowledge; and

g. exit signs over each exit door and also at every corridor junction. At least one exit sign must be visible from any location in the building;

9. locks:

a. no door equipped with a self closure device (except entry/exit doors) may ever be blocked open;

b. every lock must be operable from inside the room or area;

10. miscellaneous:

a. the facility shall have one fire extinguisher (minimum size 2A) for each 1500 square feet. It must be inspected and tagged annually; and, the gauge must show in the white, green, or "overcharged" areas. It may be Type A or Type ABC;

b. Any storage room over 50 square feet must have an automatic door closure device. No flammable liquids (such as gasoline, diesel, etc.) may be stored inside the facility. However, alcohol and cleaning supplies are allowed in reasonable quantities;

c. any compressed gas cylinder, regardless of type and/or amount of contents, must be on a rack or chained to avoid tipping;

d. at a minimum a fire wall rated for one hour must separate the facility from any other occupied area. Criteria for the wall include:

i. one layer of 5/8 inch fire code sheetrock or other limited or non-combustible material on each side;

ii. separation wall must extend completely to the roof deck with no unsealed penetrations or holes;

iii. one and 3/4 inch doors (if doors are present) must be solid core with automatic self-closure device.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2197.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1852 (October 1999).

Chapter 76. Medicare Rural Hospital Flexibility Program (MRHF)

Subchapter A. Critical Access Hospitals

§7601. Definitions

A. The following word and terms, when used in this Chapter 76 shall have the following meanings, unless the context clearly indicates otherwise.

BPCRH—Department of Health and Hospital, Office of the Secretary, Bureau of Primary Care and Rural Health.

CAH—Critical Access Hospital.

CMS—Centers for Medicare and Medicaid Services.

EACH/RPCH—Essential Access Community Hospital/Rural Primary Care Hospital—a limited service rural hospital program.

EMS—Emergency Medical Services.

Health Care Network—an organization consisting of at least one CAH and one acute care hospital with agreements for patient referrals, emergency/non-emergency transportation and other services as feasible.

HPSA—Health Professional Shortage Area.

HSS—Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section.

MRHF—Medicare Rural Hospital Flexibility Program.

MSA—Metropolitan Statistical Area.

MUA—Medically Underserved Area designated by the federal Office of Shortage Designations.

Necessary Provider—a facility located in a primary care HPSA or MUA; or located in a parish in which the percentage of Medicare beneficiaries is higher than the percentage of Medicare beneficiaries residing in the state; or a facility located in a parish in which the percentage of the population under 100 percent of the federal poverty level is higher than the percentage of the state population under 100 percent of the federal poverty level or qualifies as a "rural hospital" under the Louisiana Rural Preservation Act.

Not-for Profit—incorporated as a non-profit corporate entity.

Primary Care—basic ambulatory health services that provide preventive, diagnostic and therapeutic care.

Primary Care Physicians—includes general, family and internal medicine, pediatrics and obstetrics/gynecology.

QIO—Quality Improvement Organization

Public Hospital—hospital supported by public funds including city, service district and state hospitals.

Rural—The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget or qualifies as a rural hospital under the Louisiana Rural Preservation Act.

AUTHORITY NOTE: Promulgated in accordance with the Balanced Budget Act of 1997 (P.L. 105-33) and Title XVIII of the Social Security Act; amended by Medicare, Medicaid, SCHIP Balance Budget Refinement Act of 1999.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, Division of Research and Development, LR 25:1478 (August 1999), amended LR 26:1480 (July 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Primary Care and Rural Health, LR 32:99 (January 2006).

§7603. Criteria for Designation as a CAH

A. A hospital must submit an application to the BPCRH and must meet the following criteria, or affirm that it can meet these criteria at the time of certification, to be designated as a CAH:

1. be a licensed hospital;

2. be currently participating in the Medicare program and meet applicable conditions of participation;

3. be located in a rural area:

a. may be a rural census tract in a Metropolitan Statistical Area as determined under the Goldsmith Modification, originally published in the *Federal Register* on February 27, 1992 and updated October 1, 2004; or

b. qualifies as a "rural hospital" under the Rural Preservation Act, RS 40:100.143;

4.a. be located more than a 35-mile drive or a 15-mile drive in mountainous terrain or areas with secondary roads, from the nearest hospital or CAH; or

b. be certified as a necessary provider by qualifying as a "rural hospital" under the Louisiana Rural Hospital Preservation Act RS 40:1300.143; and meeting at least one of the following:

i. be located in a primary care health professional shortage area (HPSA) or a medically underserved area (MUA); or

ii. be located in a parish in which the percentage of Medicare beneficiaries is higher than the percentage of Medicare beneficiaries residing in the state; or

iii. be located in a parish in which the percentage of the population under 100 percent of the federal poverty level is higher than the percentage of the state population under 100 percent of the federal poverty level;

c. provide not more than 25 acute care inpatient beds or swing-beds, meeting such standards as the secretary may establish, for providing inpatient care that does not exceed, as determined on an annual, average basis, 96 hours per patient.

AUTHORITY NOTE: Promulgated in accordance with the Balanced Budget Act of 1997 (P.L. 105-33) and Title XVIII of the Social Security Act; amended by Medicare, Medicaid, SCHIP Balance Budget Refinement Act of 1999.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, Division of Research and Development, LR 25:1478 (August 1999),

amended LR 26:1480 (July 2000), amended by the Departmetn of Health and Hospitals, Office of the Secretary, Bureau of Primary Care and Rural Health, LR 32:99 (January 2006)

§7609. Application Submission and Review

A. A hospital that wishes to be designated as a CAH is required to submit an application to the BPCRH. Application forms may be requested and submitted by interested hospitals at any time following HCFA approval of the state's Rural Health Care Plan and application.

B. On receipt of an application, the BPCRH will conduct a review to determining the eligibility of the applicant hospital for conversion and consistency with the criteria for designation detailed in §7603.

C. The supporting information to be included with the application is:

1. documentation of ownership, including names of owners and percent of ownership;

2. board resolution to seek CAH certification;

3. documentation of Medicare participation;

4. notification from BPCRH that location is in a HPSA or MUA;

5. affirmation that 24-hour emergency medical care services and medical control agreements are available including information on staffing arrangements;

6. documentation that facility meets rural hospital staffing requirements with the following exceptions:

a. the facility need not meet hospital standards regarding the number of hours per day or days of the week in which it must be open and fully staffed, except as required to make emergency medical care services available and to have nursing staff present if an inpatient is in the facility;

b. the facility may provide the services of a dietician, pharmacist, laboratory technician, medical technologist, and/or radiological technologist on a part-time, off site basis; and

c. inpatient care may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist, subject to the oversight of a physician who need not be present in the facility but immediately available in accordance with state requirements for scope of practice;

7. copy of a needs assessment, if available;

8. copy of a strategic plan for conversion;

9. copy of financial feasibility assessment.

D. Decision. If an application is complete, and all supporting documentation provided, the BPCRH will provide written notice to the applicant hospital.

1. If the application and required documentation supports conversion to a MRHF, after the effective date of the published rule, the BPCRH will provide a written notice of the designation to the applicant hospital and HSS.

2. If the application is incomplete or otherwise insufficient to allow designation, the BPCRH will provide written notice to the applicant outlining the actions necessary to correct the deficiencies. The hospital may then address the deficiencies and resubmit its application.

E. Once designated, a hospital may apply to the Bureau of Health Services Financing, Health Standards Section (HSS) of the Department of Health and Hospitals for an onsite survey.

AUTHORITY NOTE: Promulgated in accordance with the Balanced Budget Act of 1997 (P.L. 105-33) and Title XVIII of the Social Security Act; amended by Medicare, Medicaid, SCHIP Balance Budget Refinement Act of 1999.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, Division of Research and Development, LR 25:1479 (August 1999), amended LR 26:1480 (July 2000), amended by the Office of the Secretary, Bureau of Primary Care and Rural Health, LR 32:100 (January 2006).

§7611. Technical Assistance

A. The BPCRH is available to furnish basic technical assistance to hospitals and communities interested in CAH conversion such as providing program information helping with interpretation and completion of the application for designation, and identifying other sources of assistance and information.

AUTHORITY NOTE: Promulgated in accordance with the Balanced Budget Act of 1997 (P.L. 105-33) and Title XVIII of the Social Security Act; amended by Medicare, Medicaid, SCHIP Balance Budget Refinement Act of 1999.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, Division of Research and Development, LR 25:1480 (August 1999), amended LR 26:1480 (July 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Primary Care and Rural Health, LR 32:100 (January 2006).

§7613. Program Monitoring and Evaluation

A. Ongoing monitoring and evaluation of the program will be conducted by the Quality Management Section of the BPCRH.

1. Strengths and weaknesses of the program and state policy affecting CAHs will be assessed, with the goal of identifying problem areas and developing solutions.

2. Results will be reported to the BPCRH Director who will assign program staff to work with other state agencies and interested parties to determine the necessity of changes and updates to the Plan and state policy.

3. All Plan changes will be forwarded to HCFA for review and approval.

AUTHORITY NOTE: Promulgated in accordance with the Balanced Budget Act of 1997 (P.L. 105-33) and Title XVIII of the Social Security Act; amended by Medicare, Medicaid, SCHIP Balance Budget Refinement Act of 1999.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, Division of Research and Development, LR 25:1480 (August 1999), amended LR 26:1480 (July 2000), amended by the Department of

Health and Hospitals, Office of the Secretary, Bureau of Primary Care and Rural Health LR 32:100 (January 2006).

Chapter 78. Pain Management Clinics

Subchapter A. General Provisions

§7801. Definitions

Addiction Facility—a facility that is licensed for the treatment of addiction to, or abuse of illicit drugs or alcohol, or both.

Administrator—the person responsible for the day-to-day management, supervision, and non-medical operation of the pain management clinic.

Board—the Louisiana State Board of Medical Examiners.

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

Chronic Pain–pain which persists beyond the usual course of a disease, beyond the expected time for healing from bodily trauma, or pain associated with a long-term incurable or intractable medical illness or disease.

Controlled Substance─any substance defined, enumerated or included in federal or state statute or regulations 21 C.F.R.§1308.11-15 or R.S.40:964, or any substance which may hereafter be designated as a controlled substance by amendment or supplementation of such regulations and statutes.

DAL—Division of Administrative Law.

Deficient Practice—a finding of non-compliance with a licensing regulation.

Department—the Department of Health and Hospitals.

Health Standards Section (HSS)—the section within the Department of Health and Hospitals with responsibility for licensing pain management clinics.

Intractable Pain–a chronic pain state in which the cause of the pain cannot be eliminated or successfully treated without the use of controlled substance therapy and, which in the generally accepted course of medical practice, no cure of the cause of pain is possible or no cure has been achieved after reasonable efforts have been attempted and documented in the patient's medical record.

Noncancer-Related Pain–pain which is not directly related to symptomatic cancer.

Non-Malignant–synonymous with noncancer-related pain.

Non-Operational—the pain management clinic is not open for business operation on designated days and hours as stated on the licensing application.

Operated By—actively engaged in the care of patients at a clinic.

OPH—the Department of Health and Hospitals, Office of Public Health.

Pain Management Clinic or "Clinic"—a publicly or privately owned facility which primarily engages in the treatment of pain by prescribing narcotic medications.

Pain Specialist—a physician, licensed in Louisiana, with a certification in the subspecialty of pain management by a member board of the American Boards of Medical Specialties.

1. For urgent care facilities in operation on or before June 15, 2005, the definition of pain specialist is a physician who is licensed in the state of Louisiana, board-certified in his or her area of residency training and certified within one year from the adoption of this Rule in the subspecialty of pain management by any board or academy providing such designation such as the American Boards of Medical Specialties, American Board of Pain Management, American Academy of Pain Management or the American Board of Interventional Pain Physicians. Any conflict, inconsistency or ambiguity with any other regulations contained in this chapter shall be controlled by §7801.

Physician—an individual who:

1. possesses a current, unrestricted license from the board to practice medicine in Louisiana;

2. during the course of his practice has not been denied the privilege of prescribing, dispensing, administering, supplying, or selling any controlled dangerous substance; and

3. during the course of his practice has not had board action taken against his medical license as a result of dependency on drugs or alcohol.

Primarily Engaged in Pain Management—during the course of any day a clinic is in operation, 51 percent or more of the patients seen are issued a narcotic prescription for the treatment of chronic non-malignant pain. Exception: A physician who in the course of his/her own private practice shall not be considered primarily engaged in the treatment of chronic non-malignant pain by prescribing narcotic medications provided that the physician:

1. treats patients within his/her area of specialty and who utilizes other treatment modalities in conjunction with narcotic medications;

2. is certified by a member board of the American Board of Medical Specialties; and

3. currently holds medical staff privileges that are in good standing at a hospital in this state.

Urgent Care Facility—a medical clinic which offers primary and acute health services to the public during stated hours of operation and which must accommodate walk-in patients seeking acute health services. For purposes of this definition, the treatment of chronic pain patients is not considered acute health services.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 34:80 (January 2008), amended LR 34:1418 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2644 (December 2015).

§7803. Ownership

A. Except as specified in §7803.B, each clinic shall be 100 percent owned and operated by a physician certified in the subspecialty of pain management by a member board of the American Boards of Medical Specialties.

B. A clinic in operation on or before June 15, 2005, is exempt from §7803.A if all of the following requirements are met.

1. The clinic is not owned, either in whole or in part, by independent contract, agreement, partnership, or joint venture with a physician who during the course of his practice has:

a. been denied the privilege of prescribing, dispensing, administering, supplying, or selling any controlled dangerous substance; and

b. had board action taken against his medical license as a result of dependency on drugs or alcohol.

2. The clinic is not owned, either in whole or in part, by an individual who has been convicted of, pled guilty or nolo contendere to a felony.

3. The clinic is not owned, either in whole or in part, by an individual who has been convicted of, pled guilty or nolo contendere to a misdemeanor, the facts of which relate to the use, distribution, or illegal prescription of any controlled substance.

4. The clinic shall operate as an urgent care facility offering primary or acute health services, in addition to caring for patients with chronic pain, and shall have held itself out to the public as an urgent care facility.

C. A pain management clinic that is not licensed by, or has not submitted a completed application to, the department for licensure on or before August 1, 2014, shall not be licensed under the exemption to §7803.B.

D. Any change of ownership (CHOW) shall be reported in writing to the Health Standards Section within five working days of the transfer of ownership by any lawful means. The license of a clinic is not transferable or assignable between individuals, clinics or both. A license cannot be sold.

1. The new owner shall submit all documents required for a new license including the licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:80 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2644 (December 2015).

Subchapter B. Licensing Procedures

§7811. General Provisions

A. It shall be unlawful to operate a clinic without obtaining a license issued by the department. The department is the only licensing agency for pain management clinics in the state of Louisiana. A pain management clinic verified to be operating without a license shall be required to immediately cease and desist operation and discharge all patients.

B. A clinic shall renew its license annually. A renewal application and licensing fee shall be submitted at least 30 days before the expiration of the current license. Failure to submit a complete renewal application shall be deemed to be a voluntary termination and expiration of the facility's license. The license shall be surrendered to the department within 10 days, and the facility shall immediately discharge all patients and cease providing services.

C. A license shall be valid only for the clinic to which it is issued and only for that specific geographic address. A license shall not be subject to sale, assignment, or other transfer, voluntary or involuntary. The license shall be conspicuously posted in the clinic.

D. Any change regarding the clinic's name, geographical or mailing address, phone number, or key administrative staff or any combination thereof, shall be reported in writing to the Health Standards Section within five working days of the change.

1. Any change that requires a change in the license shall be accompanied by the required fee.

2. Any change in geographic location of the clinic requires that the provider requests, and satisfactorily meets the requirements of, the following prior to any patient receiving service at the new location:

a. plan review for life safety code and licensing and inspection report with approvals for occupancy from the Office of the State Fire Marshal (OSFM); and

b. a copy of the health inspection report with a recommendation for licensure or a recommendation for denial of licensure from the Office of Public Health (OPH); and

c. an on-site survey prior to issuance of new license by the department.

3. Exception. Pursuant to R.S. 40:2198.12(D)(1)(g), a pain management clinic which is exempted from the requirement of being owned and operated by a physician certified in the subspecialty of pain management may relocate and continue to be exempted from the requirement of being owned and operated by a physician certified in the subspecialty of pain management if the new location is in the same parish in which the original clinic was located.

E. A separately licensed clinic shall not use a name which is substantially the same as the name of another clinic

licensed by the department unless the clinic is under common ownership and includes a geographic identifier.

F. The clinic shall not use a name which may mislead the patient or their family into believing it is owned, endorsed, or operated by the state of Louisiana.

G. Any request for a duplicate license shall be accompanied by the required fee.

H. A clinic intending to have controlled dangerous medications on the premises shall make application for a controlled dangerous substance (CDS) license, and shall comply with all of the federal and state regulations regarding procurement, maintenance and disposition of such medications.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:81 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2644 (December 2015).

§7813. Initial Application Process

A. An application packet for licensing as a pain management clinic shall be obtained from the Department of Health and Hospitals. A completed application packet for a clinic shall be submitted to and approved by the department prior to an applicant providing services.

B. To be considered complete, the initial licensing application packet shall include the following:

1. the current non-refundable licensing fee pursuant to R. S. 40:2198.13;

2. a copy of the plan review for life safety code and licensing and the on-site inspection report with approvals for occupancy from the OSFM;

3. a copy of the health inspection report with a recommendation for licensure or a recommendation for denial of licensure from the OPH;

4. a zoning approval from local governmental authorities;

5. a statewide criminal background check on all owners conducted by the Louisiana State Police or its designee;

6. verification of the physician owner's certification in the subspecialty of pain management;

7. proof of professional liability insurance of at least $500,000;

a. proof of maintenance of professional liability insurance of at least $500,000 shall be provided to the department at the time of initial licensure, at renewal of licensure, and upon request;

8. an organizational chart identifying the name, position, and title of each person composing the governing body and key administrative personnel;

9. a floor sketch or drawing of the premises to be licensed; and

10. any other documentation or information required by the department for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:81 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2645 (December 2015).

§7815. Licensing Surveys

A. After approval of the initial application by the department, a clinic shall undergo an initial licensing survey to determine that the clinic is in compliance with all licensing regulations. The clinic will receive advance notification of this survey.

1. No patient shall be provided service until the initial licensing survey has been performed and the clinic found to be in compliance.

2. In the event the initial licensing survey finds that a clinic is not in compliance with regulations of this Chapter, the department shall deny the initial license.

B. After the initial licensing survey, the department shall conduct a licensing survey at regular intervals as it deems necessary to determine compliance with licensing regulations. These surveys shall be unannounced to the clinic.

C. The department may conduct a complaint investigation in accordance with R. S. 40:2009.13, et seq. for any complaint received against a clinic. A complaint survey shall be unannounced to the clinic.

D. A follow-up survey may be done following any licensing survey or any complaint survey to ensure correction of a deficient practice cited on the previous survey. Such surveys shall be unannounced to the clinic.

E. Following any survey, the pain management clinic shall receive a statement of deficiencies documenting relevant findings, including the deficiency, the applicable governing rule, and the evidence supporting why the rule was not met.

1. The following statements of deficiencies issued by the department to the pain management clinic must be posted in a conspicuous place on the licensed premises:

a. the most recent annual licensing survey statement of deficiencies; and

b. any follow-up and/or complaint survey statement of deficiencies issued after the most recent annual licensing survey.

2. Any statement of deficiencies issued by the department to a pain management clinic shall be available for disclosure to the public within 30 calendar days after the pain management clinic submits an acceptable plan of

correction to the deficiencies or within 90 days of receipt of the statement of deficiencies, whichever occurs first.

F. The department may require a plan of correction from a pain management clinic following any survey wherein deficiencies have been cited. The fact that a plan of correction is accepted by the department does not preclude the department from pursuing other actions against the pain management clinic as a result of the cited deficiencies.

G. The applicant and/or pain management clinic shall have the right to request an informal reconsideration of any deficiencies cited during any initial licensing survey, annual licensing survey, and follow-up survey.

1. The request for an informal reconsideration must be in writing and received by HSS within 10 calendar days of receipt of the statement of deficiencies. If a timely request for an informal reconsideration is received, HSS shall schedule the informal reconsideration and notify the pain management clinic in writing.

a. The request for an informal reconsideration does not delay submission of the plan of correction within the prescribed timeframe.

2. The request for an informal reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

3. Correction of the deficiency or deficiencies cited in any survey shall not be the basis for an informal reconsideration.

4. The pain management clinic may appear in person at the informal reconsideration and may be represented by counsel.

5. The pain management clinic shall receive written notice of the results of the informal reconsideration.

6. The results of the informal reconsideration shall be the final administrative decision regarding the deficiencies and no right to an administrative appeal shall be available.

H. Complaint Survey Informal Reconsideration. Pursuant to R.S. 40:2009.13 et seq., a pain management clinic shall have the right to request an informal reconsideration of the validity of the deficiencies cited during any complaint survey, and the complainant shall be afforded the opportunity to request an informal reconsideration of the survey findings.

1. The department shall conduct the informal reconsideration by administrative desk review.

2. The pain management clinic and/or the complainant shall receive written notice of the results of the informal reconsideration.

3. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the results of the informal reconsideration shall be the final administrative decision and no right to an administrative appeal shall be available.

I. Sanctions. The department may impose sanctions as a result of deficiencies cited following any survey. A sanction may include, but is not limited to:

1. civil fine(s);

2. revocation of license;

3. denial of license renewal;

4. immediate suspension of license; and

5. any and all sanctions allowed under federal or state law or regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:81 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2645 (December 2015).

§7817. Issuance of Licenses

A. The department shall have authority to issue two types of licenses: a full license or provisional license.

B. A full pain management clinic license may be issued only to applicants that are in compliance with all applicable federal, state and local laws and regulations. This license shall be valid until the expiration date shown on the license, unless the license has been revoked, terminated, or suspended.

C. A provisional license may be issued to those existing licensed pain management clinics that do not meet the criteria for full licensure. This license shall be valid for no more than six months, unless the license has been revoked, terminated, or suspended.

1. A provisional license may be issued by the department for one of the following reasons, including but not limited to:

a. the clinic has more than five deficient practices during any one survey;

b. the clinic has more than three valid complaints in a one-year period;

c. there is a documented incident of placing a patient at risk;

d. the clinic fails to correct deficient practices within 60 days of being cited or at the time of the follow-up survey, whichever occurs first.

2. A pain management clinic with a provisional license may be issued a full license if at the follow-up survey the clinic has corrected the deficient practice. A full license may be issued for the remainder of the year until the clinic's license anniversary date.

3. The department may re-issue a provisional license or allow a provisional license to expire when the clinic fails to correct deficient practice within 60 days of being cited or at the time of the follow-up survey, whichever occurs first.

4. The department may also issue a provisional license if there is documented evidence that any representative of the clinic has (without the knowledge or consent of clinic's owner, medical director and/or administrator) bribed, harassed, offered, paid for or received something of economic value for the referral of an individual to use the services of a particular clinic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:82 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2646 (December 2015).

§7819. Initial License Denial, License Revocation or Denial of License Renewal

A. Pursuant to R.S. 49:950, the Administrative Procedures Act, the department may:

1. deny an application for a license;

2. refuse to renew a license; or

3. revoke a license.

B. A pain management clinic license may not be renewed or may be revoked for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with pain management clinic licensing regulations;

2. failure to uphold patient rights whereby deficient practice may result in harm, injury or death of a patient;

3. failure of the clinic to protect a patient from a harmful act by a clinic employee or other patient(s) on the premises, including but not limited to:

a. an action posing a threat to patient or public health and safety;

b. coercion;

c. threat or intimidation;

d. harassment;

e. abuse; or

f. neglect;

4. failure to notify proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof;

5. failure to maintain sufficient staff to meet the needs of the patient;

6. failure to employ qualified personnel;

7. failure to remain operational on the days, and during the hours, the clinic has reported to the department that it will be open, unless the closure is unavoidable due to a man-made or natural disaster and in accordance with §7825;

8. failure to submit fees, including but not limited to:

a. fee for the change of address or name;

b. any fine assessed by the department; or

c. fee for a CHOW;

9. failure to allow entry to a clinic or access to requested records during a survey;

10. failure to protect patients from unsafe care by an individual employed by a clinic;

11. failure to correct areas of deficient practice;

12. when clinic staff or owner has knowingly, or with reason to know, made a false statement of a material fact in any of the following:

a. application for licensure;

b. data forms;

c. clinical records;

d. matters under investigation by the department;

e. information submitted for reimbursement from any payment source; or

f. advertising;

13. clinic staff misrepresented or fraudulently operated a clinic;

14. conviction of a felony, or entering a plea of guilty or nolo contendere to a felony by an owner, administrator, director of nursing, or medical director as evidenced by a certified copy of the conviction;

15. failure to comply with all reporting requirements in a timely manner as requested by the department; or

16. action taken by the board against a physician owning, employed or under contract to a clinic for violation of the board's Pain Management Rules or other violations of the Medical Practice Act which would make him ineligible for licensure.

C. In the event a clinic's license is revoked or denied renewal, no other license application shall be accepted by the department from the owners of the revoked or denied clinic for a period of two years from the date of the final disposition of the revocation or denial action.

D. When a clinic is under a denial of license renewal action, provisional licensure, or license revocation action, that clinic is prohibited from undergoing a change of ownership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:82 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2646 (December 2015).

§7821. Notice and Appeal Procedures

A. The department shall furnish the applicant or clinic with written notice of the department's decision to deny a license, revoke a license, or refusal to renew a license.

1. The notice shall specify reasons for the action and shall notify the applicant or clinic of the right to request an administrative reconsideration or to request an appeal. A voluntary termination or expiration of the license is not an adverse action and is not appealable.

2. The clinic shall have the right to file a suspensive appeal from the department's decision to revoke the clinic's license.

B. Administrative Reconsideration. A clinic may request an administrative reconsideration of the department's decision to revoke, deny, or refuse to renew a license.

1. A request for an administrative reconsideration shall be submitted in writing to the Health Standards Section within 15 calendar days of receipt of notification of the department's action.

2. Administrative reconsideration is an informal process and shall be conducted by a designated official of the department who did not participate in the initial decision to impose the action taken.

a. A department spokesman and a clinic spokesman may make an oral presentation to the designated official during the administrative reconsideration.

3. Administrative reconsideration may be made solely on the basis of documents or oral presentations, or both, before the designated official and shall include:

a. the statement of deficient practice; and

b. any documentation the clinic may submit to the department at the time of the clinic's request for such reconsideration.

4. Correction of a deficiency shall not be a basis for administrative reconsideration.

5. An administrative reconsideration is not in lieu of the administrative appeals process.

C. Administrative Appeal Process. Upon denial or revocation of a license by the department, the clinic shall have the right to appeal such action by submitting a written request to the Division of Administrative Law (DAL), or its successor, within 30 days after receipt of the notification of the denial or revocation of a license, or within 30 days after receipt of the notification of the results of the administrative reconsideration.

1. Correction of a deficiency shall not be the basis of an administrative appeal.

2. Notwithstanding the provisions of §7821.C, the department may immediately revoke a license in any case in which the health and safety of a client or the community may be at risk.

a. The clinic which is adversely affected by the action of the department in immediately revoking a license may, within 30 days of the closing, devolutively appeal from the action of the department by filing a written request for a hearing to the DAL or its successor.

D. If an existing licensed pain management clinic has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal application.

1. The denial of the license renewal application does not affect in any manner the license revocation.

2. If the final decision by the DAL or its successor is to reverse the initial license denial, the denial of license renewal, or the license revocation, the provider's license will be reinstated or granted upon the payment of any licensing or other fees due to the department.

E. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license. An existing provider who has been issued a provisional license remains licensed and operational and also has no right to an administrative reconsideration or an administrative appeal. The issuance of a provisional license to an existing pain management clinic is not considered to be a denial of license, a denial of license renewal, or a license revocation.

1. A follow-up survey may be conducted prior to the expiration of a provisional initial license to a new pain management clinic or the expiration of a provisional license to an existing provider.

2. A new provider that is issued a provisional initial license or an existing provider that is issued a provisional license shall be required to correct all noncompliance or deficiencies at the time the follow-up survey is conducted.

3. If all noncompliance or deficiencies have not been corrected at the time of the follow-up survey, or if new deficiencies that are a threat to the health, safety, or welfare of residents are cited on the follow-up survey, the provisional initial license or provisional license shall expire on its face and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

4. The department shall issue written notice to the clinic of the results of the follow-up survey.

5. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an administrative reconsideration and the right to an administrative appeal of the deficiencies cited at the follow-up survey.

a. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the administrative reconsideration or for the administrative appeal.

b. The administrative reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

c. The provider must request the administrative reconsideration of the deficiencies in writing, which shall be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for an administrative reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

d. The provider must request the administrative appeal within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request for an administrative appeal must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

e. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this Section must cease providing services unless the DAL or its successor issues a stay of the expiration. The stay may be granted by the DAL or its successor upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing, and only upon a showing that there is no potential harm to the residents being served by the pain management clinic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:83 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2646 (December 2015).

§7823. Cessation of Business

A. Except as provided in Section §7825 of these licensing regulations, a license shall be immediately null and void if a pain management clinic becomes non-operational.

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

C. Upon the cessation of business, the pain management clinic shall immediately return the original license to the department.

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

E. The pain management clinic shall notify the department in writing 30 days prior to the effective date of the closure or cessation. In addition to the notice, the provider shall submit a written plan for the disposition of patient medical records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

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

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

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

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

F. Failure to comply with the provisions concerning submission of a written plan for the disposition of patient medical records to the department may result in the provider being prohibited from obtaining a license for any provider type issued by the department.

G. Once the pain management clinic has ceased doing business, the provider shall not provide services until the clinic has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2647 (December 2015).

§7825. Inactivation of License due to Declared Disaster or Emergency

A. A licensed pain management clinic in an area or areas which have been affected by an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed two years, provided that the following conditions are met:

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

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

b. the licensed pain management clinic intends to resume operation as a pain management clinic in the same service area; and

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

NOTE: Pursuant to these provisions, an extension of the 60-day deadline may be granted at the discretion of the department.

2. the licensed pain management clinic resumes operating as a pain management clinic in the same service area within two years of the approval of construction plans by all required agencies upon issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed pain management clinic continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

4. the licensed pain management clinic continues to submit required documentation and information to the department, including but not limited to cost reports.

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

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

1. the pain management clinic shall submit a written license reinstatement request to the licensing agency of the department within two years of the executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

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

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

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

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

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

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the pain management clinic license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2648 (December 2015).

Subchapter C. Clinic Administration

§7831. Medical Director

A. Each clinic shall be under the direction of a medical director who shall be a physician who:

1. possesses a current, unrestricted license from the board to practice medicine in Louisiana;

2. during the course of his practice, has not been denied the privilege of prescribing, dispensing, administering, supplying, or selling any controlled dangerous substance; and

3. during the course of his practice has not had any board action taken against his medical license as a result of dependency on drugs or alcohol.

B. The medical director shall be a physician certified in the subspecialty of pain management by a member board of the American Boards of Medical Specialties, except for the following exemption.

1. A licensed pain management clinic which has been verified by the department as being in operation on or before June 15, 2005, is required to have a medical director, but is exempt from having a medical director who is certified in the subspecialty of pain management by a member board of the American Boards of Medical Specialties.

C. Responsibilities. The medical director is responsible for the day-to-day clinical operation and shall be on-site, at a minimum, 50 percent of the time during the operational hours of the clinic. When the medical director is not on-site during the hours of operation, then the medical director shall be available by telecommunications and shall be able to be on-site within 30 minutes.

1. The medical director shall oversee all medical services provided at the clinic.

2. The medical director shall ensure that all qualified personnel perform the treatments or procedures for which each is assigned. The clinic shall retain documentation of staff proficiency and training.

3. The medical director, or his designee, is responsible for ensuring a medical referral is made to an addiction facility, when it has been determined that a patient has been diverting drugs or participating in the illegal use of drugs.

4. The medical director is responsible for ensuring a urine drug screen of each patient is obtained as part of the initial medical evaluation and intermittently, no less than quarterly, during the course of treatment for chronic pain.

5. The medical director shall ensure that patients are informed of after-hours contact and treatment procedures.

6. The medical director is responsible for applying to access and query the Louisiana Prescription Monitoring Program (PMP).

a. The PMP is to be utilized by the medical director and the pain specialist as part of the clinic's quality assurance program to ensure adherence to the treatment agreement signed by the patient.

i. The treatment agreement states that the patient has been informed that he shall only obtain and receive narcotic prescriptions from the clinic where he is being treated for chronic pain.

(a). The patient shall be subject to periodic unannounced drug screens and shall not participate in diversion of any controlled dangerous substance.

b. Compliance to this agreement is to be determined, evaluated, and documented at each subsequent visit to a clinic when the patient receives a prescription for a controlled dangerous substance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:83 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2648 (December 2015).

§7832. Administrator

A. The pain management clinic shall have an administrator designated by the governing body who is responsible for the day-to-day management, supervision, and non-medical operation of the clinic. The administrator shall be available during the designated business hours. The provisions of this Chapter do not prohibit the medical director dually serving as the administrator.

1. Qualifications. The administrator shall be at least 18 years of age and possess a high school diploma or equivalent.

2. The pain management clinic shall designate a person to act in the administrator's absence, and shall ensure this person meets the qualifications of the administrator pursuant to this Chapter. The pain management clinic shall maintain documentation on the licensed premises identifying this person and evidence of their qualifications.

3. Duties and Responsibilities. The administrator shall be responsible for:

a. employing licensed and non-licensed qualified personnel to provide the medical and clinical care services to meet the needs of the patients being served;

b. ensuring that upon hire and prior to providing care to patients, each employee is provided with orientation, training, and evaluation for competency as provided in this Chapter;

c. ensuring that written policies and procedures for the management of medical emergencies are developed, implemented, monitored, enforced, and annually reviewed, and readily accessible to all staff;

d. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The pain management clinic shall maintain documentation on the licensed premises indicating the date, type of drill, participants, and materials;

e. maintaining current credentialing and/or personnel files on each employee that shall include documentation of the following:

i. a completed employment application;

ii. job description;

iii. a copy of current health screening reports conducted in accordance with the clinic's policies and procedures and in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, and regulations;

iv. documentation that each employee has successfully completed orientation, training, and evaluation for competency related to each job skill as delineated in their respective job description; and

v. documentation that all licensed nurses, if employed, shall:

(a). have successfully completed a Basic Life Support course; and

(b). be in good standing and hold current licensure with their respective state nurse licensing board;

f. ensuring all credentialing and/or personnel files are current and maintained on the licensed premises at all times, including but not limited to, documentation of employee health screening reports; and

g. ensuring that appropriate law enforcement agency(s) are notified when it has been determined that a staff member has been diverting drugs or participating in the illegal use of drugs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2649 (December 2015).

§7833. Clinic Operations

A. A licensed pain management clinic shall establish and implement policies and procedures consistent with all pain management rules and regulations issued by the board.

B. A licensed pain management clinic shall verify the identity of each patient who is seen and treated for chronic pain management and who is prescribed a controlled dangerous substance.

C. A licensed pain management clinic shall establish practice standards to assure quality of care, including but not limited to, requiring that a prescription for a controlled dangerous substance may have a maximum quantity of a 30 day supply and shall not be refillable.

D. On each visit to the clinic which results in a controlled dangerous substance being prescribed to a patient, the patient shall be personally examined by a pain specialist and such shall be documented in the patient's clinical record.

E. A pain management clinic shall have enough qualified personnel who are available to provide direct patient care as needed to all patients and to provide administrative and nonclinical services needed to maintain the operation of the clinic in accordance with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:84 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2649 (December 2015).

§7835. Governing Body

A. A pain management clinic shall be in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances.

B. A pain management clinic shall have a governing body that assumes full responsibility for the total operation of the pain management clinic.

1. The governing body shall consist of at least one individual who assumes full responsibility.

2. The pain management clinic shall maintain documentation on the licensed premises identifying the following information for each member of the governing body:

a. name;

b. contact information;

c. address; and

d. terms of membership.

3. The governing body shall develop and adopt bylaws which address its duties and responsibilities.

4. The governing body shall, at minimum, meet annually and maintain minutes of such meetings documenting the discharge of its duties and responsibilities.

C. The governing body shall be responsible for:

1. ensuring the pain management clinic's continued compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees;

2. designating a person to act as the administrator and delegating sufficient authority to this person to manage the non-medical day-to-day operations of the facility;

a. provisions of this Chapter do not prohibit the medical director dually serving as the administrator with responsibility for both medical and non-medical operations of the clinic;

3. designating a person to act as the medical director and delegating authority to this person to allow him/her to direct the medical staff, nursing personnel, and medical services provided to each patient consistent with all pain management rules and regulations issued by the Board;

4. evaluating the administrator and medical director's performance annually, and maintaining documentation of such in their respective personnel files;

5. ensuring that upon hire and prior to providing care to patients, and annually thereafter, each employee is provided with orientation, training, and evaluation for competency according to their respective job descriptions in accordance with the provider's policies and procedures;

6. developing, implementing, enforcing, monitoring, and annually reviewing in collaboration with the administrator and medical director written policies and procedures governing the following:

a. the scope of medical services offered;

b. personnel practices, including, but not limited to:

i. developing job descriptions for licensed and non-licensed personnel consistent with the applicable scope of practice as defined by federal and state law;

ii. developing a program for orientation, training, and evaluation for competency; and

iii. developing a program for health screening;

c. the management of medical emergencies; and

d. disaster plans for both internal and external occurrences;

7. approving all bylaws, rules, policies, and procedures formulated in accordance with all applicable state laws, rules, and regulations;

8. ensuring all bylaws, rules, policies, and procedures formulated in accordance with all applicable state laws, rules, and regulations are maintained on the licensed premises and readily accessible to all staff;

9. maintaining organization and administration of the pain management clinic;

10. acting upon recommendations from the medical director relative to appointments of persons to the medical staff;

11. ensuring that the pain management clinic is equipped and staffed to meet the needs of its patients;

12. ensuring services that are provided through a contract with an outside source, if any, are provided in a safe and effective manner;

13. ensuring that the pain management clinic develops, implements, monitors, enforces, and reviews at a minimum,

quarterly, a quality assurance and performance improvement (QA) program;

14. developing, implementing, monitoring, enforcing, and annually reviewing written policies and procedures relating to communication with the administrator, medical director, and medical staff to address problems, including, but not limited to, patient care, cost containment, and improved practices;

15. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The pain management clinic shall maintain documentation on the licensed premises indicating the date, type of drill, participants, and materials;

16. ensuring that the pain management clinic procures emergency medical equipment and medications that will be used to provide for basic life support until emergency medical services arrive and assume care;

17. ensuring that the pain management clinic orders and maintains a supply of emergency drugs for stabilizing and/or treating medical conditions on the licensed premises, subject to approval by the medical director; and

18. ensuring that the pain management clinic develops, implements, enforces, monitors, and annually reviews written policies and procedures to ensure compliance with all applicable federal, state, and local statutes, laws, ordinances, and department rules and regulations, including but not limited to, appropriate referrals when it has been determined that a patient or staff member has been diverting drugs or participating in the illegal use of drugs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2649 (December 2015).

§7837. Orientation and Training

A. Orientation and Training. The administrator shall develop, implement, enforce, monitor, and annually review, in collaboration with the medical director, written policies and procedures regarding orientation and training of all employees.

1. Orientation. Upon hire and prior to providing care to patients, all employees shall be provided orientation related to the clinic's written policies and procedures governing:

a. organizational structure;

b. confidentiality;

c. grievance process;

d. disaster plan for internal and external occurrences;

e. emergency medical treatment;

f. program mission;

g. personnel practices;

h. reporting requirements; and

i. basic skills required to meet the health needs of the patients.

2. Training. Upon hire, and at a minimum, annually, all employees shall be provided training in each job skill as delineated in their respective job description.

a. Medical training of a licensed medical professional shall only be provided by a medical professional with an equivalent or higher license.

b. Training of a non-licensed employee related to the performance of job skills relative to medical and clinical services shall only be provided by a licensed medical professional consistent with the applicable standards of practice.

c. All training programs and materials used shall be available for review by HSS.

d. The administrator shall maintain documentation of all of the training provided in each employee's personnel files.

B. Evaluation for Competency. Upon hire, and at a minimum, annually, the clinic shall conduct an evaluation for competency of all employees related to each job skill as delineated in their respective job description.

1. The evaluation for competency shall include the observation of job skills and return demonstration by the employee.

2. Evaluation for competency of a licensed medical professional shall only be provided by a medical professional with an equivalent or higher license.

3. Evaluation for competency of a non-licensed employee related to the performance of job skills relative to medical and clinical services shall only be provided by a licensed medical professional consistent with their applicable scope of practice.

4. The administrator shall maintain documentation of all evaluations for competencies in each employee's personnel file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2650 (December 2015).

Subchapter D. Facility Requirements

§7843. Facility Inspections

A. A licensed pain management clinic shall successfully complete all of the required inspections and maintain a current file of reports and other documentation that is readily available for review demonstrating compliance with all applicable laws and regulations. The inspections shall indicate current approval for occupancy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:84 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2651 (December 2015).

§7845. Physical Environment

A. A licensed pain management clinic shall be constructed, arranged and maintained to ensure the safety and well-being of the clinic's patients and the general public.

B. The clinic premises shall meet the following requirements including, but is not limited to:

1. a sign maintained on the clinic premises that can be viewed by the public which shall contain, at a minimum, the:

a. name of the clinic; and

b. days and hours of operation;

2. a neat and clean general appearance of the clinic with established policies and procedures for maintaining a clean and sanitary environment on a regular basis;

3. an effective pest control program shall be maintained to ensure the clinic is free of insects and rodents;

4. proper ventilation, lighting and temperature controls in all areas of the clinic;

5. provisions for emergency lighting and communications, in the event of sudden interruptions in utilities to the clinic; and

6. clearly marked exits and exit pathways with exit signs in appropriate locations.

C. Administrative and public areas of the clinic shall include at least the following:

1. a reception area;

2. a waiting area with seating containing not less than two seating spaces for each examination or treatment room;

3. at least one multipurpose room large enough to accommodate family members for consultations or for staff meetings, in addition to treatment rooms;

4. designated rooms or areas for administrative and clerical staff to conduct business transactions, store and secure records, and carry out administrative functions separate from public areas and treatment areas;

5. filing cabinets and storage for providers utilizing paper medical records; such records shall be protected from theft, fire, and unauthorized access and having provisions for systematic retrieval of such records;

6. electronic medical records keeping systems for providers utilizing electronic records, such equipment shall be protected from unauthorized access and having provisions for systematic retrieval of such records; and

7. secured storage facilities for supplies and equipment.

D. Clinical Facilities shall at least include the following.

1. General-Purpose Examination Room. Each room shall allow at least a minimum floor area of 80 square feet, excluding vestibules, toilets, and closets. Room arrangement should permit at least 2 feet 8 inches clearance at each side and at the foot of the examination table. A hand washing station and a counter or shelf space adequate for writing shall be provided.

2. Treatment Room. A room for minor surgical and cast procedures, in the event such services are provided, shall have a minimum of 120 square feet, excluding vestibules, toilets, and closets. The minimum room dimension shall be 10 feet by 12 feet. A lavatory and a counter or shelf space for writing shall be provided.

3. Medication Storage Area. All drugs and biologicals shall be kept under proper temperature controls in a locked, well illuminated, clean medicine cupboard, closet, cabinet or room.

a. Drugs and biologicals shall be accessible only to individuals authorized to administer or dispense such drugs or biologicals;

b. All controlled dangerous drugs or biologicals shall be kept separately from non-controlled drugs or biologicals in a locked cabinet or compartment;

c. Drugs or biologicals that require refrigeration shall be maintained and monitored under proper temperature controls in a separate refrigerator.

4. Clean Storage Area. A separate room or closet for storing clean and sterile supplies shall be provided.

5. Soiled Utility Room. Provisions shall be made for separate collection, storage, and disposal of soiled materials.

6. Sterilization Area. An area in the clinic shall be designated for sterilizing equipment if sterilization of supplies, equipment, utensils and solutions are performed in the clinic.

7. Housekeeping Room. A separate housekeeping room shall contain a service sink and storage for housekeeping supplies and equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:84 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2651 (December 2015).

§7847. Infection Control Requirements

A. A pain management clinic shall have written policies and procedures, annually reviewed and signed by the medical director, to address the following:

1. decontamination;

2. disinfection;

3. sterilization;

4. storage of sterile supplies;

5. disposal of biomedical and hazardous waste; and

6. training of all staff in universal precautions upon initial employment and annually thereafter.

B. The clinic shall make adequate provisions for furnishing properly sterilized supplies, equipment, utensils and solutions.

1. Some disposable supplies and equipment shall be utilized but when sterilizers and autoclaves are utilized to sterilize supplies, equipment, utensils and solutions, they shall be of the proper type and necessary capacity to adequately sterilize such implements as needed by the clinic.

2. The clinic shall have policies and procedures that address the proper use of sterilizing equipment and monitoring performed to ensure that supplies, equipment, utensils and solutions are sterile according to the manufacturers' recommendations and standards of practice.

a. Such procedures and policies shall be in writing and readily available to personnel responsible for sterilizing procedures.

3. To avoid contamination, appropriate standards of care techniques for handling sterilized and contaminated supplies and equipment shall be utilized.

C. There shall be a separate sink for cleaning instruments and disposal of non-infectious liquid waste.

D. Each clinic shall develop, implement and enforce written policies and procedures for the handling, processing, storing and transporting of clean and dirty laundry.

1. In the event a clinic provides an in-house laundry, the areas shall be designed in accordance with appropriate clinic laundry design in which a soiled laundry holding area is provided and physically separated from the clean laundry area. Dirty or contaminated laundry shall not be stored or transported through the clean laundry area.

2. In the event an in-house laundry is utilized, special cleaning and decontamination processes shall be used for contaminated linens, if any.

E. A clinic shall provide housekeeping services which assure a safe and clean environment. Housekeeping procedures shall be in writing. Housekeeping supplies shall be made available to adequately maintain the cleanliness of the clinic.

F. Garbage and biohazardous or non-biohazardous waste shall be collected, stored and disposed of in a manner which prevents the transmission of contagious diseases and to control flies, insects, and animals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:85 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2651 (December 2015).

§7849. Health and Safety Requirements

A. Environmental Requirements. The clinic, including its grounds, buildings, furniture, appliances, and equipment, shall be structurally sound, in good repair, clean, and free from health and safety hazards.

1. The environment of the clinic shall ensure patient dignity and confidentiality.

2. The clinic shall prohibit weapons of any kind in the clinic or on the clinic premises.

B. Evacuation Procedures and First Aid. The clinic shall respond effectively during a fire or other emergency. Each clinic shall:

1. have an emergency evacuation procedure including provisions for the handicapped;

2. conduct fire drills at least quarterly and correct identified problems promptly;

3. be able to evacuate the building safely and in a timely manner;

4. post exit diagrams conspicuously throughout the clinic; and

5. post emergency telephone numbers by all telephones.

C. The clinic shall take all necessary precautions to protect its staff, patients and visitors from accidents of any nature.

D. The clinic shall have a written, facility-specific, disaster plan and its staff shall be knowledgeable about the plan and the location of the plan.

E. Emergency Care.

1. At least one employee on-site at each clinic shall be certified in basic cardiac life support (BCLS) and be trained in dealing with accidents and medical emergencies until emergency medical personnel and equipment arrive at the clinic.

2. A licensed pain management clinic shall have first aid supplies which are easily accessible to the clinic staff.

3. The following equipment and supplies shall be maintained and immediately available to provide emergency medical care for problems which may arise:

a. emergency medications, as designated by the medical director; and

b. any emergency medical supplies deemed necessary by the medical director and/or the governing body.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:85 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2651 (December 2015).

§7851. Quality Assurance

A. A licensed pain management clinic, with active participation of its medical staff, shall conduct an ongoing, comprehensive quality assurance (QA) program which shall be a self-assessment of the quality of care provided at the clinic. Quality indicators shall be developed to track and trend potential problematic areas. These quality indicators shall include, at a minimum, the following:

1. the medical necessity of procedures performed, complications as a result of such performed procedures, and appropriateness of care;

2. any significant adverse effects of medical treatment or medical therapy, including the number of overdoses of prescribed medications or the number of deaths resulting from such overdoses, or both;

3. the number of patients referred to other health care providers for additional treatment or to an addiction facility;

4. the number of patient or family complaints or grievances and their resolutions;

5. the number of patients the clinic refuses to continue to treat due to misuse, diversion of medications, or non-compliance with prescribed medication treatment regimen;

6. identified infection control incidents; and

7. the monitoring of patients who have been treated with prescribed narcotic pain medication for a continuous period of 12 months and longer.

B. At least quarterly, the clinic shall systematically analyze all data and develop a corrective action plan for identified problems determined through the clinic's QA process.

1. When appropriate, the clinic shall make revisions to its policies and procedures and provide written documentation that the corrective action plan has been monitored for continued sustained compliance to the appropriate standard of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:86 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2652 (December 2015).

Subchapter E. Patient Records

§7861. Patient Records

A. Retention of Patient Records

1. The clinic shall establish and maintain a medical record on each patient. The record shall be maintained to assure that the medical treatment of each patient is completely and accurately documented, records are readily available and systematically organized to facilitate the compilation and copying of such information.

a. Safeguards shall be established to maintain confidentiality and protection of the medical record, whether stored electronically or in paper form, from fire, water, or other sources of damage and from unauthorized access.

2. The department shall have access to all business records, patient records or other documents maintained by or on behalf of the clinic to the extent necessary to ensure compliance with this Chapter.

a. Ensuring compliance includes, but is not limited to:

i. permitting photocopying of records by the department; and

ii. providing photocopies to the department of any record or other information the department may deem necessary to determine or verify compliance with this Chapter.

3. Patient records shall be kept for a period of six years from the date a patient is last treated by the clinic. The patient records shall:

a. remain in the custody of the clinic, whether stored in paper form or electronically, in clinic or off-site; and

b. be readily available to department surveyors as necessary and relevant to complete licensing surveys or investigations.

B. Content of Medical Record

1. A medical record shall include, but is not limited to, the following data on each patient:

a. patient identification information;

b. medical and social history, including results from an inquiry to the Prescription Monitoring Program (PMP), if any;

c. physical examination;

d. chief complaint or diagnosis;

e. clinical laboratory reports, including drug screens, if any;

f. pathology report (when applicable), if any;

g. physicians orders;

h. radiological report (when applicable), if any;

i. consultation reports (when applicable), if any;

j. current medical and surgical treatment, if any;

k. progress or treatment notes;

l. nurses' notes of care, if any, including progress notes and medication administration records;

m. authorizations, consents, releases, and emergency patient or family contact number;

o. special procedures reports, if any;

p. an informed consent for chronic pain narcotic therapy; and

q. an agreement signed by the patient stating that he/she:

i. has been informed and agrees to obtain and receive narcotic prescriptions only from the licensed pain management clinic where he is receiving treatment for chronic pain;

ii. shall be subject to quarterly, periodic, unannounced urine drug screens;

iii. shall not participate in diversion of any controlled dangerous substance or narcotic medications, or both;

iv. shall not participate in illicit drug use; and

v. acknowledges that non-compliance with this agreement may be a reason for the clinic's refusal to treat.

2. An individualized treatment plan shall be formulated and documented in the patient's medical record. The treatment plan shall be in accordance with the board's pain rules and shall include, but is not limited to, the following:

a. medical justification for chronic pain narcotic therapy;

b. documentation of other medically reasonable alternative treatment for relief of the patient's pain have been considered or attempted without adequate or reasonable success; and

c. the intended prognosis of chronic pain narcotic therapy which shall be specific to the individual medical needs of the patient.

3. Signatures. Clinical entries shall be signed by a physician, as appropriate, i.e., attending physician, consulting physician, anesthesiologist, pathologist, etc. Nursing progress notes and assessments shall be signed by the nurse.

4. Progress Notes. All pertinent assessments, treatments and medications given to the patient shall be recorded in the progress notes. All other notes, relative to specific instructions from the physician, shall also be recorded.

5. Completion of the medical record shall be the responsibility of the patient's physician.

C. Provided the regulations herein are met, nothing in this Section shall prohibit the use of automated or centralized computer systems, or any other electronic or non-electronic techniques used for the storage of patient medical records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.2198.11-13.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:86 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2652 (December 2015).

Chapter 80. Children's Respite Care Centers

Subchapter A. General Provisions

§8001. Definitions

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

1. mobility;
2. transferring;
3. walking;
4. grooming;
5. bathing;
6. dressing and undressing;
7. eating;
8. toileting.

Advance Directives—an instruction given to the patient's family (see definition of family) such as a durable power of attorney for health care, a directive pursuant to patient self-determination initiatives, a living will, or an oral directive which either states a person's choices for medical treatment, or in the event the person is unable to make treatment choices, designates who shall make those decisions.

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

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

Branch—a location or site from which a children's respite care center (CRCC) agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the parent CRCC agency and is located within a 50-mile radius of the parent agency and shares administration and supervision.

Bureau—the Bureau of Health Services Financing of the Department of Health and Hospitals.

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

Children's Respite Care Center (CRCC)—an autonomous, centrally administered, pediatric medical respite program providing a continuum of home, outpatient, and homelike inpatient care for children living with life-limiting illnesses and their families. The CRCC employs an interdisciplinary team to assist in providing palliative and supportive care

combined with curative treatment to meet the special needs arising out of physical, emotional, spiritual, social, and economic stresses experienced during life-limiting illnesses as well as during dying and bereavement if a cure is not attained.

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

Core Services—medical respite program services, nursing services, physician services, social work services, counseling services, including bereavement counseling, pastoral counseling, and any other counseling services provided to meet the needs of the individual and family, and support services including trained volunteers. These services must be provided by employees of the CRCC, through contracted services and/or volunteers.

CRCC Premises—the physical site where the CRCC maintains staff to perform administrative functions, maintains personnel records, maintains client service records, provides a homelike environment for inpatient respite care, and holds itself out to the public as being a location for receipt of client referrals.

CRCC Services—a coordinated program of a continuum of care to children with life-threatening conditions, their families and caregivers, which allows access to palliative care while continuing with aggressive and curative treatment from the time of admission through bereavement, in the child's home, at the CRCC, and/or in medical facilities.

Department—the Department of Health and Hospitals (DHH).

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

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

Emotional Support—counseling provided to assist the individual and/or family in coping with stress, grief, and loss.

Employee—an individual whom the CRCC pays directly for services performed on an hourly or per visit basis and the CRCC is required to issue a form W-2 on his/her behalf. If a contracting service or another agency pays the individual, and is required to issue a form W-2 on the individual's behalf, or the individual is self-employed, the individual is not considered a CRCC employee. An individual is also considered a CRCC employee if the individual is a volunteer under the jurisdiction of the CRCC.

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

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

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

Home—a person's place of residence.

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

Inpatient Services—care available for treatment, pain control, symptom management and/or respite purposes that are provided in a participating facility.

Interdisciplinary Team (IDT)—an interdisciplinary group designated by the CRCC, composed of representatives from all the core services. The *IDT* must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The *interdisciplinary team* is responsible for:

1. participation in the establishment of the plan of care;

2. provision or supervision of CRCC care and services;

3. periodic review and updating of the plan of care for each individual receiving CRCC care; and

4. establishment of policies governing the day-to-day provision of CRCC care and services.

License (CRCC)—a document permitting an organization to provide children's respite care for a specific period of time under the rules and policies set forth by the state of Louisiana.

Life-Limiting Illness—a medical prognosis of limited expected survival because of ailment, illness, disease, or misfortune including, but not limited to:

1. injury;

2. accident;

3. cancer;

4. heart disease; and

5. congenital and chronic obstructive pulmonary disease.

Medical Director—a person who is a doctor of medicine or osteopathy, currently and legally authorized to practice medicine in the state of Louisiana who will:

1. serve as a consultant to the interdisciplinary team;

2. write orders in the event of an emergency in which the child's primary physician cannot be reached; and

3. attend monthly IDT meetings.

Medical Respite Care—the temporary care and supervision of a child living with a life-limiting illness so that the primary caregiver can be relieved of such duties. Such services may be performed in the home of the child or in a facility owned or leased by the children's respite care center.

Medical Social Services—includes:

1. a comprehensive psychosocial assessment;

2. ongoing support for the patient and family; and

3. assistance with coping skills, anticipatory grief, and grief reactions.

Non-Core Services—services provided directly by the CRCC employees, under arrangement, or through referral which include, but are not limited to:

1. home health aide;

2. physical therapy services;

3. occupational therapy services;

4. speech-language pathology services;

5. in-patient care for pain control and symptom management and respite purposes; and

6. medical supplies and appliances, including drugs and biologicals.

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

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

Pediatric—birth through age 20.

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

Representative—a person authorized under state law to act on behalf of an individual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:443 (February 2005).

§8003. Licensing

A. An application packet shall be obtained from the Department of Health and Hospitals (department or DHH). A completed application packet for a CRCC facility shall be submitted to and approved by DHH prior to an applicant providing CRCC services.

B. It shall be unlawful to operate or maintain a CRCC without first obtaining a license from the department. The Department of Health and Hospitals is the only licensing agency for CRCC in the state of Louisiana.

C. A separately licensed CRCC shall not use a name which is substantially the same as the name of another CRCC licensed by the department unless the applicant is part of a corporation or is chain affiliated.

D. The licensing agency shall have authority to issue two licenses as described below.

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

2. Provisional license is issued to those existing licensed applicants which do not meet the criteria for full licensure. The license shall be valid for six months or until the termination date stated on such license.

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

b. DHH may re-issue a provisional license or initiate licensing revocation of a provisional license when the CRCC fails to correct violations within 60 days of being cited, or at the time of the follow-up survey, whichever occurs first.

c. A provisional license may be issued by DHH for the following nonexclusive reasons:

i. the applicant has more than five violations of CRCC regulations during one survey;

ii. the applicant has more than three valid complaints in a one-year period;

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

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

v. the applicant has an inadequate referral base, other than at the time of the initial survey for licensure, has less than 10 new patients admitted since the last annual survey;

vi. the applicant fails to submit assessed fees after notification by DHH; or

vii. there is documented evidence that the applicant has bribed, or harassed any person to use the services of any particular CRCC agency.

E. The current license shall be displayed in a conspicuous place inside the CRCC program office at all times. A license shall be valid only in the possession of the CRCC to which it is issued and for only that particular physical address. A license shall not be subject to sale, assignment, or other transfer, voluntary or involuntary. A license shall not be valid for any CRCC other than the CRCC for which originally issued.

F. All requirements of the application process shall be completed by the applicant before the application will be processed by DHH. No application will be reviewed until payment of the application fee.

1. The applicant, with the exception of the demonstration model, must become fully operational and prepared for an initial survey within 90 days after payment of the application fee. If the agency is unable to do so, the application shall be considered closed and the agency shall be required to submit a new application packet, including fees.

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

a. a complete and accurate CRCC application packet. (This packet shall be purchased from DHH which contains the forms required for initial CRCC licensure. The fee for this packet shall be set by DHH.) The physical address provided on the application must be the physical address from which the applicant will be operating;

b. current licensing fee (as established by statute) by certified check, company check, or money order;

c. documentation of qualifications for the administrator and director of nursing. Any changes in the individuals designated or in their qualifications must be submitted to and approved by DHH prior to the initial survey;

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

e. approval for occupancy from the Office of the State Fire Marshal;

f. approval of plan review from the DHH's Division of Engineering and Architectural Services; and

g. a recommendation for licensure from the Office of Public Health.

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

H. All CRCCs required to be licensed by the law shall comply with the applicable rules and regulations contained in the Louisiana State Sanitary Code [Title 51 of the *Louisiana Administrative Code* (LAC 51)] as promulgated by the Office of Public Health. It shall be the primary responsibility of the Office of Public Health to determine if applicants are complying with those requirements. If a nursing facility published rule conflicts with this Chapter 80, the stricter of the two rules shall govern. No initial license shall be issued without the applicant furnishing a copy of the LHS-48 (Institution Report) form from the Office of Public Health stating that the applicant is complying with their provisions and is recommended for licensure. A provisional license may be issued to the applicant if the Office of Public Health issues the applicant a conditional certificate.

I. Construction documents (plans and specifications) are required to be submitted and approved by the Louisiana State Fire Marshal, the DHH's Division of Engineering and Architectural Services, and the Office of Public Health as a part of the licensing procedure and prior to obtaining a license.

1. Submission of Plans

a. The following documents shall be submitted for review and approval prior to construction:

i. one set of the final construction documents shall be submitted to the Louisiana State Fire Marshal for approval. The Fire Marshal's letter of approval and final inspection shall be sent to DHH's Division of Engineering and Architectural Services;

ii. one set of the final construction documents (plans and specifications) shall be submitted to the Louisiana Department of Health and Hospitals, Division of Engineering and Architectural Services, along with the appropriate review fee, and a plan review application form for approval; and

iii. one set of the final construction documents (plans and specifications) shall be submitted to the Office of Public Health for any ancillary facilities associated with the project including, but not limited to, plans and specifications for any food service facilities, swimming/treatment pools, water supply system (such as a facility's own water well/surface water treatment plant), or sewerage disposal system (such as the facility's own sewage treatment plant). Such plans and specifications shall be accompanied by a completed cover sheet which identifies the type of facility for which a license is to be applied for along with any of the proposed project's ancillary facilities. This Section shall not be interpreted to preclude the possibility of the necessity for the applicant to submit additional plans and specifications which may be required by the Office of Public Health.

b. Applicable Projects. Construction documents (plans and specifications) are required to be approved for the following type projects:

i. new construction;

ii. new CRCCs; or

iii. major alterations/substantial renovations.

c. The project shall be designed in accordance with the following criteria:

i. current Edition of *Guidelines for Design and Construction of Hospital and Health Care Facilities*, published by the American Institute of Architects, 1735 New York Ave., NW, Washington, D. C. 20006-5292 (Internet URL address: http://www.aia.org/);

ii. current edition of *NFPA 101*X*Life Safety Code*, published by the National Fire Protection Association, 1 Batterymarch, Quincy, MA 02169-7471 *(*Internet URL address: http://www.nfpa.org/);

iii. Part XIV (Plumbing) of the Louisiana State Sanitary Code (LAC 51:XIV);

iv. current edition of the Americans with Disabilities ActXAccessibility Guidelines for Buildings and Facilities (ADAAG);

v. the current Louisiana Department of Health and Hospitals licensing standards for children's respite care centers (LAC 48:I.Chapter 80); and

vi. applicable provisions of the Louisiana State Sanitary Code (LAC 51).

d. Preparation of Construction Documents. Construction documents (plans and specifications) for submission to the Louisiana Department of Health and Hospitals shall be prepared only by a Louisiana licensed architect or qualified licensed engineer as governed by the licensing laws of the state of Louisiana for the type of work to be performed. Construction documents submitted shall be of an architectural or engineering nature, and thoroughly illustrate the project through accurately drawn, dimensioned, and noted plans, details, schedules, and specifications. At a minimum, the following shall be submitted:

i. site plan(s);

ii. floor plan(s). These shall include architectural, mechanical, plumbing, electrical, fire protection, and if required by code, sprinkler, and fire alarm plans;

iii. building elevations;

iv. room finish, door, and window schedules;

v. details pertaining to Americans with Disabilities Act (ADA) requirements;

vi. specifications for materials; and

vii. an additional set of basic preliminary type, legible site plan and floor plans in either 8-1/2" x 11"; 8-1/2" x 14"; or 11" x 17" format. (These are for use by DHH in doing the final inspection of the facility and should include legible room names).

2. Approval of Plans

a. Notice of satisfactory review from DHH's Division of Engineering and Architectural Services, the Office of State Fire Marshal, and the Office of Public Health constitutes compliance with this requirement if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, ordinances, codes or rules of any responsible agency.

b. In the event that submitted materials do not appear to satisfactorily comply with all design criteria, the Department of Health and Hospitals, Division of Engineering and Architectural Services and/or the Office of Public Health shall furnish a letter to the party submitting the application for review, which lists the particular items in question and request further explanation and/or confirmation of necessary modifications.

3. Waivers

a. The secretary of the department may, within his sole discretion, grant waivers to building and construction guidelines which are not otherwise required under the provisions of the Louisiana State Sanitary Code. The facility must submit a waiver request in writing to the Division of Engineering and Architectural Services. The facility shall demonstrate how patient safety and the quality of care offered are not compromised by the waiver. The facility must demonstrate their ability to completely fulfill all other requirements of the waiver. The department will make a written determination of the request. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related to the waiver.

b. The secretary, in exercising his discretion, must at a minimum, require the applicant to comply with the edition of the building and construction guidelines which immediately preceded the 2001 edition of the *Guidelines for Design and Construction of Hospital and Health Care Facilities.*

c. The state health officer of the department may, within his sole discretion, grant waivers to building and construction guidelines which are required under the provisions of the Louisiana State Sanitary Code. The facility must submit a waiver request in writing to the state health officer. The facility shall demonstrate how public health and the quality of care offered are not compromised by the waiver. The facility must demonstrate their ability to completely fulfill all other requirements of the waiver. The state health officer will make a written determination of the request. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related to the waiver.

J. An applicant may be denied a license for the following reasons:

1. failure to comply with applicable federal, state, and local laws;

2. failure to complete the application process;

3. conviction of a felony by the following, as shown by a certified copy of the record of the court of the conviction:

a. owner;

b. administrator;

c. director of nursing;

d. members or officers, or the person(s) designated to manage or supervise the CRCC if the applicant is a firm or corporation.

K. Physical Environment

1. Equipment and furnishings in a CRCC facility shall provide for the health care needs of the resident while providing a home-like atmosphere.

2. The CRCC facility shall design and equip areas for the comfort and privacy of patients and family members. The facility shall have:

a. physical space for private patient/family visiting;

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

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

d. decor which is homelike in design and function.

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

a. be equipped with toilet and bathing facilities;

b. be equipped with a lavatory in each patient's room;

c. be at or above grade level;

d. contain room décor that is homelike and noninstitutional in design and function. Room furnishings for each patient shall include a bed with side rails, a bedside stand, an over-the-bed table, and individual reading light easily accessible to each patient, and a comfortable chair. The patient shall be permitted to bring personal items of furniture or furnishing into their rooms, unless medically inappropriate;

e. have closet space that provides security and privacy for clothing and personal belongings;

f. contain no more than two patient beds;

g. measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi patient room;

h. be equipped with a device for calling the staff member on duty. A call bell or other communication mechanism shall be placed within easy reach of the patient and shall be functioning properly. A call bell shall be provided in each patient's toilet, bath, and shower room; and

i. all patient rooms shall be outside rooms with a window of clear glass of not less than 12 square feet.

4. Water Temperature. The CRCC facility shall:

a. provide an adequate supply of hot water at all times for patient use;

b. have plumbing fixtures with a scald preventative valve of the pressure balancing, thermostatic, or combination mixing valve type that automatically regulates the temperature of the hot water used by patients to a maximum of 120°F; and

c. designate a staff member responsible for monitoring and logging water temperatures at least monthly. This person is responsible for reporting any problems to the administrator.

5. Linen Supply

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

b. The linen supply shall at all times be adequate to accommodate the number of beds and the number of incontinent patients.

c. Soiled linen and clothing shall be collected and enclosed in suitable bags or containers (covered carts or receptacles) and stored in a well ventilated area. Soiled linen shall not be permitted to accumulate in the facility.

d. The CRCC facility shall have policies and procedures that address:

i. frequency of linen changes;

ii. storage of clean linen; and

iii. storage of soiled linen.

6. The CRCC facility shall make provisions for isolating patients with infectious diseases. The CRCC should institute the most current recommendations of the Centers for Disease Control and Prevention (CDC) relative to the specific infection(s) and communicable disease(s). The CRCC facility shall isolate infected patients only to the degree needed to isolate the infecting organism. The method shall be the least restrictive possible while maintaining the integrity of the process and the dignity of the patient. The CRCC facility provisions for isolating patients with infectious diseases shall include:

a. definition of nosocomial infections and communicable diseases;

b. measures for assessing and identifying patients and health care workers at risk for infections and communicable diseases;

c. measures for prevention of infections, especially those associated with immunosupressed patients and other factors which compromise a patient's resistance to infection;

d. measures for prevention of communicable disease outbreaks;

e. provision of a safe environment consistent with the current CDC recommendations for identified infection and/or communicable disease;

f. isolation procedures and requirements for infected or immunosuppressed patients;

g. use and techniques for universal precautions;

h. methods for monitoring and evaluating practice of asepsis;

i. care of contaminated laundry, i.e., covered containers or receptacles, clearly marked bags and separate handling procedures;

j. care of dishes and utensils, i.e., clearly marked and handled separately;

k. use of any necessary gowns, gloves, or masks posted and observed by staff, visitors, and anyone else in contact with the patient;

l. techniques for hand washing, respiratory protection, asepsis sterilization, disinfection, needle disposal, solid waste disposal, as well as any other means for limiting the spread of contagion;

m. orientation of all CRCC personnel to the infection control program, and to communicable diseases; and

n. employee health policies regarding infectious diseases. When infected or ill, employees shall not render direct patient care.

7. The CRCC facility shall provide:

a. storage for administrative supplies;

b. hand washing facilities provided with hot and cold water, hand soap, and paper towels located convenient to each nurse's station and drug distribution station;

c. charting facilities for staff at each nurse's station;

d. a clean workroom which contains a work counter, sink with hot and cold water, storage facilities and covered waste receptacles;

e. a soiled workroom which contains a sink with hot and cold water and other facilities necessary for the receiving and cleanup of soiled equipment;

f. parking for stretchers and wheelchairs in an area out of the path of normal traffic and of adequate size for the facility;

g. a janitor's closet equipped with a floor drain and hot and cold water as well as mop hooks over the sink and storage space for housekeeping equipment and supplies;

h. a suitable multi-purpose lounge or lounges furnished for reception, recreation, dining, visitation, group social activities and worship. Such lounge or lounges shall be located convenient to the patient rooms designed to be served;

i. a conference and consultation room suitable and furnished for family privacy, clergy visitation, counseling, and viewing of a deceased patient's body during bereavement. The conference and consultation room shall be located convenient to the patient rooms it is designed to serve;

j. public telephone; and

k. public restrooms.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:444 (February 2005).

§8005. Survey

A. A survey shall be an on-site visit conducted to assure compliance with CRCC licensing standards. Home visits may be conducted as part of the survey to ascertain compliance.

B. Types of Survey

1. Initial Survey. After approval of the application by DHH, the CRCC must become fully operational, in substantial compliance with applicable federal, state, and local laws, and providing care to two and only two patients at the time of the initial survey. No inpatients shall be admitted until the initial on-site survey has been performed. The initial on-site survey shall be scheduled after the agency notifies the department that the agency is fully operational and providing services. If, at the initial licensing survey, an agency has violations of licensing standards which are determined to be of such a serious nature that they may cause or have the potential to cause actual harm, DHH may deny licensing.

2. Licensing Survey. A licensing survey is an unannounced on-site visit periodically conducted to assure compliance with CRCC licensing standards.

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

4. Complaint Survey. A complaint survey shall be conducted to investigate allegations of noncompliance.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:447 (February 2005).

§8007. License Renewal Process

A. A CRCC license must be renewed annually.

B. An agency seeking a renewal of its CRCC license shall:

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:447 (February 2005).

§8009. Fees

A. Any remittance submitted to DHH in payment of a required fee must be in the form of a company or certified check or money order made payable to the Department of Health and Hospitals.

B. Fee amounts shall be determined by DHH.

C. Fees paid to DHH are not refundable.

D. A fee is required to be submitted with the following:

1. an initial application;

2. a renewal application;

3. a change of controlling ownership; and

4. a change of name or physical address.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:448 (February 2005).

§8011. Changes

A. The Department of Health and Hospitals shall be notified, in writing, of any of the following within five working days of the occurrence:

1. change in physical address. (An agency must notify and receive approval from DHH prior to a change of physical address);

2. change of agency name;

3. change of phone number;

4. change of hours of operation/24 hour contact procedure;

5. change of ownership (controlling);

6. change in address or phone number of any branch office;

7. change of administrator (completed Key Personnel Change Form, obtained from DHH, is required); and

8. change of director of nursing (completed Key Personnel Change Form required); or

9. cessation of business.

B. Change of Ownership

1. Change of Ownership (CHOW) packets may be obtained from DHH. Only an agency with a full license shall be approved to undergo a change of ownership. A CRCC license is not transferable from one entity or owner to another.

2. The following must be submitted within five working days after the act of sale:

a. a new license application and the current licensing fee. The purchaser of the agency must meet all criteria required for initial licensure for CRCC;

b. any changes in the name and/or address of the CRCC;

c. any changes in administrative personnel (DON, administrator, medical director);

d. disclosure of ownership forms;

e. a copy of the Bill of Sale and Articles of Incorporation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:448 (February 2005).

§8013. Revocation or Denial of Renewal of License

A. The secretary of DHH may deny an application for a license, or refuse to renew a license or revoke a license in accordance with the Administrative Procedure Act. An agency's license may not be renewed and/or may be revoked for any of the following:

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

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

3. failure of the agency to protect patients/persons in the community from harmful actions of the agency employees; including, but not limited to:

a. health and safety;

b. coercion;

c. threat;

d. intimidation; and

e. harassment;

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

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

6. failure to employ qualified personnel;

7. failure to remain fully operational at any time for any reason other than a disaster;

8. failure to submit fees including, but not limited to:

a. annual fee;

b. renewal fee;

c. provisional follow-up fee; or

d. change of agency address or name; or

e. any fines assessed by DHH;

9. failure to allow entry to CRCC or access to any requested records during any survey;

10. failure to protect patients from unsafe, skilled and/or unskilled care by any person employed by CRCC;

11. failure of CRCC to correct violations after being issued a provisional license;

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

a. application for licensure;

b. data forms;

c. clinical records;

d. matters under investigations by the department;

e. information submitted for reimbursement from any payment source;

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

g. agency staff misrepresented or was fraudulent in conducting CRCC business; or

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:448 (February 2005).

§8015. Notice and Appeal

A. Notice shall be given in accordance with the current state statutes.

B. Administrative Reconsideration. The CRCC agency may request an administrative reconsideration of the violation(s) which support the department's actions. This is an informal process and reconsideration shall be conducted by a designated official(s) of the department who did not participate in the initial decision to impose the actions taken. Reconsideration shall be made solely on the basis of documents and/or oral presentations placed before the official and shall include the survey report and statement of violations and all documentation the CRCC submits to the department at the time of the agency's request for reconsideration. Correction of a violation shall not be a basis for reconsideration and a hearing shall not be held. Oral presentations can be made by the department's spokesperson(s) and the CRCC's spokesperson(s). This process is not in lieu of the administrative appeals process and does not extend the time limits for filing an administrative appeal. The designated official shall have the authority only to affirm the decision, to revoke the decision, to affirm part and revoke part, or to request additional information from either the department or the CRCC.

C. Administrative Appeal Process. Upon refusal of DHH to grant a license as provided in the current state statutes, or upon revocation or suspension of a license, or the imposition of a fine, the agency, institution, corporation, person, or other group affected by such action shall have the right to appeal such action by submitting a written request to the secretary of the department within 30 days after receipt of the notification of the refusal, revocation, suspension of a license, or imposition of a fine.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:449 (February 2005).

Subchapter B. Core Services

§8021. Core Services

A. Core services may be provided by employees of the CRCC or on a contractual basis. The CRCC is responsible for all actions of the contract personnel.

B. The CRCC must provide the following core services:

1. medical respite program services;

2. nursing services;

3. physician services;

4. social work services;

5. counseling services; and

6. support services, including trained volunteers and bereavement and pastoral care.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:449 (February 2005).

Subchapter C. Personnel

§8027. Administrator

A. The administrator is a person who is designated, in writing, by the governing body as administratively responsible for all aspects of CRCC operations. When the administrator serves more than one licensed agency, he/she

shall designate, in writing, an alternate to serve as administrator for each site where he/she is not physically housed continuously. The alternate shall be a full-time, on-site employee of the CRCC and shall meet the same qualifications as the administrator. The administrator and the director of nurses/alternates may be the same individual if that individual is dually qualified. An administrator serving as director of nurses, while employed by the CRCC, may not be employed by any other licensed health care agency.

1. An administrator must be a licensed physician, a licensed registered nurse, a social worker with a master's degree, or a college graduate with a bachelor's degree. An administrator shall have at least three years of documented management experience in a health care service delivery.

2. The administrator shall be responsible for compliance with all regulations, laws, policies and procedures applicable to the CRCC facility specifically and to Medicare/Medicaid issues when applicable. The administrator shall:

a. implement personnel and employment policies to assure that only qualified personnel are hired. Licensure and/or certification (as required by law) shall be verified prior to employment and annually thereafter and records shall be maintained to support competency of all allied health personnel;

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

c. ensure the CRCC employs qualified individuals;

d. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the CRCC, and available after hours as needed;

e. be responsible for and direct the day-to-day operations of the CRCC facility;

f. act as liaison among staff, patients and the governing board;

g. ensure that all services are correctly billed to the proper payer source;

h. designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the CRCC if the administrator is unavailable; and

i. designate in advance the IDT he/she chooses to establish policies governing the day-to-day provisions of the CRCC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:449 (February 2005).

§8029. Counselor-Bereavement

A. The bereavement counselor shall have documented evidence of appropriate training and experience in the care of the bereaved, received under the supervision of a qualified professional. The counselor shall implement bereavement counseling in a manner consistent with standards of practice and CRCC policy. Services include, but are not limited to:

1. assessment of grief counseling needs;

2. providing bereavement information and referral services to the bereaved, as needed, in accordance with the POC;

3. providing bereavement support to the CRCC staff as needed;

4. attending CRCC end of life IDT meetings; and

5. documenting bereavement services provided and progress of bereaved on clinical progress notes to be incorporated in the clinical record within one week of the visit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:449 (February 2005).

§8031. Counselor-Pastoral

A. The pastoral counselor shall have documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training. The counselor shall provide pastoral counseling based on the initial and ongoing assessment of spiritual needs of the patient/family, in a manner consistent with standards of practice including, but not limited to:

1. serving as a liaison and support to community chaplains and/or pastoral counselors;

2. providing consultation, support, and education to the IDT members on spiritual care;

3. attending IDT meetings; and

4. documenting pastoral services provided on clinical progress notes to be incorporated in the clinical record within one week of the visit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:450 (February 2005).

§8033. Dietician

A. The dietician shall be a registered dietician or a person who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association. The dietician shall implement dietary services consistent with standards of practice including, but not limited to:

1. clinical progress notes, including the nutritional status of the patient, are to be incorporated into the clinical records within one week of the visit;

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

3. instruct patient/family and/or CRCC staff as needed;

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

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

6. participate in IDT conference as needed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:450 (February 2005).

§8035. Dietary Manager

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:450 (February 2005).

§8037. Director of Nurses

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

B. The director of nurses shall be a registered nurse and must be currently licensed to practice in the state of Louisiana:

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

2. be a full-time employee of only one CRCC facility. The director of nurses is prohibited from simultaneous/concurrent employment.

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

1. the POC;

2. supervise employee health program, implement policies and procedures that establish and support quality patient care;

3. assure compliance with local, state, and federal laws, and promote health and safety of employees, patients and the community, using the following nonexclusive methods:

a. resolve problems;

b. perform complaint investigations;

c. refer impaired personnel to proper authorities;

d. provide orientation and in-service training to employees to promote effective CRCC services and safety of the patient, to familiarize staff with regulatory issues, and agency policy and procedures;

e. orient new direct health care personnel;

f. perform timely annual performance evaluations of health care personnel;

g. assure participation in regularly scheduled appropriate continuing education for all health professionals and home health aides;

h. assure that the care provided by the health care personnel promotes effective respite/end of life services and the safety of the patient; and

i. assure that the CRCC polices are enforced.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:450 (February 2005).

§8039. Governing Body

A. The CRCC shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the CRCC's total operation. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body. The governing body shall:

1. designate an administrator who is responsible for the day to day management of the CRCC program;

2. ensure that all services provided are consistent with accepted standards of practice;

3. develop and approve policies and procedures which define and describe the scope of services offered;

4. review policies and procedures at least annually and revise them as necessary; and

5. maintain an organizational chart that delineates lines of authority and responsibility for all CRCC personnel.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:451 (February 2005).

§8041. Home Health Aide

A. The home health aide shall be a qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse. The home health aide competency evaluation is to be completed by a registered nurse prior to the home health aide being assigned to provide patient care.

B. The home health aide shall:

1. have a current nursing assistant certification and have successfully completed a competency evaluation; or

2. have successfully completed a training program and have successfully completed a competency evaluation; or

3. have successfully completed a competency evaluation; and

4. exhibit maturity, an empathetic, sympathetic attitude, and ability to deal effectively with the demands of the job;

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

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

C. The home health aide shall provide services established and delegated in POC, record and notify the primary registered nurse of deviations according to standard practice including, but not limited to:

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

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

a. helping the patient with a bath, care of the mouth, skin and hair;

b. helping the patient to the bathroom or in using a bed pan or urinal;

c. helping the patient to dress and/or undress;

d. helping the patient in and out of bed, assisting with ambulating;

e. helping the patient with prescribed exercises which the patient and home health aide have been taught by appropriate personnel; and

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

D. The home health aide shall document each visit made to the patient and incorporate notes into the clinical record within one week of the visit.

E. The home health aide shall not:

1. perform any intravenous procedures, procedures involving the use of Levine tubes or Foley catheters, suctioning, or any other sterile or invasive procedures, other than rectal temperatures or enemas;

2. administer medications to any patient.

F. The home health aide shall attend an initial orientation. The orientation and training curricula for home health aides shall be detailed in a policies and procedures manual maintained by the CRCC agency. Provision of orientation and training shall be documented in the employee personnel record. The content of the basic orientation provided to home health aides shall include:

1. policies and objectives of the agency;

2. duties and responsibilities of a home health aide;

3. the role of the home health aide as a member of the health care team;

4. emotional problems associated with life-limiting illnesses;

5. information on the stages of childhood development;

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

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

8. ethics; and

9. confidentiality.

G. Home health aide initial training shall include the following areas of instruction:

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

2. documentation;

3. procedures for maintaining a clean healthful environment; and

4. changes in the patient's condition to be reported to the supervisor.

H. The home health aide must have a minimum of 12 hours of appropriate in-service training annually. In-service training may be prorated for employees working a portion of the year. However, part-time employees who worked throughout the year must attend all 12 hours of in-service training. In-services may be furnished while the aide is providing services to the patient, but must be documented as training.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:451 (February 2005).

§8043. Licensed Practical Nurse

A. The licensed practical nurse (LPN) shall work under the direct supervision of a registered nurse and perform skilled nursing services as delegated by a registered nurse.

B. A licensed practical nurse must:

1. be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions; and

2. have at least two years full-time experience as an LPN; and

3. when employed by more than one agency, inform all employers and coordinate duties to assure quality provision of services.

C. The LPN shall perform skilled nursing services under the supervision of a registered nurse, in a manner consistent with standard of practice including, but not limited to, such duties as:

1. observing, recording and reporting to the registered nurse or director of nurses on the general physical and mental conditions of the patient;

2. administering prescribed medications and treatments as permitted by state or local regulations;

3. assisting the physician and/or registered nurse in performing specialized procedures;

4. preparing equipment for treatments, including sterilization, and adherence to aseptic techniques;

5. assisting the patient with activities of daily living;

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

7. performing complex wound care, if an in-service is documented for the specific procedure;

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

9. may receive verbal orders from the physician regarding their assigned patients.

D. An LPN shall not:

1. access any intravenous appliance for any reason;

2. perform supervisory aide visits;

3. develop and/or alter the POC;

4. make an assessment visit;

5. evaluate recertification criteria;

6. make aide assignments; or

7. function as a supervisor of the nursing practice of any registered nurse.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:452 (February 2005).

§8045. Medical Director/Physician Designee

A. The medical director/physician designee is a physician, currently and legally authorized to practice medicine in the state, and knowledgeable about the medical and psychosocial aspects of pediatric palliative care. The medical director reviews, coordinates, and is responsible for the management of clinical and medical care for all patients. The medical director or physician designee may be an employee or a volunteer of the agency. The agency may also contract for the services of the medical director or physician designee. The medical director/physician designee shall be a doctor of medicine or osteopathy licensed to practice in the state of Louisiana.

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

1. serving as a consultant with the attending physician regarding pain and symptom control as needed;

2. serving as the attending physician, if designated by the patient/family unit;

3. reviewing patient eligibility for CRCC services;

4. serving as a medical resource for the interdisciplinary team;

5. developing and coordinating procedures for the provision of emergency medical care;

6. participating in the development of the POC prior to providing care, unless the POC has been established by an attending physician; and

7. participating in the review and update of the POC, unless the plan of care has been reviewed/updated by the attending physician. These reviews must be documented.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:452 (February 2005).

§8047. Occupational Therapist

A. An occupational therapist, when provided, must be licensed by the state of Louisiana and registered by the American Occupational Therapy Association.

B. The occupational therapist shall assist the physician in evaluating the patient's level of functioning by applying diagnostic and prognostic procedures including, but not limited to:

1. providing occupational therapy in accordance with physician's orders and the POC;

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

3. observing, recording, and reporting to the physician and/or interdisciplinary team the patient's reaction to treatment and any changes in the patient's condition;

4. instructing and informing other health team personnel including, when appropriate, home health aides and family members in certain phases of occupational therapy in which they may work with the patient;

5. documenting each visit made to the patient and incorporating notes into the clinical record within one week of the visit;

6. participating in IDT conferences as needed; and

7. preparing a written discharge summary when applicable, with a copy retained in patient's clinical record and a copy forwarded to the attending physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:452 (February 2005).

§8049. Pharmacist

A. The CRCC shall employ a pharmacist licensed in the state of Louisiana or have a written agreement with a pharmacist licensed in the state of Louisiana to advise the CRCC facility on ordering, storage, administration, disposal, and record keeping of drugs and biologicals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:453 (February 2005).

§8051. Physical Therapist

A. The physical therapist (PT), when provided, must be currently licensed by the Louisiana State Board of Physical Therapy Examiners. The physical therapist shall assist the physician in evaluating the patient's functional status and physical therapy needs in a manner consistent with standards of practice to include, but not limited to:

1. assisting in the formation of the POC;

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

3. observing and reporting to the physician and the IDT, the patient's reaction to treatment and any changes in the patient's condition;

4. instructing and informing participating members of the IDT, the patient, family/care givers, regarding the POC, functional limitations and progress toward goals;

5. documenting each visit made to the patient and incorporating notes into the clinical record within one week of the visit;

6. when physical therapy services are discontinued, preparing a written discharge summary, with a copy retained in the patient's clinical record and a copy forwarded to the attending physician; and

7. participating in IDT conferences as needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:453 (February 2005).

§8053. Registered Nurse

A. The CRCC facility shall designate a registered nurse (RN) to coordinate the implementation of the POC for each patient.

B. A licensed RN must be currently licensed to practice in the state of Louisiana with no restrictions and:

1. have at least two years full-time experience as a registered nurse; and

2. if employed by more than one agency, he/she must inform all employers and coordinate duties to assure quality service provision.

C. The registered nurse shall:

1. identify the patient's physical, psychosocial, and environmental needs and reassess as needed;

2. provide nursing services in accordance with the POC;

3. document problems, appropriate goals, interventions, and patient/family response to CRCC care;

4. collaborate with the patient/family, attending physician and other members of the IDT in providing patient and family care;

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

6. supervise ancillary personnel and delegate responsibilities when required;

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

8. prepare specific written instructions for patient care when home health aide services are provided;

9. supervise and evaluate the home health aides ability to perform assigned duties, to relate to the patient and to work effectively as a member of the health care team;

10. when home health aides are assigned, will perform supervisory visits to the patient's residence at least every 30 days to assess relationships and determine whether goals are being met; and

11. document supervision, to include the aide/patient/family relationships, services provided and instructions and comments given, as well as other requirements on the clinical notes.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:453 (February 2005).

§8055. Social Worker

A. The social worker shall have a master's degree from a school of social work and be licensed by the Louisiana State Board of Social Work Examiners. The social worker shall have documented clinical experience appropriate to the counseling and casework needs of children with life-limiting illnesses and their families. When the social worker is employed by one or more agencies he/she must inform all employers and cooperate and coordinate duties to assure the highest performance of quality when providing services to the patient and family.

B. The social worker shall assist the physician and other IDT members in understanding significant social and emotional factors relating to the patient's health status and shall include, but not be limited to:

1. assessment of the social and emotional, and familial factors having an impact on the patient's health status;

2. assisting in the formulation of the POC;

3. providing services within the scope of practice as defined by state law and in accordance with the POC;

4. coordination with other IDT members and participating in IDT conferences;

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

6. participating in discharge planning, and in-service programs related to the needs of the patient and family;

7. acting as a consultant to other members of the IDT; and

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:453 (February 2005).

§8057. Speech Pathologist

A. A speech pathologist, when provided, must be licensed by the Louisiana Board of Examiners for Speech-Language Pathology and Audiology. The speech pathologist shall assist the physician in evaluation of the patient to determine the type of speech or language disorder and the appropriate corrective therapy in a manner consistent with standards of practice to include, but not limited to:

1. providing rehabilitative services for speech and language disorders;

2. observing, recording and reporting to the physician and the IDT the patient's reaction to treatment and any changes in the patient's condition;

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

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

5. participating in IDT conferences, as needed;

6. documenting each visit made to the patient and incorporating notes in the clinical record within one week of the visit; and

7. preparing a written discharge summary as indicated with a copy retained in patient's clinical record and a copy forwarded to the attending physician.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:454 (February 2005).

§8059. Volunteers

A. Volunteers play a vital role in enhancing the quality of care delivered to the patient/family by encouraging community participation in the overall CRCC program. Volunteers who provide patient care and support services according to their experience and training must be in compliance with agency policies, and under the supervision of a CRCC employee. Volunteers shall be mature, nonjudgmental, caring individuals supportive of the CRCC concept of care, willing to serve others, and appropriately oriented and trained. Volunteers who are qualified to provide professional services must meet all standards associated with their specialty area.

B. The volunteer shall:

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

2. provide input into the plan of care and interdisciplinary group meetings, as appropriate;

3. document services provided:

4. maintain strict patient/family confidentiality; and

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

C. The volunteers must receive appropriate documented training which shall include at a minimum:

1. an introduction to CRCC;

2. the role of the volunteer in CRCC;

3. concepts of death and dying;

4. communication skills;

5. care and comfort measures;

6. diseases and medical conditions;

7. stages of child development;

8. the concept of the CRCC family;

9. stress management;

10. bereavement;

11. infection control;

12. safety;

13. confidentiality;

14. patient rights; and

15. the role of the IDT.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:454 (February 2005).

Subchapter D. Patient Care Services

§8067. Admission Criteria

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

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

2. documentation of a life-threatening illness signed by a physician;

3. assessment of the patient/family needs and desire for CRCC services;

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

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

B. Admission Procedures. Patients are to be admitted only upon the order of the patient's physician. An assessment visit shall be made by a registered nurse, who will assess the patient's needs. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by the physician or unless a request for delay is made by the patient/family. Documentation at admission will be retained in the clinical record and shall include:

1. signed consent forms;

2. signed patient's rights statement;

3. clinical data including physician order for care;

4. patient release of information;

5. orientation of the patient/care giver, which includes:

a. advanced directives;

b. agency services;

c. patient's rights; and

d. agency contact procedures; and

6. physician's documentation of the life-limiting illness.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:454 (February 2005).

§8069. Plan of Care (POC)

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

B. At least one of the persons involved in developing the POC must be the registered nurse who conducted the initial assessment. Within three days of the assessment, the IDT must establish the POC. The POC shall be signed by the physician and an appropriate member of the IDT.

C. At a minimum the POC will include:

1. an assessment of the individual's needs and identification of services;

2. detailed description of the scope and frequency of services needed to meet the patient's and family's needs;

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

4. medical supplies and appliances, including drugs and biologicals needed for the palliation and management of the life-limiting illness and related conditions;

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

6. recognition of the patient/family's psychological, social, religious and cultural variables, values, strengths, and risk factors.

D. The POC shall be incorporated into the clinical record within one week of its completion.

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

F. The plan of care shall be reviewed and updated when the patient's condition changes, and at a minimum every 90 days for home care and every 14 days for inpatient care, collaboratively with the IDT and the physician.

G. the agency shall have documented policies and procedures for the following:

1. the physician's participation in the development, revision, and approval of the POC. This is evidenced by a change in patient orders and documented communication between CRCC staff and the physician;

2. physician orders must be signed and dated in a timely manner, not to exceed 30 days.

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

I. The CRCC shall adhere to the following additional principles and responsibilities:

1. an assessment of the patient/family needs and desire for services and the CRCC programs' specific admission, transfer, and discharge criteria to determine any changes in services;

2. core services routinely available to CRCC patients on a 24-hour basis, seven days a week;

3. all other covered services available to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of a life-limiting illness and related conditions;

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

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

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

7. maintenance of contracts/agreements for the provision of services not directly provided by the CRCC;

8. provision or access to emergency medical care;

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

10. maintenance of appropriately qualified IDT health care professionals and volunteers to meet the patient's need;

11. maintenance and documentation of a volunteer staff that provide administrative and/or direct patient care. The CRCC must document a continuing level of volunteer activity; and

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:455 (February 2005).

§8071. Pharmaceutical Services

A. The CRCC facility shall ensure that pharmaceutical services are provided under the directions of a pharmacist licensed to practice in the state of Louisiana. The facility shall ensure that pharmaceutical services are provided in accordance with appropriate methods and procedures for the storage, dispensing and administering of drugs and biologicals. The CRCC facility is responsible for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate federal, state, and local laws, whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility. The CRCC shall ensure the appropriate monitoring and supervision of the pharmaceutical needs of the patient, and have written policies governing prescribing, administering, controlling, storing and disposing of all biologicals and drugs.

B. The CRCC shall provide for the pharmaceutical needs of the patient, consistent with the Board of Pharmacy regulations.

C. The CRCC shall institute procedures which protect the patient from medication errors.

D. CRCC procedures shall provide verbal and written instructions to patient and family as indicated.

E. CRCC policies and procedures shall describe which drugs and treatments are administered by the agency. All drugs shall be administered in compliance with the needs of the client and applicable laws and regulations.

F. The CRCC pharmacy shall have a pharmacy permit issued by the Louisiana Board of Pharmacy to allow ordering, storage, dispensing, and delivering of legend prescriptive orders. The CRCC shall have a current controlled dangerous substance license and a DEA registration. Pharmacy services shall be directed by a registered pharmacist licensed to practice in Louisiana.

G. A physician must order all medications for the patient.

1. If the medication order is verbal, the physician shall give it only to a licensed nurse, pharmacist, or another

physician; and the individual receiving the order shall record and sign it immediately.

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

H. Patients shall be accurately identified prior to administration of a medication.

1. Medications shall be administered only by a physician, a licensed nurse, the patient, or the parent or guardian, if his or her attending physician has approved.

2. Physicians' orders shall be checked at least daily to assure that changes are noted.

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

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

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

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

c. times of administration;

d. the initials of persons administering the medication (the initials shall be identified on the MAR to identify the individual by name);

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

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

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

h. medication errors and drug reactions shall be immediately reported to the director of nurses, pharmacist and physician and an entry made in the patients' medical record and/or an incident report. This procedure shall include recording and reporting to the physician the failure to administer a drug, for any reason other than refusal of a patient to take a drug. The refusal of a patient to take a drug shall be reported to the DON and the physician and an entry made in the patients' medical record;

i. the nurses station or medicine room for all CRCC facilities shall have readily available items necessary for the proper administration and accounting of medications;

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

I. Each CRCC facility shall have a procedure for at least quarterly monitoring of medication administration. This monitoring shall be accomplished by a registered nurse or a pharmacist, to assure accurate administration and recording of all medications.

J. Procedures for storing and disposing of drugs and biologicals shall be established and implemented by the CRCC facility.

1. In accordance with state and federal laws, all drugs and biologicals shall be stored in locked compartments under proper temperature controls and only authorized personnel shall have access to the keys. A separately locked compartment shall be provided for storage of all controlled drugs and other drugs subject to abuse.

2. Controlled drugs no longer needed by the patient shall be disposed of in compliance with state requirements. In the absence of state requirements, the pharmacist and a registered nurse shall dispose of the drugs and prepare a record of the disposal. Each CRCC shall establish procedures for release of patient's own medications upon discharge or transfer of the patient. An entry of such release shall be entered in the medical record to include drugs released, amounts, who received the drugs and signature of the person carrying out the release.

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

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

5. Sufficient lighting shall be provided and the temperature of the medicine storage area shall not be lower than 48ºF or above 85ºF and the room shall have adequate ventilation.

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

7. No laboratory solutions or materials awaiting laboratory pickup or foods shall be stored in the same

storage area (i.e., cupboard, refrigerator, or drawer) with drugs and biologicals. The areas designated for drug and biological storage shall be clearly marked.

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

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

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

9. The CRCC shall develop policies and procedures for maintaining an emergency medicine cabinet for the purpose of keeping a minimum amount of stock medications that may be needed quickly or after regular duty hours. The following rules shall apply to such a cabinet.

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

b. There shall be a minimum number of doses of any medication in the emergency medicine cabinet based upon the established needs of the CRCC facility.

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

d. There shall be written procedures for utilization of the emergency medicine cabinet with provisions for prompt replacement of used items.

e. The emergency medicine cabinet shall be inspected at least monthly replacing outdated drugs and reconciliation of its prior usage. Information obtained shall be included in a monthly report.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:455 (February 2005).

§8073. Pathology and Laboratory Services

A. The CRCC shall provide or have access to pathology and laboratory services which comply with Clinical Laboratory Improvement Amendments (CLIA) guidelines and meet the patient's needs.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:457 (February 2005).

§8075. Discharge/Transfer

A. The CRCC shall provide adequate and appropriate patient/family information at the time discharge or transfer.

B. The CRCC shall develop appropriate policies/procedures for discharge planning.

C. The CRCC shall clearly document the reason for discharge. The CRCC patient shall be discharged only under following circumstances:

1. change in status of the life-limiting illness;

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

3. patient no longer qualifies for CRCC services due to age;

4. patient/family's noncompliance with the POC;

5. if the patient transfers to another agency or services; or

6. when the patient's representative elects to discontinue services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:457 (February 2005).

§8077. Patient Rights and Responsibilities

A. The CRCC shall ensure that the patient has the right to:

1. be cared for by a team of professionals who provides high quality comprehensive services as needed and appropriate for patient/family;

2. have a clear understanding of the availability of CRCC services;

3. receive appropriate and compassionate care regardless of race, gender, creed, disability, sexual orientation or the ability to pay for services rendered;

4. be fully informed regarding patient status in order to participate in the POC. The professional team shall assist patient/family in identifying which services and treatments will help attain these goals;

5. be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to patient/family personal wishes;

6. be treated with respect and dignity;

7. have patient/family trained in effective ways of caring for the patient;

8. confidentiality with regard to provision of services and all client records, including information concerning patient/family health status, as well as social, and/or financial circumstances. The patient information and/or records shall be released only with patient/family's written consent, and or as required by law;

9. voice grievances concerning patient care, treatment, and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the CRCC; and

10. be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible.

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

C. The patient/family has the responsibility to:

1. participate in developing the POC and update as his or her condition/needs change;

2. provide CRCC with accurate and complete health information;

3. remain under a doctor's care while receiving CRCC services; and

4. assist CRCC staff in developing and maintaining a safe environment in which patient care can be provided.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:457 (February 2005).

§8079. Clinical Records

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

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

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

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

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

F. Records for individuals under the age of majority shall be kept in accordance with current state and federal law.

G. When applicable, the agency shall obtain a signed Release of Information Form from the patient and/or the patient's family. A copy shall be retained in the record.

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

1. initial and subsequent plans of care and initial assessment;

2. documentation of a life-limiting diagnosis;

3. written physician's orders for admission and changes to the POC;

4. current clinical notes {at least the past 60 days);

5. plan of care;

6. signed consent and authorization forms;

7. pertinent medical history; and

8. identifying data, including:

a. name;

b. address;

c. date of birth;

d. sex;

e. agency case number; and

f. next of kin.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:458 (February 2005).

§8081. Nursing Services

A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction of a director of nursing, who is a registered nurse licensed to practice in Louisiana, employed full time by only one licensed agency. There shall be a similarly qualified registered nurse available to act in the absence of the director of nursing.

B. The CRCC facility shall have staff on the premises on a 24-hour a day, seven-day a week basis. There shall be a registered nurse on duty at all times when patients are in the facility. In addition, the facility shall provide nursing services sufficient to meet the total nursing needs of the patients in the facility. When there are no patients in the

CRCC facility, the facility shall have a registered nurse on-call to be immediately available to the CRCC facility. The services provided must be in accordance with the patient's plan of care. Each shift shall include at least two direct patient care staff, one of which must be a registered nurse who provides direct patient care. The nurse to patient ratio shall be at least one nurse to every eight patients. In addition, there shall be sufficient number of direct patient care staff on duty to meet the patient care needs.

C. Written nursing policies and procedures shall define and describe the patient care provided.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:458 (February 2005).

§8083. Nutritional Services

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

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

C. The CRCC facility shall have a dietary manager who is responsible for:

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

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

D. The CRCC facility shall:

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

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

3. be designed and equipped to procure, store, prepare, distribute, and serve all food under the requirements of Part XXIII (Retail Food Establishments) of the Louisiana State Sanitary Code (LAC 51:XXIII); and

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

E. Sanitary Conditions

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

2. All food provided by the CRCC shall be procured from sources that comply with all laws and regulations related to food and food labeling.

3. All food shall be stored, prepared, distributed and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink at or below 41ºF, except when being prepared and served. Refrigerator temperatures shall be maintained at 41ºF or below; freezers at 0ºF or below.

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

5. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized and stored. This includes maintaining a water temperature in dish washing machines at 140ºF during the wash cycle (or according to the manufacturer's specifications or instructions) and 180ºF for the final rinse. Low temperature machines shall maintain a water temperature of 120ºF with 50 ppm (parts per million) of hypochlorite (household bleach) on dish surfaces. For manual washing in a three-compartment sink, a wash water temperature of 75ºF with 50 ppm of hypochlorite or equivalent or 12.5 ppm of iodine; or a hot water immersion at 171ºF for at least 30 seconds shall be maintained. An approved lavatory shall be convenient and equipped with hot and cold water tempered by means of a mixing valve or combination faucet for dietary services staff use. Any self-closing, slow-closing, or metering faucet shall be designed to provide a flow of water for at least 15 seconds without the need to reactivate the faucet.

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

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

8. Toxic items such as insecticides, detergents, polishes and the like shall be properly stored, labeled and used.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:458 (February 2005).

Subchapter E. Administration

§8089. Agency Operations

A. Premises (see definition of *CRCC premises*)

1. The CRCC must have a distinct telephone number. If the telephone number is shared with other health care related agencies, the telephone operator(s) shall demonstrate knowledge and ability to distinguish and direct calls to the appropriate persons. If an answering service is used after normal hours, there shall be evidence of distinct CRCC staff and the answering service should be able to direct calls to the appropriate persons for each service. Staff shall be able to distinguish and describe the scope and delineation of all activities being provided by the CRCC.

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

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

B. Hours of Operation

1. CRCC provides medical and nursing services 24 hours a day, seven days per week. In addition the facility shall ensure staff availability to assess and meet changing patient/family needs, provide instruction and support, and conduct additional assessment or treatment, 24 hours a day, seven days per week.

2. If the CRCC has no inpatients, there still shall be an RN on call at all times.

C. All policies and procedures:

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

2. shall contain policies and procedures specific to agency addressing personnel standards and qualifications, personnel records, agency operations, emergency procedures, patient care standards, patient rights and responsibilities, problem and complaint resolution, purpose and goals of operation, the defined service area, emergency/disaster procedures, as well as regulatory and compliance issues; and

3. shall meet or exceed requirements of the licensing standards and all applicable federal, state, and local laws.

D. Operational Requirements

1. CRCC's responsibility to the community:

a. shall not accept orders to assess or admit from any source other than a licensed physician or authorized physician representative (e.g., hospital discharge planner);

b. shall use only factual information in advertising;

c. shall not participate in solicitation;

d. shall not accept as a patient any person who does not have a diagnosis of a life-limiting illness and meet the age requirements;

e. shall develop policies/procedures for patients with no or limited payor source;

f. shall have policies and procedures and a written plan for emergency operations in case of disaster;

g. is prohibited from harassing or coercing a prospective patient or staff member to use a specific facility or to change to another CRCC;

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

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

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

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

a. being in compliance with licensing standards and all applicable federal, state, and local laws at all times;

b. acting as the patient advocate in medical decisions affecting the patient;

c. protecting the patient from unsafe skilled and unskilled practices;

d. protecting the patient from being harassed, bribed, and or any form of mistreatment by an employee or volunteer of the agency;

e. providing patient information on the patient's rights and responsibilities;

f. providing information on advanced directives in compliance with all applicable federal, state, and local laws;

g. protecting and assuring that patient's rights are not violated;

h. encouraging the patient/family to participate in developing the POC and provision of services;

i. making appropriate referrals for family members outside the CRCC's service area for bereavement follow-up.

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

a. providing a safe working environment;

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

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

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

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

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

v. a safe and sanitary system for identifying, handling, and disposing of potentially infectious biomedical wastes; and

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

c. have policies which encourage realistic performance expectations;

d. provide adequate time on schedule for required travel;

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

f. provide in-service training to promote effective, quality CRCC care.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:459 (February 2005).

§8091. Contract Services

A. The administrator and the DON shall be direct employees of the CRCC.

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

1. identification of the services to be provided;

2. a stipulation that services shall be provided only with the express authorization of the CRCC;

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

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

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

6. the qualifications of the personnel providing the services;

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

8. payment fees and terms; and

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

C. The CRCC shall document review of contracts on an annual basis.

D. The CRCC shall coordinate services with contract personnel to assure continuity of patient care.

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

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

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

§8093. Quality Assurance

A. The CRCC shall have an on-going comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care is provided at all times in compliance with accepted standards of professional practice.

B. The CRCC shall have written plans, policies and procedures addressing quality assurance.

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

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

1. goals and objectives;

2. the identity of the person responsible for the program;

3. a system to ensure systematic, objective regular reports are prepared and distributed to the governing body and any other committees as directed by the governing body;

4. the method for evaluating the quality and the appropriateness of care;

5. a method for resolving identified problems; and

6. a method for implementing practices to improve the quality of patient care.

E. The plan shall be reviewed at least annually and revised as appropriate by the governing body.

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

1. services provided by professional and volunteer staff;

2. audits of patient charts;

3. reports from staff, volunteers, and clients about services;

4. concerns or suggestions for improvement in services;

5. organizational review of the CRCC program;

6. patient/family evaluations of care; and

7. high-risk, high volume and problem-prone activities.

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

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

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

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

§8095. Cessation of Business

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

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

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

1. have had at least 10 new patients admitted since the last annual survey;

2. be able to accept referrals at any time;

3. have adequate staff to meet the needs of their current patients;

4. have required designated staff on the premises at all times during operation;

5. be immediately available by telecommunications 24 hours per day. A registered nurse shall answer calls from patients and other medical personnel after hours; and

6. be open for the business of providing CRCC services to those who need assistance.

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

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

Chapter 82. Minimum Standards for Licensure of Hospice Agencies

Subchapter A. General Provisions

§8201. Definitions

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

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

a. mobility;

b. transferring;

c. walking;

d. grooming;

e. bathing;

f. dressing and undressing;

g. eating; and

h. toileting.

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

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

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

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

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

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

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

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

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

Chaplain—a member of the clergy.

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

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

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

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

Department—the Department of Health (LDH).

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

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

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

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

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

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

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

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

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

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

Home—a person's place of residence.

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

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

experienced during the final stages of illness and during dying and bereavement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. hospice aide and homemaker;

b. physical therapy services;

c. occupational therapy services;

d. speech-language pathology services;

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

f. medical supplies and appliances including drugs and biologicals.

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

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

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

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

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

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

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

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

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

a. the former inmate shall not have been convicted of a sex offense as defined by R.S. 27 15:541;

b. while incarcerated, the former inmate shall have been a caregiver in the licensed hospice program, with documentation of such, and successfully completed the training pursuant to subsection B of R.S.40:2192;

c. the former inmate shall hold a certification issued by the Department of Public Safety and Corrections;

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

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

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

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

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

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

§8203. Licensing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Display of License. The current license shall be displayed in a conspicuous place inside the hospice program office at all times. A license shall be valid only in the possession of the agency to which it is issued. A license shall not be subject to sale, assignment, or other transfer, voluntary or involuntary. A license shall not be valid for any

hospice other than the hospice for which originally issued. If an agency has been issued a sublicense for its hospice inpatient facility, both license and sublicense shall be displayed.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. failure to comply with applicable federal, state, and local laws;

2. failure to complete the application process;

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

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

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

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

b. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new application packet and fee.

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

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

§8205. Survey

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

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

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

3. The initial survey will be scheduled after the agency notifies the department that the agency had become

operational and is ready for the survey as provided in §8205.A.1.

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

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

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

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

D. Statement of Deficiencies

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

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

E. Complaint Investigations

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

2. Complaint investigations shall be unannounced.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. failure to employ qualified personnel;

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

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

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

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

a. application for licensure;

b. data forms;

c. clinical record;

d. matter under investigation by the department;

e. information submitted for reimbursement from any payment source;

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

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

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

12. failure to maintain proper insurance; or

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

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

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

§8209. License Renewal Process

A. License shall be renewed annually.

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

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

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

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

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

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

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

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

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

B. Administrative Reconsideration

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

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

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

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

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

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

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

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

C. Administrative Appeal Process

1. Upon refusal of LDH to grant or renew a license as provided in the current state statutes, or upon revocation or suspension of a license, or the imposition of a fine, the affected agency, institution, corporation, person, or other group shall have the right to appeal such action by

submitting a written request to the Division of Administrative Law (DAL) or its successor:

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

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

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

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

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

§8213. Fees

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

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

C. Fees paid to LDH are not refundable.

D. A licensing fee is required for:

1. an initial application;

2. a renewal;

3. a change of controlling ownership; and

4. a change of location.

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

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

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

§8215. Changes

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

1. address/location (an inpatient hospice facility shall notify and receive approval by LDH prior to a change of address/location)—fee required;

2. agency name - fee required;

3. phone number;

4. hours of operation/24 hour contact procedure;

5. ownership (Controlling) - fee required;

6. change in address of any branch office—fee required;

7. administrator (completed key personnel change form, obtained from LDH required);

8. director of nursing (completed key personnel change form required); or

9. cessation of business in accordance with the requirements of §8243.

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

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

2. Submit the following documents for a CHOW:

a. a new license application and the current licensing fee. The purchaser of the agency shall meet all criteria required for initial licensure for hospice in accordance with the provisions of §8203;

b. any changes in the name and or address of the agency;

c. any changes in administrative personnel;

d. disclosure of ownership forms; and

e. a copy of the bill of sale and articles of incorporation.

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

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

§8216. Emergency Preparedness

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

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

1. preparation for evacuation;

2. training of employees;

3. patient and caregiver education and individual preparedness;

4. tracking of staff and patients;

5. communication and chain of command;

6. sheltering in place; and

7. coordination with local and state emergency operation offices.

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

1. patients who live alone, without a caregiver and are unable to evacuate themselves;

2. patients with a caregiver physically or mentally incapable of carrying through on an evacuation order;

3. patients/caregivers without the financial means to carry through on an evacuation order; or

4. patients/caregivers refusing to evacuate.

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

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

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

Subchapter B. Organization and Staffing

§8217. Personnel Qualifications/Responsibilities

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

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

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

a. ensure the hospice employs qualified individuals;

b. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the hospice, and available after hours as needed;

c. be responsible for and direct the day-to-day operations of the hospice;

d. act as liaison among staff, patients, and governing board;

e. ensure that all services are correctly billed to the proper payer source;

f. designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and

g. designate in advance the IDT he/she chooses to establish policies governing the day-to-day provisions of hospice care.

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

a. Medicare and Medicaid regulations;

b. management practices;

c. labor laws; and

d. Occupational Safety and Health Administration rules, laws, etc.

B. Counselor—Bereavement

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

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

a. assess grief counseling needs;

b. provide bereavement information and referral services to the bereaved, as needed, in accordance with the POC;

c. provide bereavement support to hospice staff as needed;

d. attend hospice IDT meetings; and

e. document bereavement services provided and progress of bereaved on a clinical progress note to be incorporated into the clinical record.

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

a. death and dying cultures;

b. suicide;

c. compassion fatigue;

d. anticipatory grief;

e. patient survivors;

f. grief groups;

g. grief;

h. loss;

i. adjustment;

j. ethics; and

k. advanced directives and LaPOST.

C. Counselor—Dietary

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

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

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

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

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

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

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

f. participate in IDT conference as needed; and

g. be an employee of the hospice agency.

D. Counselor—Spiritual

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

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

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

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

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

d. attend IDT meetings.

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

a. end of life care;

b. cultural religious practices;

c. compassion fatigue;

d. suicide;

e. documentation;

f. ethics;

g. grief;

h. loss;

i. adjustment; and

j. advanced directives and LaPOST.

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

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

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

b. be a full time, salaried employee of only the hospice agency. The Director of Nurses is prohibited from

simultaneous/concurrent employment. While employed by the hospice, he or she may not be employed by any other licensed health care agency.

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

a. the POC;

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

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

d. supervise employee health program;

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

i. resolve problems;

ii. perform complaint investigations;

iii. refer impaired personnel to proper authorities;

iv. provide for orientation and in-service training to employees to promote effective hospice services and safety of the patient, to familiarize staff with regulatory issues, and agency policy and procedures;

v. orient new direct health care personnel;

vi. perform timely annual evaluation of performance of health care personnel;

vii. assure participation in regularly scheduled appropriate continuing education for all health professionals and hospice aides and homemakers;

viii. assure that the care provided by the health care personnel promotes effective hospice services and the safety of the patient; and

ix. assure that the hospice policies are enforced.

F. Governing Body

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

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

3. The governing body shall:

a. designate an individual who is responsible for the day to day management of the hospice program;

b. ensure that all services provided are consistent with accepted standards of practice;

c. develop and approve policies and procedures which define and describe the scope of services offered;

d. review policies and procedures at least annually and revise them as necessary; and

e. maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

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

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

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

b. have successfully completed a hospice aide training program and have successfully completed a competency evaluation; or

c. have successfully completed a hospice aide competency evaluation; and

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

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

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

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

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

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

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

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

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

i. helping the patient with a bath, care of the mouth, skin and hair;

ii. helping the patient to the bathroom or in using a bed pan or urinal;

iii. helping the patient to dress and/or undress;

iv. helping the patient in and out of bed, assisting with ambulating;

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

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

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

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

a. perform any intravenous procedures, procedures involving the use of Levine tubes or Foley catheters, or any other sterile or invasive procedures, other than rectal temperatures or enemas;

b. administer medications to any patient.

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

a. policies and objectives of the agency;

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

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

d. emotional problems associated with terminal illness;

e. the aging process;

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

g. information on the emotional problems accompanying terminal illness;

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

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

j. ethics; and

k. confidentiality.

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

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

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

b. principles of nutrition and meal preparation;

c. record keeping;

d. procedures for maintaining a clean, healthful environment;

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

f. confidentiality;

g. patients' rights and responsibilities; and

h. emergency preparedness.

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

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

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

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

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

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

a. with at least two years of full time experience as an L.P.N.

b. be an employee of the hospice agency; and

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

2. Responsibilities. The L.P.N. shall perform skilled nursing services under the supervision of a registered nurse, in a manner consistent with standards of practice, including but not limited to, such duties as follows:

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

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

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

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

e. assist the patient with activities of daily living;

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

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

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

i. receive orders from the licensed medical practitioner and follow those that are within the realm of practice for an LPN and within the standards of hospice practice.

3. Restrictions. An LPN shall not:

a. access any intravenous appliance for any reason;

b. perform supervisory aide visit;

c. develop and/or alter the POC;

d. make an assessment visit;

e. evaluate recertification criteria;

f. make aide assignments;

g. function as a supervisor of the nursing practice of any registered nurse; or

h. function as primary on-call nurse.

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

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

NOTE: The medical director or physician designee may be an employee or a volunteer of the hospice agency. The hospice agency may also contract for the services of the medical director or physician designee.

a. Qualifications. A doctor of medicine or osteopathy licensed to practice in the state of Louisiana.

b. Responsibilities. The medical director or physician designee assumes overall responsibility for the medical component of the hospice's patient care program and shall include, but not be limited to:

i. serve as a consultant with the attending physician regarding pain and symptom control as needed;

ii. serve as the attending physician if designated by the patient/family unit;

iii. review patient eligibility for hospice services;

iv. serve as a medical resource for the hospice interdisciplinary team;

v. act as a liaison to physicians in the community;

vi. develop and coordinate procedures for the provision of emergency care;

vii. provide a system to assure continuing education for hospice medical staff as needed;

viii. participate in the development of the POC prior to providing care, unless the POC has been established by an attending physician who is not also the medical director or physician designee;

ix. participate in the review and update of the POC, unless the plan of care has been reviewed/updated by the attending physician who is not also the medical director or physician designee. These reviews shall be documented;

x. develop and coordinate policies and procedures for the provision of patient care;

xi. attend IDT meetings;

xii. document evidence of active participation in the hospice program (i.e. performance of above responsibilities and time spent upon performance of those responsibilities); and

xiii. shall be readily available to the hospice staff.

c. Continuous Medical Education (CME). The medical director shall annually complete two hours of CME related to end of life care. Documentation of this CME shall be maintained in the medical director's personnel record.

2. An advanced practice registered nurse (APRN), legally authorized to practice advanced practice nursing in the state, shall not function as the medical director of the hospice but may be the licensed medical practitioner of individual hospice patients and meet the requirements of §8217.I.1.b.i-xii.

a. The APRN shall not be the referring practitioner and shall not be the signer of certification of terminal illness (CTI).

J. Social Worker

1. Qualifications. The social worker shall be an individual who holds a current, valid license as a social worker (LMSW) issued by the Louisiana State Board of Social Work Examiners (LSBSWE), has master's degree from a school of social work accredited by the Council on Social Work Education, and who meets the following:

a. has at least one year of health care experience;

b. has documented clinical experience appropriate to the counseling and casework needs of the terminally ill;

c. shall be an employee of the hospice; and

d. when the social worker is employed by one or more agencies, he/she shall inform all employers and cooperate and coordinate duties to assure the highest performance of quality when providing services to the patient.

2. Responsibilities. The social worker shall assist the licensed medical practitioner and other IDT members in understanding significant social and emotional factors related to the patient's health status and shall include, but not be limited to:

a. assessment of the psychological, social and emotional factors having an impact on the patient's health status;

b. assist in the formulation of the POC;

c. provide services within the scope of practice as defined by state law and in accordance with the POC;

d. coordination with other IDT members and participate in IDT conferences;

e. prepare clinical and/or progress notes and incorporate them into the clinical record within one week of the visit;

f. participate in discharge planning, and in-service programs related to the needs of the patient;

g. acts as a consultant to other members of the IDT; and

h. when medical social services are discontinued, submit a written summary of services provided, including an assessment of the patient's current status, to be retained in the clinical record.

3. Continuing Education. The social worker shall annually obtain two hours of continuing education hours related to end of life care including but not limited to the following topics:

a. Medicare/Medicaid regulations;

b. psychosocial issues;

c. community resources/services;

d. death and dying;

e. family/patient dynamics;

f. ethics; and

g. advanced directives and LaPOST.

K. Occupational Therapist

1. Qualifications. An occupational therapist shall be licensed by the state of Louisiana and registered by the American Occupational Therapy Association.

2. Responsibilities. The occupational therapist shall assist the licensed medical practitioner in evaluating the patient's level of functioning by applying diagnostic and prognostic procedures including, but not limited to, the following:

a. provide occupational therapy in accordance with the licensed medical practitioner's orders and the POC;

b. guide the patient in his/her use of therapeutic, creative, and self-care activities for the purpose of improving function, in a manner consistent with accepted standards of practice;

c. observe, record, and report to the licensed medical practitioner and/or interdisciplinary team the patient's reaction to treatment and any changes in the patient's condition;

d. instruct and inform other health team personnel including, when appropriate, hospice aides/homemakers and family members in certain phases of occupational therapy in which they may work with the patient;

e. document each visit made to the patient and incorporate notes into the clinical record within one week of the visit;

f. participate in IDT conference as needed with hospice staff; and

g. prepare written discharge summary when applicable, with a copy retained in patient's clinical record and a copy forwarded to the attending licensed medical practitioner.

3. Supervision of an Occupational Therapy Assistant

a. The occupational therapist shall conduct the initial assessment and establish the goals and treatment plan before the licensed and certified occupational therapy assistant may treat the patients on site without the physical presence of the occupational therapist.

b. The occupational therapist and the occupational therapy assistant shall schedule joint visits at least once every two weeks or every four to six treatment sessions.

c. The occupational therapist shall review and countersign all progress notes written by the licensed and certified occupational therapy assistant.

d. In the occupational therapist/occupational therapy assistant relationship, the supervising occupational therapist retains overall personal responsibility to the patient, and accountability to the Louisiana Board of Medical Examiners for the patients' care.

e. The supervising occupational therapist is responsible for:

i. assessing the competency and experience of the occupational therapy assistant;

ii. establishing the type, degree and frequency of supervision required in the hospice care setting.

L. Occupational Therapy Assistant (OTA)

1. Qualifications. The occupational therapist assistant shall be licensed by the Louisiana Board of Medical Examiners to assist in the practice of occupational therapy under the supervision of a licensed registered occupational therapist and have at least two years' experience as a licensed OTA before starting their hospice caseload.

M. Physical Therapist (PT). The physical therapist, when provided, shall be available to perform in a manner consistent with accepted standards of practice.

1. Qualifications. The physical therapist shall be currently licensed by the Louisiana State Board of Physical Therapy Examiners.

2. Responsibilities. The physical therapist shall evaluate the patient's functional status and physical therapy needs in a manner consistent with standards of practice to include, but is not limited to, the following:

a. assist in the formation of the POC;

b. provide services within the scope of practice as defined by state law governing the practice of physical therapy, in accordance with the POC, and in coordination with the other members of the IDT;

c. observe, and report to the licensed medical practitioner and the IDT, the patient's reaction to treatment and any changes in the patient's condition;

d. instruct and inform participating members of the IDT, the patient, family/care givers, regarding the POC, functional limitations and progress toward goals;

e. prepare clinical and progress notes for each visit and incorporate them into the clinical record within one week of the visit;

f. when physical therapy services are discontinued, prepare written discharge summary, with a copy retained in the patient's clinical record and a copy forwarded to the attending licensed medical practitioner;

g. participate in IDT conference as needed with hospice staff.

3. Supervision of Physical Therapy Assistant (PTA)

a. The physical therapist shall be readily accessible by telecommunications.

b. The physical therapist shall evaluate and establish a written treatment plan on the patient prior to implementation of any treatment program.

c. The physical therapist shall treat and reassess the patient on at least every sixth visit, but not less than once per month.

d. The physical therapist shall conduct, once weekly, a face-to-face patient care conference with each PTA to review progress and modification of treatment programs for all patients.

e. The physical therapist shall assess the final treatment rendered to the patient at discharge and write a discharge summary.

N. Physical Therapy Assistant (PTA)

1. Qualifications. A physical therapy assistant shall be licensed by the Physical Therapy Board of Louisiana and supervised by a physical therapist.

2. Responsibilities. The physical therapy assistant shall:

a. provide therapy in accordance with the POC;

b. document each visit made to the patient and incorporate notes into the clinical record at least weekly; and

c. participates in IDT conference as needed with hospice staff.

O. Registered Nurse (RN). The hospice shall designate a registered nurse to coordinate the implementation of the POC for each patient.

1. Qualifications. A licensed registered nurse shall be currently licensed to practice in the state of Louisiana with no restrictions:

a. have at least two years of full-time experience as a registered nurse. However, two years of full-time clinical experience in hospice care as a licensed practical nurse may be substituted for the required two years of experience as a registered nurse; and

b. be an employee of the hospice. If the registered nurse is employed by more than one agency, he/she must inform all employers and coordinate duties to assure quality service provision.

2. Responsibilities. The registered nurse shall identify the patient/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days:

a. provide nursing services in accordance with the POC;

b. document problems, appropriate goals, interventions, and patient/family response to hospice care;

c. collaborate with the patient/family, attending licensed medical practitioner and other members of the IDT in providing patient and family care;

d. instruct patient/family in self-care techniques when appropriate;

e. supervise ancillary personnel and delegates responsibilities when required;

f. complete and submit accurate and relevant clinical notes regarding the patient's condition into the clinical record within one week of the visit;

g. if a home hospice/homemaker is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN in charge of that patient;

h. supervise and evaluate the hospice aide/homemaker's ability to perform assigned duties, to

relate to the patient and to work effectively as a member of the health care team;

i. perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present shall be made at least annually. Documentation of the aide present supervisory visit shall be placed in the hospice aide's personnel record;

j. document supervision, to include the aide/homemaker-patient relationships, services provided and instructions and comments given as well as other requirements of the clinical note;

k. annual performance review for each aide/homemaker documented in the individual's personnel record; and

l. annually conduct an on-site LPN supervisory visit with the LPN present. Documentation of such visit shall be kept in the LPN's personnel record.

3. Continuing Education. The registered nurse shall annually obtain at least two hours of continuing education hours related to end of life care.

P. Speech Pathology Services

1. Qualifications. A speech pathologist shall:

a. be licensed by the state of Louisiana and certified by the American Speech and Hearing Association; or

b. completed the academic requirements and is in the process of accumulating the necessary supervised (as directed by the state certifying body) work experience required for certification. Evidence of this supervision will be retained in the non-certified speech pathologist's personnel folder.

2. Responsibilities. The speech pathologist shall assist the attending licensed medical practitioner in evaluation of the patient to determine the type of speech or language disorder and the appropriate corrective therapy in a manner consistent with standards of practice to include, but is not limited to, the following:

a. provide rehabilitative services for speech and language disorders;

b. observe, record and report to the attending licensed medical practitioner and the IDT the patient's reaction to treatment and any changes in the patient's condition;

c. instruct other health personnel and family members in methods of assisting the patient to improve and correct speech disabilities;

d. communicate with the registered nurse, director of nurses, and/or the IDT the need for a continuation of speech pathology services for the patient;

e. participate in IDT conferences;

f. document each visit made to the patient and incorporate notes into the clinical record within one week of the visit; and

g. prepare written discharge summary as indicated, with a copy retained in patient's clinical record and a copy forwarded to the attending licensed medical practitioner.

Q. Volunteers. Volunteers play a vital role in enhancing the quality of care delivered to the patient/family by encouraging community participation in the overall hospice program. Volunteers that provide patient care and support services according to their experience and training shall do so in compliance with agency policies, and under the supervision of a designated hospice employee.

1. Qualifications. A mature, non-judgmental, caring individual supportive of the hospice concept of care, willing to serve others, and appropriately oriented and trained. Volunteers who are qualified to provide professional services shall meet all standards associated with their specialty area.

2. Responsibilities. The volunteer shall:

a. provide assistance to the hospice program, and/or patient/family in accordance with designated assignments;

b. provide input into the plan of care and interdisciplinary team meetings, as appropriate;

c. document services provided as trained and instructed by the hospice agency;

d. maintain strict patient/family confidentiality; and

e. communicate any changes or observations to the assigned supervisor.

3. Training. The volunteers shall receive appropriate documented training which shall include at a minimum:

a. an introduction to hospice;

b. the role of the volunteer in hospice;

c. concepts of death and dying;

d. communication skills;

e. care and comfort measures;

f. diseases and medical conditions;

g. psychosocial and spiritual issues related to death and dying;

h. the concept of the hospice family;

i. stress management;

j. bereavement;

k. infection control;

l. safety;

m. confidentiality;

n. patient rights;

o. the role of the IDT; and

p. additional supplemental training for volunteers working in specialized programs (e.g. nursing facilities).

4. The hospice shall offer relevant in-service training on a quarterly basis and maintain documentation of such.

5. Pursuant to state law, requirements for minimum volunteer services shall be at least 5 percent of the total hours of service of the hospice agency.

R. Volunteer Coordinator. The hospice shall designate an employee of the agency who is skilled in organization and documentation as a volunteer coordinator.

1. Responsibilities. The volunteer coordinator shall be responsible for:

a. overseeing the volunteer program;

b. recruitment, retention, and education of volunteers;

c. coordinating the services of volunteers with the patient and/or family; and

d. attending IDT meetings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR:15:482 (June 1989), amended LR 24:2262 (December 1998), LR 25:2409 (December 1999), LR 29:2801 (December 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 44:594 (March 2018).

Subchapter C. Patient Care Services

§8219. Patient Care Standard

A. Patient Certification. To be eligible for hospice care, an individual, or his/her representative, shall sign an election statement with a licensed hospice; the individual shall have a certification of terminal illness and shall have a plan of care (POC) which is established before services are provided.

B. Admission Criteria. The hospice shall have written policies to be followed in making decisions regarding acceptance of patients for care. Decisions are based upon medical, physical and psychosocial information provided by the patient's attending licensed medical practitioner, the patient/family and the interdisciplinary team. The admission criteria shall include:

1. the ability of the agency to provide core services on a 24-hour basis and provide for or arrange for non-core services on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

2. certification of terminal illness (CTI) signed by the attending licensed medical practitioner and the medical director of the agency;

NOTE: The CTI shall not be signed by an APRN

3. assessment of the patient/family needs and desires for hospice services;

4. informed consent signed by patient or representative who is authorized in accordance with state law to elect the hospice care, which will include the purpose and scope of hospice services; and

5. patient meets all other criteria required by any applicable payor sources.

C. Admission procedure. Patients are to be admitted only upon the order of the patient's attending physician.

1. An assessment visit shall be made by a registered nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by physician or unless a request for delay is made by patient/family.

2. Documentation at admission will be retained in the clinical record and shall include:

a. signed consent forms;

b. signed patient's rights statement;

c. clinical data including physician order for care;

d. patient release of information;

e. patient’s signed designation of attending licensed medical practitioner;

f. orientation of patient/caregiver, which includes:

i. advanced directives and LaPOST;

ii. agency services;

iii. patient's rights; and

iv. agency contact procedures; and

g. for an individual who is terminally ill, certification of terminal illness signed by the medical director or the physician member of the IDT and the individual's attending physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2268 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:598 (March 2018).

§8221. Plan of Care (POC)

A. Prior to providing care, a written plan of care is developed for each patient/family by the attending physician, the medical director, physician designee or the APRN and the IDT. The care provided to an individual shall be in accordance with the POC.

1. The initial plan of care (IOPC) will be established on the same day as the assessment if the day of assessment is to be a covered day of hospice.

2. The IDT member who assesses the patient's needs shall meet or call at least one other IDT member before writing the IPOC. At least one of the persons involved in

developing the IPOC shall be a registered nurse or physician. Within two days of the assessment, the other members of the IDT shall review the IPOC and provide their input. This input may be by telephone. The IPOC shall be signed by the attending licensed medical practitioner and an appropriate member of the IDT.

3. At a minimum the POC shall include the following:

a. an assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;

b. in detail, the scope and frequency of services needed to meet the patient's and family's needs;

c. identification of problems with realistic and achievable goals and objectives;

d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;

e. patient/family understanding, agreement and involvement with the POC; and

f. recognition of the patient/family's physiological, social, religious and cultural variables and values.

4. The POC is incorporated into the individual clinical record.

5. The hospice shall designate a registered nurse to coordinate the implementation of the POC for each patient.

B. Review and Update of the Plan of Care. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's health status changes, and a minimum of every 14 days for home care and every 7 days for general inpatient/continuous care, collaboratively with the IDT and the attending licensed medical practitioner.

NOTE: In the event that the day of the regularly scheduled IDT meeting falls on a holiday, 15 days is acceptable.

1. The hospice agency shall have policy and procedures for the following:

a. the attending licensed medical practitioner's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between hospice staff and the attending licensed medical practitioner;

b. orders shall be signed and dated in a timely manner, not to exceed 14 days, unless the hospice has documentation that verifies attempts to get orders signed (in this situation up to 30 days will be allowed).

2. The agency shall have documentation that the patient's health status and POC is reviewed and the POC updated, even when the patient's health status does not change.

C. Coordination and Continuity of Care. The hospice shall adhere to the following additional principles and responsibilities:

1. an assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;

2. nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24-hour basis, seven days a week;

3. all other covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

4. case-management is provided and an accurate and complete documented record of services and activities describing care of patient/family is maintained;

5. collaboration with other providers to ensure coordination of services;

6. maintenance of professional management responsibility and coordination of the patient/family care regardless of the setting;

7. maintenance of contracts/ agreements for the provision of services not directly provided by the hospice, including but not limited to:

a. radiation therapy;

b. infusion therapy;

c. inpatient care;

d. consulting physician;

8. provision or access to emergency medical care;

9. when home care is no longer possible, assistance to the patient in transferring to an appropriate setting where hospice care can be delivered;

10. when the patient is admitted to a setting where hospice care cannot be delivered, hospice adheres to standards, policies and procedures on transfer and discharge and facilitates the patient's transfer to another care provider;

11. maintenance of appropriately qualified IDT health care professionals and volunteers to meet patients need;

12. maintenance and documentation of a volunteer staff to provide administrative or direct patient care. The hospice shall document a continuing level of volunteer activity;

13. coordination of the IDT, as well as of volunteers, by a qualified health care professional, to assure continuous assessment, continuity of care and implementation of the POC;

14. supervision and professional consultation by qualified personnel, available to staff and volunteers during all hours of service;

15. hospice care provided in accordance with accepted professional standards and accepted code of ethics;

16. each member of the IDT accepts a fiduciary relationship with the patient/family, maintaining professional boundaries and an understanding that it is the responsibility

of the IDT to maintain appropriate agency/patient/family relationships;

17. has a written agency policy to follow at the time of death of the patient; and

18. has written agency policies and procedures for emergency response based on an all hazards risk assessment, inclusive of training for employees, patients and their caregivers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2268 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8223. Pharmaceutical Services

A. Hospice provides for the pharmaceutical needs of the patient, consistent with the Board of Pharmacy regulations.

1. Agency shall institute procedures which protect the patient from medication errors.

2. Agency shall provide verbal and written instruction to patient and family as indicated.

3. Drugs and treatments are administered by agency staff only as ordered by the licensed medical practitioner.

B. Hospice ensures the appropriate monitoring and supervision of pharmaceutical services and has written policies and procedures governing prescribing, dispensing, administering, controlling, storing and disposing of all biologicals and drugs in compliance with applicable laws and regulations.

C. Hospice ensures timely pharmaceutical services on a 24 hour a day/seven day a week basis that include provision of drugs, biologicals and infusion services which are consistent with patient's individual drug profile.

D. Hospice provides the IDT and the patient/family with coordinated information and instructions about individual drug profiles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8225. Pathology and Laboratory Services

A. Hospice provides or has access to pathology and laboratory services which comply with CLIA guidelines and meet patient's needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8227. Radiology Services

A. Radiology services provided by hospice either directly; or under arrangements that shall comply with applicable federal and state laws, rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8229. Discharge/Revocation/Transfer

A. Hospice provides adequate and appropriate patient/family information at discharge, revocation, or transfer.

B. Discharge. Patient shall be discharged only in the following circumstance:

1. change in terminal status;

2. patient relocates from the hospice's defined geographical service area;

3. if the safety of the patient or of the hospice staff is compromised. The hospice shall make every effort to resolve these problems satisfactorily before discharge. All efforts by the hospice to resolve the problem shall be documented in detail in the patient's clinical record; and

4. if the patient enters a non-contracted nursing facility or hospital and all options have been exhausted (a contract is not attainable or the patient chooses not to transfer to a facility with which the hospice has a contract, the hospice shall then discharge the patient. The hospice shall notify the payor source to document that all options have been pursued and that the hospice is not “dumping” the patient;

5. the hospice shall clearly document why the hospice found it necessary to discharge the patient.

C. Revocation. Occurs when the patient or representative makes a decision to discontinue receiving hospices services:

1. a recipient may revoke hospice care at any time. This is a right that belongs solely and exclusively to the patient or representative;

2. an effective date earlier than the actual date the revocation is made and signed cannot be designated;

3. if a patient or representative chooses to revoke from hospice care, the patient shall sign a statement that he or she is aware of the revocation and stating why revocation is chosen.

D. Non Compliance. When a patient is non-compliant, the hospice may counsel the patient/family on the option to revoke and any advantages or disadvantages of the decision that is made. A patient is considered non-compliant if:

1. the patient seeks or receives curative treatment for the illness; or

2. the patient seeks treatment related to the terminal illness in a facility that does not have a contract with the hospice;

3. the patient seeks treatment related to the terminal illness that is not in the POC, or is not pre-approved by the hospice.

E. Transfer. To change the designation of hospice programs, the individual must file with the hospice from which he/she has received care and with the newly designated hospice, a signed statement which includes the following information:

1. the name of the hospice from which the individual has received care;

2. the name of the hospice to which he/she plans to receive care;

3. the date of discharge from the first hospice and the date of admission to the second hospice; and

4. the reason for the transfer;

5. appropriate discharge plan/summary is to be written, and appropriate continuity of care is to be arranged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8231. Patient Rights and Responsibilities

A. The hospice shall insure that the patient has the right to:

1. be cared for by a team of professionals who provide high quality comprehensive hospice services as needed and appropriate for patient/family;

2. have a clear understanding of the availability of hospice services and the hospice team 24 hours a day, 7 days a week;

3. receive appropriate and compassionate care, regardless of diagnosis, race, age, gender, creed, disability, sexual orientation, place of residence, or the ability to pay for the services rendered;

4. be fully informed regarding patient status in order to participate in the POC. The hospice professional team will assist patient/family in identifying which services and treatments will help attain these goals;

5. be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to patient/family personal wishes;

6. be treated with respect and dignity;

7. have patient/family trained in effective ways of caring for patient;

8. confidentiality with regard to provision of services and all patient records, including information concerning patient/family health status, as well as social, and/or financial circumstances. The patient information and/or records may be released only with patient/family's written consent, and/or as required by law;

9. voice grievances concerning patient care, treatment, and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the hospice; and

10. be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible.

B. Informed Consent. An informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness shall be obtained, either from the individual or representative.

C. The patient has the responsibility to the best of their ability to:

1. participate in developing the POC and update as his or her condition/needs change;

2. provide hospice with accurate and complete health information;

3. remain under a doctor's care while receiving hospice services; and

4. assist hospice staff in developing and maintaining a safe environment in which patient care can be provided.

D. The agency shall have written policies and procedures to address these concerns identified under §8231.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2270 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:600 (March 2018).

§8233. Clinical Records

A. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record (either hard copy or electronic) for every individual receiving care and services. The record shall be complete, promptly and accurately documented, legible, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social, and other therapeutic information, including the current POC under which services are being delivered.

B. Hospice records shall be maintained in a distinct location and not mingled with records of other types of health care related agencies.

C. Original clinical records shall be kept in a safe and confidential area which provides convenient access to clinicians.

D. The agency shall have policies addressing who is permitted access to the clinical records. No unauthorized person shall be permitted access to the clinical records.

E. All clinical records shall be safeguarded against loss, destruction and unauthorized use.

F. Records shall be maintained for six years from the date of discharge, unless there is an audit or litigation affecting the records. Records for individuals under the age of majority shall be kept in accordance with current state and federal law.

G. When applicable, the agency will obtain a signed "release of information" from the patient and/or the patient's family; a copy will be retained in the record.

H. The clinical record shall contain a comprehensive compilation of information including, but not limited to, the following:

1. initial and subsequent Plans of Care and initial assessment;

2. certifications of terminal illness;

3. written orders for admission and changes to the POC;

4. current clinical notes (at least the past 60 days);

5. plan of care;

6. signed consent, authorization and election forms;

7. pertinent medical history; and

8. identifying data, including name, address, date of birth, sex, agency case number; and next of kin.

I. Entries are made for all services provided and are signed by the staff providing the service.

J. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

K. The agency may produce, maintain and store records either in paper documentation form or in electronic form. Records stored in electronic form shall be password protected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2270 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:600 (March 2018).

Subchapter D. Administration

§8235. Agency Operations

A. Premises (see definition of Hospice Premises).

1. Staff shall be able to distinguish and describe the scope and delineation of all activities being provided by the hospice.

2. Staff working areas are to be designed so that when planning for services, patient confidentiality is maintained.

3. The hospice shall have a distinct telephone number. If the telephone number is shared with other health care related agencies, the telephone operator(s) shall demonstrate knowledge and ability to distinguish and direct calls to the appropriate persons. If an answering service is used after normal hours, there shall be evidence of distinct hospice staff and the answering service should be able to direct calls to the appropriate persons for each service.

4. The hospice shall not share office space with a non-health care related entity. When office space is shared with another health care related entity the hospice agency shall operate separate and apart.

B. Hours of Operation

1. The hospice shall be required to have regular posted (in a prominent and easily accessible manner) business days and hours and be fully operational at least 8 hours a day, 5 days a week between 7 a.m. and 6 p.m. Hospice services are available 24 hours per day, 7 days a week, which include, at a minimum:

a. professional registered nurse services;

b. palliative medications;

c. other services, equipment or supplies necessary to meet the patient’s immediate needs.

2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, 7 days per week.

a. The on-call RN shall triage calls and may delegate to another employee as appropriate.

C. Policies and Procedures:

1. shall be written, current, and annually reviewed by appropriate personnel;

2. shall contain policies and procedures specific to agency addressing personnel standards and qualifications, agency operations, patient care standards, problem and complaint resolution, purpose and goals of operation, the hospice's defined service area, as well as regulatory and compliance issues, inclusive of but not limited to, a full disclosure policy when employing and assigning to a patient, a state certified hospice attendant;

3. shall clarify the agency’s prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media that includes, at a minimum, confidentiality of patient information, preservation of patient dignity and respect, protection of patient privacy and personal and property rights;

4. shall meet or exceed requirements of the minimum standards and all applicable federal, state, and local laws, including but not limited to criminal histories conducted by the Louisiana State Police, or its designee, on all non-

licensed persons providing nursing care, health-related services, or supportive services to any patient; and

5. shall include a process for checking the direct service worker registry and the Louisiana certified nurse aide registry upon hiring an employee, and every six months thereafter, to ensure that non-licensed direct care staff do not have a finding placed against him/her of abuse, neglect, or misappropriation of funds of an individual. If there is such a finding on the DSW and/or CNA registry, the applicant shall not be employed nor does a current employee have continued employment with the hospice agency.

D. Operational Requirements

1. Hospice's responsibility to the community:

a. shall not accept orders to assess or admit from any source other than licensed physician or authorized physician representative (e.g. hospital discharge planner). Although the hospice may provide care to relatives of employees, the order to admit to the hospice shall be initiated by the primary attending physician;

b. shall use only factual information in advertising;

c. shall not participate in door to door solicitation;

d. shall not accept as a patient any person who is not terminally ill;

e. shall develop policy/procedure for patients with no or limited payor source;

f. shall have policy and procedures and a written plan for emergency operations in case of disaster including that at any time the hospice has an interruption in services or a change in the licensed location due to an emergency situation, the hospice shall notify the HSS no later than the next stated business day;

g. provide all services needed in a timely manner, at least within 24 hours, unless orders by the licensed medical practitioner indicate otherwise. However, admission timeframes shall be followed as indicated in the admission procedures subsection;

h. is prohibited from harassing or coercing a prospective patient or staff member to use a specific hospice or to change to another hospice;

i. shall have policy and procedures for post-mortem care in compliance with all applicable federal, state, and local laws;

j. may participate as community educators in community/health fairs; and

k. may provide free non-invasive diagnostic tests, such as blood pressure screening.

2. Hospice's responsibility to the patient shall include, but is not limited to, the following:

a. be in compliance with Minimum Standards and all applicable federal, state, and local laws at all times;

b. provide all Core services directly by the hospice agency and any non-core services required to meet the patient/family's needs;

c. act as the patient advocate in medical decisions affecting the patient;

d. protect the patient from unsafe skilled and unskilled practices;

e. protect the patient from being harassed, bribed, and/or any form of mistreatment by any employee or volunteer of the agency;

f. provide patient information on the patient's rights and responsibilities;

g. provide information on advanced directives and LaPost in compliance with all applicable federal, state, and local laws;

h. protect and assure that patient's rights are not violated;

i. focus on enabling the patient remaining in the familiar surroundings of his/her place of residence as long as possible and appropriate;

j. encourage the patient/family to participate in developing the POC and provision of hospice services;

k. with the permission of the patient, include in the POC specific goals for involving the patient/family;

l. make appropriate referrals for family members outside the hospice's service area for bereavement follow-up;

m. whenever a hospice program manages and/or delivers care in a facility, ensure that an appropriate standard of care is provided to the patient in the facility, regardless of whether or not hospice is responsible for the direct provision of those services;

n. ensure that any facility where hospice care is provided meets appropriate licensing requirements and any payor source requirements when applicable;

o. ensure that any facility in which hospice care is provided have the following:

i. areas that are designed and equipped for the comfort and privacy of each patient and family member;

ii. physical space for private patient/family visiting;

iii. accommodations for family members to remain with the patient throughout the night;

iv. accommodations for family privacy after a patient's death;

v. decor which is homelike in design and function; and

vi. patients shall be permitted to receive visitors at any hour, including small children.

3. Responsibility of the hospice to the staff shall include, but is not limited to, the following:

a. provide safe environment whenever the hospice knows or has reason to know that environment might be dangerous;

b. have safety and emergency preparedness programs that conform with federal, state, and local requirements and that include:

i. a plan for reporting, monitoring, and follow-up on all accidents, injuries, and safety hazards;

ii. documentation of all reports, monitoring activity, and follow-up actions, education for patient/family, care givers, employees and volunteers on the safe use of medical equipment;

iii. evidence that equipment maintenance and safety requirements have been met;

iv. policies and procedures for storing, accessing, and distributing controlled drugs, supplies and equipment;

v. a safe and sanitary system for identifying, handling, and disposing of hazardous wastes; and

vi. a policy regarding use of smoking materials in all care settings;

c. have policies which encourage realistic performance expectations;

d. maintain insurance and worker's compensation at all times;

e. provide adequate time on schedule for required travel;

f. meet or exceed Wage and Hour Board requirements;

g. provide adequate information, in-service training, supplies, and other support for all employees to perform to the best of their ability;

h. provide in-service training to promote effective, quality hospice care; and

i. have training on the prohibited use of social media.

4. Responsibility of the hospice prior to employment of a state certified hospice attendant includes, but is not limited to, the following:

a. the hospice provider shall notify HSS of the intent to hire a state certified hospice attendant; and

b. the hospice provider shall have documentation of certification of the state certified hospice attendant meeting the requirements of R.S. 40:2192.

5. Responsibility of the hospice subsequent to employment of a state certified hospice attendant includes, but is not limited to, the following:

a. the hospice provider shall disclose to its employees, patients, and patients' immediate family members that the state certified hospice attendant has successfully completed all state certification training and registry requirements for employment, including successful completion and release from a sentence served at a state prison;

b. upon change in status of employment of the state certified hospice attendant, the hospice provider shall notify HSS;

c. the hospice provider shall ensure that the state certified hospice attendant receives required continuing education or training requirements to maintain state certification in good standing continuously during employment by the hospice provider; and

d. the hospice provider shall ensure that the state certified hospice attendant has continuing education equivalent to a hospice aide/CNA, inclusive of the following:

i. a minimum of 12 hours of job-related in-service training annually, specific to their job responsibilities within the previous 12 months;

ii. at least two of the required 12 hours of annual job-related in-service training shall focus on end of life care; and

iii. ensure six of the 12 hours of required annual job-related in-service training shall be provided every six months.

6. Access by the hospice agency to the state certified hospice attendant registry established by the department pursuant to R.S. 40:2192 shall be limited to an inquiry for a specific state certified hospice attendant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2181-2192.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2271 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:600 (March 2018), LR 46:344 (March 2020).

§8237. Contract Services

A. When the hospice provides services on a contractual basis to a patient the hospice is responsible for all actions of the contract personnel.

B. The hospice shall not at any time use contract employees as administrator/alternate or for the provision of core services, except that physician or physician designee services may be provided through contract.

C. Whenever services are provided by an organization/individual other than the hospice, a written agreement will delineate services available and procedures for accessing those services.

D. Whenever services are provided by an outside agency or individual, a legally binding written agreement shall be

effected. The legally binding written agreement shall include at least the following items:

1. identification of the services to be provided;

2. a stipulation that services may be provided only with the express authorization of the hospice;

3. the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;

4. the delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the IDT conferences;

5. requirements for documenting that services are furnished in accordance with the agreement;

6. the qualifications of the personnel providing the services;

7. assurance that the personnel contracted complete the clinical record in the same timely manner as required by the staff personnel of the hospice;

8. payment fees and terms; and

9. statement that the hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.

E. The hospice shall document review of its contracts on an annual basis.

F. The hospice is to coordinate services with contract personnel to assure continuity of patient care.

G. Hospice maintains professional management responsibilities for those services and ensures that they are furnished in a safe and effective manner by qualified persons and in accordance with the patient's POC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2272 (December 1998), LR 29:2801 (December 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 44:601 (March 2018).

§8239. Quality Assurance/Performance Improvement

A. Agency shall have an on-going, comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care, including inpatient care, home care, and care provided by arrangement, is provided at all times in compliance with accepted standards of professional practice.

B. The hospice shall have written plans, policies and procedures addressing quality assurance and performance improvement.

C. Hospice shall monitor and evaluate its resource allocation regularly to identify and resolve problems with the utilization of its services, facilities and personnel.

D. Hospice shall follow a written plan for continually assessing and improving all aspects of operations which include:

1. goals and objectives;

2. the identity of the person responsible for the program;

3. a system to ensure systematic, objective regular reports are prepared and distributed to appropriate areas;

4. the method for evaluating the quality and the appropriateness of care;

5. a method for resolving identified problems; and

6. application to improving the quality of patient care.

E. The plan is reviewed at least annually and revised as appropriate.

F. The governing body and administration shall strive to create a work environment where problems can be openly addressed and service improvement ideas encouraged.

G. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes:

1. services provided by professional and volunteer staff;

2. outcome audits of patient charts;

3. reports from staff, volunteers and patients about services;

4. concerns or suggestions for improvement in services;

5. organizational review of the hospice program;

6. patient/family evaluations of care; and

7. high-risk, high-volume and problem-prone activities.

H. When problems are identified in the provision of hospice care, there shall be evidence of corrective actions, including ongoing monitoring, revisions of policies and procedures, educational intervention and changes in the provision of services.

I. The effectiveness of actions taken to improve services or correct identified problems is evaluated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2273 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:601 (March 2018).

§8241. Branch Offices

A. No branch office may be opened without written approval from LDH.

B. No branch office may be opened unless the parent office has had full licensure for at least the immediately preceding 12 months and has a current census of at least 10 active patients.

C. Each branch shall serve the same or part of the geographic area approved for the parent.

D. Each branch office shall have a registered nurse immediately available to be on site, or on site in the branch office at all times during stated operating hours.

E. All services provided by the parent agency shall be available in the branch.

F. The branch site shall retain all clinical records for its patients. Duplicate records need not be maintained at the parent agency, but shall be made available to federal/state surveyors during any review upon request.

G. Original personnel files are to be kept at the parent agency, but shall be made available to federal/state surveyors during any review upon request.

H. A statement of personnel policies is maintained in each branch for staff usage.

I. Approval for branch offices will be issued, in writing, by LDH for one year and will be renewed at time of annual renewal if the branch office:

1. is operational and providing hospice services;

2. serves only patients who are geographically nearer to the branch than to the parent office;

3. offers exact same services as the parent agency; and

4. if the parent office meets requirements for full licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2273 (December 1998), LR 25:2409 (December 1999), amended by the Department of Health, Bureau of Health Services Financing, LR 44:602 (March 2018).

§8243. Cessation of Business

A. Except as provided in §8245 and §8246 of these licensing regulations, a license shall be immediately null and void if a hospice ceases to operate.

B. A cessation of business is deemed to be effective the date on which the hospice stopped offering or providing services to the community.

C. Upon the cessation of business, the hospice shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the hospice. The hospice does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the hospice shall:

1. give 30 days' advance written notice to:

a. the HSS;

b. each patient's attending licensed medical practitioner; and

c. each patient or patient's legal representative, if applicable; and

2. provide for an orderly discharge and transition of all of the patients in the hospice.

F. In addition to the advance notice of voluntary closure, the hospice shall submit a written plan for the disposition of all patient medical records for approval by the department. The plan shall include:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed hospice's patients' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing hospice, at least 15 days prior to the effective date of closure.

G. If a hospice fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a hospice for a period of two years.

H. Once the hospice has ceased doing business, the hospice shall not provide services until the hospice has obtained facility need review approval and applied for initial licensure in accordance with requirements of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2274 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:602 (March 2018).

§8245. Inactivation of Licensure due to a Declared Disaster or Emergency

A. A hospice agency licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed agency shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the hospice agency has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the hospice agency intends to resume operation as a hospice in the same service area;

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

d. includes an attestation that all patients have been properly discharged or transferred to another agency or facility; and

e. provides a list of patients and where that patient is discharged or transferred to;

2. the agency resumes operating as a hospice in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 et seq., or R.S. 29:766 et seq.;

3. the hospice continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the hospice continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate a hospice license, the department shall issue a notice of inactivation of license to the hospice.

C. Upon completion of repairs, renovations, rebuilding or replacement, a hospice agency which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The hospice shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening, and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The agency resumes operating as a hospice in the same service area within one year.

D. Upon receiving a completed written request to reinstate a hospice license, the department shall conduct a licensing survey. If the hospice meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the hospice license.

1. The licensed capacity of the reinstated license shall not exceed the licensed capacity of the hospice agency at the time of the request to inactivate the license.

E. No change of ownership of the hospice agency shall occur until such agency has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as a hospice agency.

F. The provisions of this Section shall not apply to a hospice agency which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the hospice license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2274 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:602 (March 2018).

§8246. Inactivation of Licensure due to a Non-Declared Disaster or Emergency

A. A hospice in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

1. the hospice shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

a. the hospice has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

b. the hospice intends to resume operation as a hospice agency in the same service area;

c. the hospice attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

d. the hospice's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility;

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

2. the hospice continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

3. the hospice continues to submit required documentation and information to the department, including but not limited to cost reports.

B. Upon receiving a completed written request to temporarily inactivate a hospice license, the department shall issue a notice of inactivation of license to the hospice.

C. Upon receipt of the department's approval of request to inactivate the agency's license, the hospice shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to the Office of the State Fire Marshal (OSFM) and the Office of Public Health (OPH) as required.

D. The hospice shall resume operating as a hospice in the same service area within one year of the approval of renovation/construction plans by OSFM and OPH as required.

EXCEPTION: If the hospice requires an extension of this timeframe due to circumstances beyond the agency's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the agency's active efforts to complete construction or repairs and the reasons for request for extension of the agency's inactive license. Any approval for extension is at the sole discretion of the department.

E. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a hospice which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the hospice shall submit a written license reinstatement request to the licensing agency of the department;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing or physical environment survey, where applicable; and

3. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

F. Upon receiving a completed written request to reinstate a hospice license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the agency has met the requirements for licensure including the requirements of this Subsection.

G. No change of ownership of the hospice shall occur until such hospice has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a hospice facility.

H. The provisions of this Subsection shall not apply to a hospice which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the hospice license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:603 (March 2018).

Subchapter E. Hospice Inpatient Facility

§8247. Requirements for Licensure of Inpatient Hospice

A. Hospice inpatient services may be provided directly by the hospice or through arrangements made by the hospice. An agency is prohibited from providing hospice inpatient services only. A hospice that elects to provide hospice inpatient services directly is required to be licensed as a hospice agency and sublicensed as a hospice inpatient facility. Separate applications and fees are required. The application process to establish a hospice inpatient facility may be completed simultaneously with an application to provide hospice services.

B. An application packet shall be obtained from LDH.

1. A completed application packet for a hospice inpatient facility shall be submitted to and approved by LDH prior to an agency providing hospice services.

2. The application submitted shall include the current licensing fee plus any bed fees. All fees shall be in the form of a company check, certified check or money order made payable to LDH. All fees submitted are non-refundable. All state-owned hospice facilities are exempt from fees.

3. The license shall be conspicuously displayed in the hospice inpatient facility.

4. Each initial applicant or an existing hospice inpatient facility requesting a change of address shall have approval from the following offices prior to an on-site survey by this department.

a. Office of Public Health—Local Health Unit. All hospice inpatient facilities shall comply with the rules, LAC Title 51, *Public Health—Sanitary Code* and enforcement policies as promulgated by OPH. It shall be the primary responsibility of OPH to determine if applicants are complying with those requirements. No initial license shall be issued without the applicant furnishing a certificate from OPH that such an applicant is complying with their provisions. A provisional license may be issued to the applicant if OPH issues the applicant a conditional certificate.

b. Office of the State Fire Marshal. All hospice inpatient facilities shall comply with the rules, established fire protection standards and enforcement policies as promulgated by OSFM. It shall be the primary responsibility of OSFM to determine if applicants are complying with those requirements. No license shall be issued or renewed without the applicant furnishing a certificate from OSFM that such applicant is complying with their provisions. A provisional license may be issued to the applicant if OSFM issues the applicant a conditional certificate.

C. New constructions shall be reviewed by OSFM for compliance with the applicable hospice licensing rules.

1. All new construction, other than minor alterations for a hospice inpatient facility, shall be done in accordance with the specific requirements of OSFM and OPH regulations covering new construction, including submission of preliminary plans and the final work drawings and specifications shall also be submitted prior to any change in facility type.

2. No new hospice inpatient facility shall be constructed, nor shall major alterations be made to existing hospice inpatient facilities, or change in facility type be made without the prior written approval of, and unless in accordance with plans and specifications approved in advance by the Department of Health and the Office of State Fire Marshal. The review and approval of plans and specifications shall be made in accordance with the requirements of OSFM to include:

a. copies of the approval letters of the architectural and the licensing facility plans from OSFM and any other office/entity designated by the department to review and approve the facility's architectural and licensing plan review;

b. a copy of the on-site inspection report with approval for occupancy by OSFM, if applicable; and

c. a copy of the on-site health inspection report with approval for occupancy from OPH. Before any new hospice inpatient facility is licensed or before any alteration or expansion of a licensed hospice inpatient facility can be approved, the applicant shall furnish one complete set of plans and specifications to OSFM, with fees and other information as required. Plans and specifications for new construction other than minor alterations shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

3. Notice of satisfactory review from OPH and OSFM for *Life Safety Code* (LSC) approval and licensing plan review constitutes compliance with this requirement if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes, or rules of any responsible agency.

D. An agency seeking to renew its license shall:

1. request a renewal application packet from LDH if one is not received at least 45 days prior to the license expiration date;

2. submit a renewal application packet annually accompanied by the current licensing fee plus any applicable bed fees.

E. An inpatient hospice facility shall maintain proof of compliance with all applicable local codes and ordinances governing health, fire, safety, and zoning regulations.

F. An agency shall notify LDH, in writing, prior to a change in name of the agency, address change, or a change in the number of beds.

1. A fee shall be submitted for a replacement license when a change occurs such as name change, address change, or a bed change.

2. The new facility location shall meet the same licensing requirements as those required for an initial survey including approval of building plans by OSFM and OPH.

G. A hospice that provides inpatient hospice services directly is required to provide or make arrangements for all hospice services on both an outpatient and an inpatient level including routine home care, continuous home care, respite care, and general inpatient care.

H. Hospice inpatient facilities and any facility that provides hospice services shall be maintained in a manner which provides for maintaining personal hygiene of the patients and implementation of infection control procedures.

I. Equipment and furnishings in an inpatient facility shall provide for the health care needs of the patient while providing a home-like atmosphere.

J. Services provided in the inpatient facility are consistent with the plan of care prepared for that patient and are consistent with services provided by the hospice program in other settings.

K. The hospice provider shall ensure that each patient residing in an inpatient facility has an identified hospice staff member who will serve as that patient's principle advocate and contact person.

L. The hospice inpatient facility shall ensure the following:

1. the facility meets appropriate licensing, regulatory, and certification requirements;

2. the facility has an acceptable, written all hazards risk assessment and emergency preparedness plan. The plan shall include:

a. the frequency/schedule for periodically rehearsing the plan with the staff;

b. the assignment of personnel for specific responsibilities;

c. the procedures for prompt identification and transfer of patients and records to an appropriate facility;

i. in the event of an evacuation, the facility shall have a method to release patient information consistent with the HIPAA Privacy Rule;

d. fire and/or other emergency drills, in accordance with the LSC;

e. procedures covering persons in the facility and in the community in cases of all hazards (i.e., hurricanes, tornadoes, floods); and

f. arrangements with community resources in the event of a disaster;

3. the facility shall design and equip areas for the comfort and privacy of each patient and family members. The facility shall have the following:

a. physical space for private patient/family visiting;

b. accommodations for family members to remain with the patient throughout the night;

c. accommodations for family privacy after a patient's death;

d. decor which is homelike in design and function; and

e. patients shall be permitted to receive visitors at any hour, including small children;

4. patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each patient's room shall:

a. be equipped with toilet and bathing facilities;

b. be equipped with a lavatory in each patient's toilet room or in each bedroom;

c. be at or above grade level;

d. contain room decor that is homelike and non-institutional in design and function. Room furnishings for each patient shall include a bed with side rails, a bedside stand, an over-the-bed table, an individual reading light easily accessible to each patient and a comfortable chair. The patient shall be permitted to bring personal items of furniture or furnishings into their rooms unless medically inappropriate;

e. have closet space that provides security and privacy for clothing and personal belongings;

f. contain no more than 4 beds;

g. measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi patient room; and

h. be equipped with a device for calling the staff member on duty. A call bell or other communication mechanism shall be placed within easy reach of the patient and shall be functioning properly. A call bell shall be provided in each patient toilet, bath, and shower room;

5. the hospice inpatient facility shall:

a. provide an adequate supply of hot water at all times for patient use;

b. have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients; and

c. designate a staff member responsible for monitoring and logging water temperatures at least monthly. This person is responsible for reporting any problems to the administrator;

6. the hospice inpatient facility shall have available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. The facility shall have a clean linen storage area;

a. the linen supply shall be adequate to accommodate the number of beds and the number of incontinent patients on a daily basis, including week-ends and holidays;

b. soiled linen and clothing shall be collected and enclosed in suitable bags or containers in well ventilated areas, separate from clean linen and not permitted to accumulate in the facility;

c. the hospice inpatient facility shall have policies and procedures that address:

i. frequency of linen changes;

ii. storage of clean linen; and

iii. storage of soiled linen;

7. the hospice inpatient facility shall make provisions for isolating patients with infectious diseases. The hospice should institute the most current recommendations of The Centers for Disease Control and Prevention (CDC) relative to the specific infection(s) and communicable disease(s). The hospice provisions for isolating patients with infectious diseases shall include:

a. definition of nosocomial infections and communicable diseases;

b. measures for assessing and identifying patients and health care workers at risk for infections and communicable diseases;

c. measures for prevention of infections, especially those associated with immunosuppressed patients and other factors which compromise a patient's resistance to infection;

d. measures for prevention of communicable disease outbreaks, especially tuberculosis;

e. provision of a safe environment consistent with the current CDC recommendations for the identified infection and/or communicable disease;

f. isolation procedures and requirements for infected or immunosuppressed patients;

g. use and techniques for universal precautions;

h. methods for monitoring and evaluating practice of asepsis;

i. care of contaminated laundry, i.e., clearly marked bags and separate handling procedures;

j. care of dishes and utensils, i.e., clearly marked and handled separately;

k. use of any necessary gowns, gloves or masks posted and observed by staff, visitors, and anyone else in contact with the patient; and

l. techniques for hand washing, respiratory protection, asepsis sterilization, disinfection, needle disposal,

solid waste disposal, as well as any other means for limiting the spread of contagion;

m. orientation of all new hospice personnel to infections, to communicable diseases and to the infection control program; and

n. employee health policies regarding infectious diseases, and when infected or ill employees shall not render direct patient care;

8. the hospice inpatient facility should isolate infected patients only to the degree needed to isolate the infecting organism. The method should be the least restrictive possible while maintaining the integrity of the process and the dignity of the patient;

9. the hospice inpatient facility shall provide the following:

a. storage for administrative supplies;

b. hand washing facilities located convenient to each nurses' station and medication distribution station;

c. charting facilities for staff at each nurses' station;

d. a "clean" workroom which contains a work counter, sink, storage facilities and covered waste receptacles;

e. a "soiled" workroom for receiving and cleanup of equipment;

f. parking for stretchers and wheelchairs in an area out of the path of normal traffic and of adequate size for the facility;

g. a janitor's closet which contains a floor receptor with mop hooks over the sink and storage space for housekeeping equipment and supplies;

h. a multi-purpose lounge or lounges shall be provided suitable and furnished for: reception, recreation, dining, visitation, group social activities, and worship. Such lounge or lounges shall be located convenient to the patient rooms designed to be served;

i. a conference and consultation room shall be provided which is suitable and furnished for family privacy, including conjugal visit rooms, clergy visitations, counseling, and viewing of a deceased patient's body during bereavement. The conference and consultation room shall be located convenient to the patient rooms it is designed to serve;

j. public telephone and restrooms shall be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2274 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:604 (March 2018).

§8253. Nursing Services

A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction of the director of nursing and in accordance with the requirements of §8217.E.1-2.e.ix.

B. The inpatient facility shall have staff on the premises on a 24 hour a day, 7 day a week basis when there are patients in the facility. The services provided shall be in accordance with the patient's plan of care. Each shift shall include two direct patient care staff, one of which shall be a registered nurse who provides direct patient care. The nurse to patient ratio shall be at least one nurse to every eight patients. In addition there shall be sufficient number of direct patient care staff on duty to meet the patient care needs. When there are no patients in the hospice inpatient facility, the hospice shall have a registered nurse on-call to be immediately available to the hospice inpatient facility.

C. Written nursing policies and procedures shall define and describe the patient care provided. There shall be a written procedure to ensure that all licensed nurses providing care in the inpatient hospice facility have a valid and current license to practice prior to providing any care.

D. Nursing services are either furnished and/or supervised by a registered nurse and all nursing services shall be evaluated by a registered nurse.

E. A registered nurse shall assign the nursing service staff for each patient in the inpatient hospice facility. The facility shall provide 24-hour nursing services which are sufficient to meet the total nursing needs of the patient and which are in accordance with the patient's plan of care. Staffing shall be planned so that each patient receives treatments, medication, and diet as prescribed, and is kept clean, well-groomed, and protected from accident, injury, and infection. Nursing services staff shall be assigned clinical and/or management responsibilities in accordance with education, experience and the current Louisiana Nurse Practice Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2277 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:605 (March 2018).

§8255. Nutritional Services

A. Nutritional services shall be under the supervision of a registered dietitian, licensed to practice in Louisiana, who is employed either full-time, part-time or on a consulting basis. If the registered dietitian is not full-time, there shall be a full-time dietary manager who is responsible for the daily management of dietary services.

1. The registered dietician shall be responsible for assuring that quality nutritional care is provided to patients by providing and supervising the nutritional aspects of patient care. The registered dietician is also responsible for:

a. recording the nutritional status of the patient;

b. plan menus for those patients who require medically prescribed special diets; and

c. supervise the preparation and serving of meals to ensure that the patient accepts the special diet.

2. The hospice inpatient facility shall have a dietary manager who is responsible for:

a. planning menus that meet the nutritional needs of each patient, following the orders of the patient's licensed medical practitioner and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences. There shall be a current therapeutic diet manual approved by the dietician and medical staff, and readily available to all medical, nursing, and food service personnel, which shall be the guide used for ordering and serving diets.

b. supervising the meal preparation and service to ensure that the menu plan is followed.

3. A dietary manager shall meet one of the following:

a. a graduate of a dietetic technician or dietetic assistant training program by correspondence or classroom, approved by the American Dietetic Association;

b. a graduate of a State approved course that provides 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or

c. has training and experience in food service supervision and management in the military or other service equivalent in content to a dietetic technician or dietetic assistant training program by correspondence or classroom, approved by the American Dietetic Association.

4. The hospice shall employ sufficient support personnel to meet the needs of the patients in the hospice inpatient facility.

5. The hospice shall have policies and procedures to ensure support personnel are competent to perform their respective duties within the dietary services department.

6. The hospice inpatient facility shall:

a. serve at least three meals or their equivalent each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast;

b. include adequate nutritional services to meet the patient’s dietary needs and food preferences, including the availability of frequent, small, or mechanically-altered meals 24 hours a day;

c. be designed and equipped to procure, store, prepare, distribute, and serve all food under sanitary conditions; and

d. provide a nourishment station which contains equipment to be used between scheduled meals such as a warming device, refrigerator, storage cabinets and counter space. There shall be provisions made for the use of small appliances and storage. This area shall be available for use by the patient, the patient’s family, volunteers, guests and staff.

B. Sanitary Conditions

1. Food shall be in sound condition, free from spoilage, filth, or other contamination and shall be safe for human consumption.

a. All food shall be procured from sources that comply with all laws and regulations related to food and food labeling.

b. The use of food in sealed containers that was not prepared in a food processing establishment is prohibited.

c. All food shall be stored, prepared, distributed and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink at or below 40 degrees Fahrenheit, except when being prepared and served. Refrigerator temperatures shall be maintained at 40 degrees Fahrenheit or below; freezers at 0 degrees Fahrenheit or below.

d. Hot foods shall leave the kitchen or steam table at or above 140 degrees Fahrenheit. In-room delivery temperatures shall be maintained at 120 degrees Fahrenheit, or above for hot foods and 50 degrees Fahrenheit or below for cold items. Food shall be covered during transportation and in a manner that protects it from contamination while maintaining required temperatures.

e. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized and stored. This includes maintaining a water temperature in dish washing machines at 140 degrees Fahrenheit during the wash cycle (or according to the manufacturer's specifications or instructions) and 180 degrees Fahrenheit for the final rinse. Low temperature machines shall maintain a water temperature of 120 degrees Fahrenheit with 50 ppm (parts per million) of hypochlorite (household bleach) on dish surfaces. For manual washing in a 3-compartment sink, a wash water temperature of 75 degrees Fahrenheit with 50 ppm of hypochlorite or equivalent, or 12.5 ppm of iodine; or a hot water immersion at 170 degrees Fahrenheit for at least 30 seconds shall be maintained. An approved lavatory shall be convenient and equipped with hot and cold water tempered by means of a mixing valve or combination faucet for dietary services staff use. Any self-closing, slow-closing, or metering faucet shall be designed to provide a flow of water for at least 15 seconds without the need to reactivate the faucet. Effective with the promulgation of these requirements, an additional lavatory shall be provided in the dishwasher area in newly constructed hospices or in existing hospices undergoing major dietary alterations.

f. No staff, including dietary staff, shall store personal items within the food preparation and storage areas.

g. Dietary staff shall use good hygienic practices. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact may transmit the disease.

h. Toxic items such as insecticides, detergents and polishes shall be properly stored, labeled and used in accordance with manufacturer's guidelines.

i. Garbage and refuse shall be kept in durable, easily cleanable, insect and rodent-proof containers that do not leak and do not absorb liquids. Containers used in food preparation and utensil washing areas shall be kept covered after they are filled.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2277 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:606 (March 2018).

§8257. Pharmaceutical Services of Inpatient Hospice

A. The hospice shall provide pharmaceutical services that meets the needs of the patients.

B. The hospice shall ensure that pharmaceutical services are provided by appropriate methods and procedures for the storage, dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the hospice facility is responsible for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate federal, state, and local laws.

C. If a pharmacy is to be constructed within the hospice inpatient facility, plans shall be submitted to the Board of Pharmacy for Licensing and Registration. The pharmacy shall have a pharmacy permit issued by the Louisiana Board of Pharmacy to allow ordering, storage, dispensing, and delivering of legend prescriptive orders. The hospice inpatient facility pharmacy shall have a current controlled dangerous substance license to dispense controlled substances to patients in the facility. The pharmacy shall be directed by a registered pharmacist licensed to practice in Louisiana.

D. Licensed Pharmacist. The hospice shall employ a licensed pharmacist or have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and record keeping of drugs and biologicals.

E. Orders for Medications. A licensed medical practitioner's order shall be obtained for all medication administered to the patient.

1. If the medication order is verbal, the licensed medical practitioner shall give it only to a licensed nurse, pharmacist, or another physician; and the individual receiving the order shall record and sign it immediately.

2. All orders (to include telephone and/or verbal) are to be signed by the prescribing licensed medical practitioner in a timely manner, not to exceed 30 days.

F. Administering Medications. Patients shall be accurately identified prior to administration of a medication.

1. Medications are administered only by a physician, a licensed nurse; or the patient, if his/her attending licensed medical practitioner has approved self-administration.

2. Orders shall be checked at least daily to assure that changes are noted.

3. Drugs and biologicals are administered as soon as possible after dose is prepared for distribution, not to exceed 2 hours.

4. Each patient has an individual medication administration record (MAR) on which the dose of each medication administered shall be properly recorded by the person administering the medication to include:

a. name, strength, and dosage of the medication;

b. method of administration to include site, if applicable;

c. times of administration;

d. the initials of persons administering the medication, except that the initials shall be identified on the MAR to identify the individual by name;

e. medications administered on a "PRN" or as needed basis shall be recorded in a manner as to explain the reason for administration and the results obtained. The Hospice shall have a procedure to define its methods of recording these medications;

f. medications brought to the hospice by the patient or other individuals for use by that patient shall be accurately identified as to name and strength, properly labeled, stored in accordance with facility policy and shall be administered to the patient only upon the written orders of the attending licensed medical practitioner;

g. medications shall not be retained at the patient's bedside nor shall self-administration be permitted except when ordered by the licensed medical practitioner. These medications shall be appropriately labeled and safety precautions taken to prevent unauthorized usage;

h. medication errors and drug reactions are immediately reported to the director of nurses, pharmacist and the licensed medical practitioner, and an entry made in the patients' medical record and on an incident report in accordance with facility policy. This procedure shall include recording and reporting to the licensed medical practitioner the failure to administer a medication, for any other reason than refusal of a patient to take a medication. The refusal of a patient to take a medication should be reported during IDT conferences. If there is adverse consequence resulting from the refusal, this is to be immediately reported to the director of nurses, pharmacist and licensed medical practitioner, and an entry made in the patients' medical record and on an incident report in accordance with facility policy;

i. the nurse's station or medicine room for all hospice inpatient facilities shall have readily available items necessary for the proper administration and accounting of medications;

j. each hospice shall have available current reference materials that provide information on the use of medications, side effects and adverse reactions to drugs and the interactions between drugs.

G. Conformance with Medication Orders. Each hospice inpatient facility shall have a procedure for at least quarterly monitoring of medication administration. This monitoring may be accomplished by a registered nurse or a pharmacist, to assure accurate administration and recording of all medications.

1. Each hospice shall establish procedures for release of patient's own medications upon discharge or transfer of the patient.

2. Medications shall be released upon discharge or transfer only upon written authorization of the attending licensed medical practitioner.

3. An entry of such release shall be entered in the medical record to include medications released, amounts, who received the medications and signature of the person carrying out the release.

H. Storage of Drugs and Biologicals. Procedures for storing and disposing of drugs and biologicals shall be established and implemented by the inpatient hospice facility.

1. In accordance with state and federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked compartments are provided for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

2. Controlled drugs no longer needed by the patient are disposed of in compliance with state requirements.

3. There shall be a secure drug or medicine room/drug preparation area at each nurses' station of sufficient size for the orderly storage of medications, both liquid and solid dosage forms and for the preparation of medications for patient administration within the unit. In the event that a drug cart is used for storage and administration of medication, the room shall be of sufficient size to accommodate placement of the cart.

4. There shall be a separate area or cubicle for the storage of each patient's medication, except where a cart is used for the administration of drugs and biologicals.

5. There shall be an operable sink provided with hot and cold water in or near the medicine room or medication preparation area for washing hands or cleaning containers used in medicine preparation. Paper towels and soap dispenser shall be provided.

6. Sufficient artificial lighting shall be provided and the temperature of the medicine storage area shall not be lower than 48 degrees Fahrenheit or above 85 degrees Fahrenheit and the room shall be provided with adequate ventilation.

7. Drugs and biologicals, including those requiring refrigeration, shall be stored within the medicine room or shall have separate locks if outside the medicine room. The refrigeration shall have a thermometer and be capable of maintaining drugs at the temperature recommended by the manufacturer of the drug.

8. No foods may be stored in the same storage area (i.e., cupboard, refrigerator, or drawer) with drugs and biologicals. The areas designated for drug and biological storage should be clearly marked.

9. Medication refrigerators shall not be used to store laboratory solutions or materials awaiting laboratory pickup.

10. The drug or medicine rooms shall be provided with safeguards to prevent entrance of unauthorized persons including locks on doors and bars on accessible windows.

a. Only authorized, designated personnel shall have access to the medicine storage area.

b. External use only drugs shall be plainly labeled and stored separate from drugs and biologicals. No poisonous substance shall be kept in the kitchen, dining area, or any public spaces or rooms. This Section shall not prohibit storage within the drug or medicine room of approved poisonous substances intended for legitimate medicinal use, provided that such substances are properly labeled in accordance with applicable federal and state law.

11. First aid supplies shall be kept in a place readily accessible to the person or persons providing care in the inpatient hospice.

12. Each hospice may maintain one "STAT" medicine cabinet for the purpose of keeping a minimum amount of stock medications that may be needed quickly or after regular duty hours. The following rules apply to such a cabinet.

a. The contents of the "STAT" medicine cabinet shall be approved by the hospice pharmacist and members of the medical and clinical staff responsible for the development of policies and procedures.

b. There shall be a minimum number of doses of any medication in the "STAT" cabinet based upon the established needs of the hospice.

c. There shall be a list of the contents of the “STAT” medicine cabinet, including the name and strength of the drug and the quantity of each.

d. There shall be records available to show amount received, name of patient and amount used, prescribing licensed medical practitioner, time of administration, name of individual removing and using the medication, and the balance on hand.

e. There shall be written procedures for utilization of the "STAT" medicine cabinet with provisions for prompt replacement of used items.

f. The pharmacist shall inspect the "STAT" medicine cabinet at least monthly, replacing outdated drugs and reconciliation of its prior usage. Information obtained shall be included in a monthly report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2278 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:606 (March 2018).

Chapter 84. End Stage Renal Disease Treatment Facilities

Subchapter A. General Provisions

§8401. Acronyms and Definitions

A. The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Abuse—any act or failure to act that caused or may have caused injury to a patient knowingly, recklessly, or intentionally, including incitement to act. Injury may include, but is not limited to: physical injury, mental disorientation, or emotional harm, whether it is caused by physical action or verbal statement. Patient abuse includes:

a. any sexual activity between facility personnel and a patient;

b. corporal punishment;

c. efforts to intimidate;

d. the use of any form of communication to threaten, curse, shame, or degrade a patient;

e. restraints that do not conform to standard practice;

f. coercive or restrictive actions that are illegal or not justified by the patient's condition, taken in response to the patient's request for discharge or refusal of medication or treatment; and

g. any other act or omission classified as abuse by Louisiana law.

Acronyms (Federal)—

a. CFR—Code of Federal Regulations

b. CMS—Centers for Medicare and Medicaid Services

c. Network (13)—Federal ESRD Quality Assurance Supplier

d. PRO—Peer Review Organization

Adequacy of Dialysis—term describing the outcome of dialysis treatment as measured by clinical laboratory procedures.

Adequate/Sufficient—reasonable, enough: e.g., personnel to meet the needs of the patients.

Advertise—to solicit or induce to purchase the services provided by a facility.

Assessment—gathering of information relative to physiological, behavioral, sociological, spiritual, functional and environmental impairments and strengths of the patient using the skills, education, and experience of one's professional scope of practice.

Board(s)—entities responsible for licensing/certification of specific professions (e.g., nursing, counselors, social workers, physicians, etc.).

Chronic Maintenance Dialysis—dialysis that is regularly furnished to an End Stage Renal Disease (ESRD) patient in a hospital-based, independent (free-standing), or home setting.

Consultation—professional oversight, advice, or services provided under contract.

Consumer/Patient—person assigned or accepted for treatment furnished by a licensed facility as specified.

Delegation of Tasks—assignment of duties by a registered nurse to a licensed practical nurse, or other personnel with respect to their training, ability and experience. The registered nurse cannot delegate complex nursing tasks that have not been approved as appropriate for delegation, responsibility, or tasks requiring judgment.

Department—the Louisiana Department of Health and Hospitals (DHH). The following is a list of pertinent sections of DHH.

a. *Health Standards Section (HSS)*—the section within the Bureau of Health Services Financing that is responsible for conducting surveys, issuing licenses, and serving as the regulatory body for health care facilities in the state.

b. *Office for Public Health (OPH)*Xthe office that is responsible for the development and enforcement of public health regulations and codes.

c. *Division of Architectural Services*—the office that is responsible for the professional review of all facility floor plans and site plans prior to licensing to assure compliance with state laws and codes.

d. *Program Integrity Section*—the section within the Bureau of Health Services Financing that is responsible for investigating alleged fraud and abuse.

Dialysis—a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane. The two types of dialysis that are currently in common use are hemodialysis and peritoneal dialysis.

End-Stage Renal Disease (ESRD)—that stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

End-Stage Renal Disease Treatment Facility—a facility that presents to the public as a supplier of chronic dialysis services including, at least, hemodialysis, but may also include peritoneal dialysis, home training, or home support.

Exploitation—any act or process to use (either directly or indirectly) the labor or resources of a patient for monetary or personal benefit, profit, or gain of another individual or organization. Examples of exploitation include:

a. use of a patient's personal resources such as credit cards, medical assistance cards, or insurance cards to bill for inappropriate services;

b. use of the patient's food stamps or other income to purchase food or services used primarily by others; and

c. using the patient to solicit money or anything of value from the public.

Facility—a supplier of services, including all employees, consultants, managers, owners, and volunteers as well as the premises and activities.

Medication Administration—the preparation and giving of legally prescribed individual doses of medication to a patient, including the observation and monitoring of the patient's response to the medication.

Medication Dispensing—the compounding, packaging, and giving of legally prescribed multiple doses of medication to a patient.

Neglect—failure to provide adequate health care or failure to provide a safe environment that is free from abuse or danger; failure to maintain adequate numbers of appropriately trained staff; or any other act or omission classified as neglect by Louisiana law.

*Office of the State Fire Marshal(OSFM)*Xthe office that is responsible for establishing and enforcing the regulations governing building codes, including Life Safety Codes for healthcare facilities.

On Call—immediately available for telephone consultation.

Sexual Exploitation—a pattern, practice, or scheme of conduct that can reasonably be construed as being for the purpose of sexual arousal or gratification or sexual abuse of any person. It may include sexual contact, a request for sexual contact, or a representation that sexual contact or exploitation is consistent with or part of treatment.

Site/Premises—an identifiable location owned, leased, or controlled by a facility where any element of treatment is offered or provided.

Staff—individuals who provide services for the facility in exchange for money or other compensation, including employees, contract providers/suppliers, and consultants.

Standards—policies, procedures, rules, and other guidelines (i.e., standards of current practice) contained in this document for the licensing and operation of end-stage renal disease treatment facilities.

Supervision—occupational oversight, responsibility and control over employees and/or service delivery by critically watching, monitoring, and providing direction.

Unethical Conduct—conduct prohibited by the ethical standards adopted by DHH, state or national professional organizations or by a state licensing agency.

Unprofessional Conduct—any act or omission that violates commonly accepted standards of behavior for individuals or organizations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2191 (October 2002).

§8403. Licensing

A. Any facility that presents itself to the public as a supplier of chronic dialysis treatment services and/or dialysis training to individuals diagnosed with end stage renal disease is required to have a valid and current license. The facility shall not provide services without the appropriate license and shall advertise (or otherwise notify the public or other referral entities) only for services that the facility is licensed to provide. Each licensed facility must comply with the minimum requirements in order to remain licensed. In addition, each facility is required to have a copy of the minimum standards on site, and all administrative and professional staff shall be familiar with the minimum standards.

B. In order to be licensed as an ESRD facility in Louisiana the facility must also be in continuous compliance with federal regulatory requirements applicable to ESRD facilities, including but not limited to: 42CFR §405.2135-2140; 42 CFR §405.2150, and §2160-2164.

C. The initial application process assures that the facility is capable of organizing and planning an operation to provide dialysis services as designated on the license. The application packet and procedures may be obtained from DHH/HSS.

D. Renewal. A license must be renewed at least annually.

E. License Types

1. Full License. A full license is issued to agencies that are in compliance with the minimum standards and all other licensing requirements. The license is valid until the date of expiration unless it is revoked or suspended prior to the date of expiration, or the license renewal is denied.

2. Provisional License. A provisional license is issued to facilities that are not in compliance with the minimum standards and whose license will be terminated if systemic changes fail to correct identified problems. Cited deficiencies shall not be detrimental to the health and safety

of clients. A provisional license is valid for six months or until a designated termination date.

F. The current license shall be displayed on-site at each facility. Any license issued by DHH supersedes all other licenses and those previously issued licenses are deemed invalid. Any facility displaying and/or using an invalid or altered license will be sanctioned.

G. Notification of Change. Failure to report any of the following changes in writing to HSS within 10 days of the occurrence of the change is considered delinquent and subject to sanction. Written approval of changes by DHH is required for the facility to remain in compliance with licensing standards. An on-site survey, at the discretion of HSS, may be required prior to issuance of a new license.

1. Change of Ownership. A license is non-transferrable. The new owners must apply for a new license and submit a new application form, copy of the bill of sale, licensing fee, disclosure of ownership form, and information regarding relocation, name change, etc.

2. New Construction. All plans must have prior approval of the OSFM and Division of Architectural Services.

3. Renovations. All plans must have prior approval of the OSFM and Division of Architectural Services, when required.

4. Change of Address. Address changes require the issuance of a replacement license and must be prior authorized. Authorization is based on the submission of requested information to HSS.

5. Change in Services. Providing additional services requires the submission of an application packet appropriate to the new service. Interim approval may be granted based on the review of the submitted documentation. Permanent approval will be granted automatically at the next on-site survey unless the facility is found to be out of compliance. Deleting existing services requires the submission of written notification to HSS.

6. Days of Operation. Written notification to HSS is required in advance of a change in the facility's days of operation.

7. Change in Stations. Facilities wishing to increase or decrease the number of stations shall be required to submit in writing to HSS at least 30 days in advance of the change.

H. If at any time the facility decides to cease operations, the facility shall notify HSS of the date of the cessation of services, the permanent location of the records and surrender the license.

1. All active patients and pertinent information shall be referred/transferred to the nearest appropriate treatment facility.

2. Written notification and the license shall be sent to HSS within five working days.

3. Notice of intent to cease operation shall be published in the local newspaper with the widest circulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2192 (October 2002).

§8405. Fees, Fines, and Assessments

A. All fees must be submitted to DHH in the form of a company or certified check or money order, and made payable to the Department of Health and Hospitals. All fees are non-refundable and non-transferable.

1. The current fee schedule is available upon request.

2. The fee for the initial application and licensing process shall be submitted prior to review and consideration of the licensing application.

3. The annual renewal fee is payable in advance of the issuance of the renewal license.

4. A fee must accompany any request requiring the issuance of a replacement license.

5. A renewal or other fee is considered delinquent after the due date and an additional fee shall be assessed beginning on the day after the date due. No license will be issued until applicable fees are paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2193 (October 2002).

§8407. Survey

A. All surveys, except the initial licensing survey, shall be unannounced. This survey may be conducted with other agency personnel and/or personnel from other local, state or federal agencies. A survey of all aspects of the facility's operation is required prior to issuing a license.

B. Initial Survey. DHH shall determine through an on-site review if the facility is capable of becoming fully operational. The procedures for the on-site review may be obtained from HSS.

C. Annual Survey. An on-site survey of the facility is performed or an attestation from the facility is received annually to assure continuous adherence to standards.

D. Follow-up Surveys. An on-site visit is performed or documentation is requested for a desk review to ensure that corrective actions have been taken as stated in the plan of corrections and to assure continued compliance between surveys.

E. DHH shall determine the type and extent of investigation to be made in response to complaints in accordance with R.S. 40: 2009.13 et seq.

1. The facility may be required to do an internal investigation and submit a report to HSS.

2. HSS and other federal, state and local agencies may conduct an on-site focused or complete survey as appropriate.

F. Written plans of correction shall be submitted to HSS to describe actions taken by the facility in response to cited violations. The plan must be submitted within 10 days of the date of the receipt of the notice of deficiencies, or the provider may be sanctioned. All components of the corrective action plan must be specific and realistic, including the dates of completion.

1. The correction plan shall include the following components:

a. the actions taken to correct any problems caused by a deficient practice directed to a specific patient;

b. the actions taken to identify other patients who may also have been affected by a deficient practice, and to assure that corrective action will have a positive impact for all patients;

c. the systemic changes made to ensure that the deficient practice will not recur;

d. a monitoring plan developed to prevent recurrence; and

e. the date(s) when corrective action will be completed.

G. Corrections must be completed within 60 days of the survey unless HSS directs that corrective action be completed in less time due to danger or potential danger to patients or staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2193 (October 2002), amended LR 30:432 (March 2004).

§8409. Adverse Actions

A. DHH reserves the right to suspend, deny (initial or renewal), or revoke any license at the discretion of the secretary or his/her designee.

B. Provisional License Designation. See §8403.E.2.

C. Denial of Initial Licensing. An initial license request may be denied in accordance with R.S. 40:2117.5(A).

D. A license may be revoked or denied for any of the following nonexclusive reasons. See also R.S. 40:2117.5:

1. cruelty or indifference to the welfare of the patients;

2. misappropriation or conversion of the property of the patients; or

3. violation of any provision of the End Stage Renal Disease Facilities statute R.S.40:2117 et seq. or of the minimum standards, rules, and regulations, as follows:

a. providing services to more stations than authorized by license;

b. repeated failure to adhere to rules and regulations that resulted in the issuance of a provisional license or other sanction;

c. serious violation of these standards or current professional standards of practice;

d. failure to submit corrective action plans for identified violations;

e. reasonable cause to suspect that patient health and/or safety is jeopardized;

f. reliable evidence that the facility has:

i. falsified records;

ii. bribed, solicited or harassed any person to use the services of any particular facility;

g. failure to submit required fees in a timely manner;

h. failure to cooperate with a survey and/or investigation by DHH and/or authorized agencies; or

i. failure to meet operational requirements as defined in §8423.C;

4. permitting, aiding, or abetting the unlawful, illicit, or unauthorized use of drugs or alcohol within the facility;

5. conviction or plea of nolo contendere by the applicant for a felony. If the applicant is an agency, the head of that agency must be free of such conviction. If a subordinate employee is convicted of a felony, the matter must be handled administratively to the satisfaction of HSS;

6. documented information of past or present conduct or practices of the facility that are detrimental to the welfare of the patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2194 (October 2002).

§8411. Appeals

A. The Health Standards Section shall give at least 30 days notice of the denial of renewal or revocation of license unless it determines that the health and/or safety of patients is in jeopardy. In the event that it is determined that the health and/or safety of patients is in jeopardy, the license may be revoked immediately with appeal rights granted after the facility ceases operation and patients are transferred to another facility. The facility may appeal within 30 days following the revocation.

B. Requests for an administrative reconsideration must be submitted in writing to HSS within 15 days of the receipt of the denial of renewal or revocation notice.

C. Requests for an administrative appeal must be submitted in writing to DHH, Office of the Secretary within 15 days of the receipt of the denial of renewal or revocation notice. Requests for administrative reconsideration do not

affect the timeframes for requesting an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2194 (October 2002), amended LR 30:432 (March 2004).

Subchapter B. Facility Operations

§8423. Operational Procedures

A. Each facility shall establish facility-specific, written policy and implement such policy in these areas:

1. procedures to ensure the health, safety, and well-being of patients;

2. The procedure to ensure sound patient care in conformity with current standards of practice;

3. protocols to assure uniform and quality assessment, diagnosis, evaluation, and referral to the appropriate level of care;

4. procedures to assure operational capability and compliance;

5. procedures to assure that only qualified personnel are providing care within their respective scope of practice;

6. procedures to assure that patient information is collected, maintained, and stored according to current standards of practice; and

7. standards of conduct for all personnel in the facility.

B. Continuous Quality Program (CQP). The facility shall:

1. have ongoing programs to assure that the overall function of the facility is in compliance with federal, state, and local laws, and is meeting the needs of the citizens of the area as well as attaining the goals and objectives developed from the mission statement established by the facility;

2. focus on improving patient outcomes and patient satisfaction;

3. have objective measures to allow tracking of performance over time to ensure that improvements are sustained;

4. develop and/or adopt quality indicators that are predictive of desired outcomes and can be measured, analyzed and tracked;

5. identify its own measure of performance for the activities that are identified as priorities in quality assessment and performance improvement strategy;

6. immediately correct problems that are identified through its quality assessment and improvement program that actually or potentially affect the health and safety of the patients;

7. develop and implement an annual internal evaluation procedure to collect necessary data for formulation of a plan. In addition, conduct quarterly meetings of a professional staff committee (at least 3 individuals) to select and assess continuous quality activities, to set goals for the quarter, to evaluate the activities of the previous quarter, and to immediately implement any changes that would protect the patients from potential harm or injury;

8. implement a quarterly utilization review of 5 percent of the active patient records (minimum of 10 records) by professional staff;

9. complete an annual documented review of policies, procedures, financial data, patient statistics, and survey data by the governing board/regional administrator; and

10. participate as requested with state and federal initiatives to assure quality care.

C. Operational Requirements. The facility shall:

1. be fully operational for the business of providing dialysis as indicated on the approved original application or notice of change;

2. be in compliance with R.S.40:2007, if the facility is operated within another health care facility;

3. have active patients at the time of any survey after the initial survey;

4. utilize staff to provide services based on the needs of their current patients;

5. have required staff present in the facility at all times whenever patients are undergoing dialysis;

6. develop, implement, and enforce policies and/or procedures that eliminate or greatly reduce the risk of patient care errors; and

7. develop procedures to communicate to staff and to respond immediately to market warnings, alerts, and recalls.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2194(October 2002).

§8425. Facility Records

A. Record keeping shall be in accordance with accepted standards to assure the development and implementation of facility specific policies and procedures to adhere to all licensing standards. Specific facility records shall contain:

1. personnel information including:

a. annual health screens in accordance with CDC/OPH guidelines and facility policy;

b. actual hours of work;

c. orientation/training/in-services;

d. disciplinary actions;

e. verification of professional credentials, licensing/certification and renewals; and

f. job descriptions/performance expectations;

2. operational information including:

a. organizational chart;

b. payment methods in accordance with the Wage and Hour Board;

c. proof of general and professional liability insurance in the amount of at least, $500,000;

d. projected plan of operations based on the findings of the facility specific continuous improvement program; and

e. written agreements with other entities to assure adherence to licensing standards and continuity of care, e.g., transplant services, lab services, waste removal, hospital, etc.;

3. identification of a governing body composed of adults who have legal authority over the policies and activities of the facility as required by 42 CFR §405.2136. All private providers must comply with this requirement.

B. Required Facility Reports. The facility director shall report the following incidents either verbally or by facsimile to HSS within 24 hours of discovery. If reporting is verbal, it will be confirmed in writing within seven calendar days.

1. fire and/or natural disasters;

2. any substantial disruption of program operation;

3. any inappropriate treatment or service resulting in death or serious injury; and

4. serious violations of laws, rules, and professional and ethical codes of conduct, e.g. abuse, neglect, exploitation by facility personnel/volunteers that resulted in harm or the potential for harm to the patient(s). Patient to patient abuse shall also be reported to the agency.

C. The facility shall post a legible copy of the following documents in full view of patients, visitors, and employees:

1. patient bill of rights/responsibilities;

2. escape routes;

3. facility specific rules, responsibilities and grievance procedures;

4. current license and variances; and

5. current licensing survey findings.

D. The facility shall maintain the following operational records:

1. equipment maintenance;

2. water testing logs;

3. reprocessing logs;

4. fire and safety logs;

5. in-services/attendance records;

6. personnel records; and

7. disinfection logs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2195 (October 2002).

§8427. Health and Safety

A. Infection Control

1. The facility shall protect staff, patients, and visitors from potential and/or actual harm from infectious disease by utilizing the following policies and procedures.

a. Development and implementation of a universal precautions program that includes education and practice.

b. Development and implementation of a infection control program to report, evaluate, and maintain documentation pertaining to the spread of infectious disease, including data collection and analysis, corrective actions, and assignment of responsibility to designated medical staff person (including "access infections").

c. The facility shall strictly adhere to all sanitation requirements.

2. The facility shall establish and maintain a clean environment by the implementation of the following housekeeping policies and procedures:

a. supplies and equipment shall be available to staff and/or patients;

b. consistent and constant monitoring and cleaning of all areas of the facility shall be practiced; and

3. the facility may contract for services necessary to maintain a clean environment.

B. Sanitation

1. Food and waste shall be stored, handled, and removed in a way that will not spread disease, cause odors, or provide a breeding place for pests.

2. If there is evidence of pests, the facility shall contract for pest control.

C. Environmental Safety

1. The entire facility (including grounds, buildings, furniture, appliances, and equipment) shall be structurally sound, in good repair, clean, and free from health and safety hazards.

2. The facility shall comply with the Americans with Disabilities Act (ADA).

3. The facility shall prohibit firearms and/or other weapons.

4. Poisonous, toxic and flammable materials shall be properly labeled, stored, and used safely.

5. The facility shall take all possible precautions to protect the staff, patients and visitors from accidents or unnecessary injuries or illnesses.

D. The facility shall respond effectively during a fire or other emergency. Every facility shall:

1. have emergency evacuation procedures that include provisions for the handicapped;

2. hold simulated fire drills on each shift at least quarterly to familiarize facility personnel with the signals and emergency actions required; patients shall not be moved during drills;

3. be able to evacuate the building in a timely manner whenever necessary;

4. conspicuously post exit diagrams throughout the facility;

5. post emergency numbers by all phones; and

6. have adequate first aid supplies that are visible and easy to access whenever necessary.

E. The facility shall have a written facility specific disaster plan. The staff shall be able to access and implement the plan when required.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2196 (October 2002).

§8429. Physical Plant Requirements

A. For licensing, an ESRD treatment facility applicant shall have architectural plans and specifications reviewed by the DHH Division of Engineering and Architectural Services using the current edition of the *American Institute of Architect's Guidelines for Construction for Hospital and Health Care Facilities*.

B. The Office of the State Fire Marshal shall determine fire safety review requirements based upon applicable regulations.

C. Required Inspections

1. The facility shall pass all required inspections and keep a current file of reports and other documentation needed to demonstrate compliance with applicable laws and regulations. The inspections must be signed, dated, and free of any outstanding violations/citations. The following inspections are required:

a. annual fire marshal inspection;

b. annual inspection by the Office of Public Health (local health unit);

c. annual inspection and maintenance of fire extinguishers by personnel licensed or certified to perform those duties; and

d. regular inspections of elevators, if applicable.

2. The following documentation shall be on file in the facility:

a. certificate of occupancy as required by the local authorities;

b. DHH approval of the water supply/system; and

c. documentation that any liquefied petroleum supply has been inspected and approved.

D. Exterior Space Requirements. The facility shall:

1. ensure that all structures on the grounds of the facility that are accessible to patients are maintained in good repair and are free from identified hazards to health or safety;

2. maintain the grounds of the facility in an acceptable manner and ensure that the grounds are free from any hazard to health or safety;

3. store garbage and rubbish securely in non-combustible, covered containers that are emptied on a regular basis;

4. separate trash collection receptacles and incinerators from patient activity areas and locate all containers so that they are not a nuisance to neighbors; and

5. store and dispose of all medical waste in accordance with local, state, and federal guidelines.

E. Interior Space Requirements

1. Bathrooms. Minimum facilities shall include:

a. adequate operational fixtures that meet *Louisiana State Plumbing Code*. All fixtures must be functional and have the appropriate drain and drain trap to prevent sewage gas escape back into the facility;

b. an adequate supply of hot water. Hot water temperature at the point of service to patients shall be between 105°F and 120°F;

c. toilets with seats;

d. an adequate supply of toilet paper, towels, and soap;

e. doors to allow for individual privacy;

f. external emergency release mechanism;

g. safe and adequate supply of cold running water; and

h. functional toilets, wash basins, and other plumbing or sanitary facilities which shall be maintained in good operating condition and kept free of any materials that might clog or otherwise impair their operation.

2. Administrative and Counseling Space

a. Administrative office(s) for records, secretarial work and bookkeeping shall be separate and secure from patient areas.

b. Space shall be designated to allow for private discussions and counseling sessions.

3. Doors and Windows. Outside doors, windows and other features of the structure necessary for the safety and comfort of patients shall be secured for safety within 24 hours after they are found to be in a state of disrepair. Total repair should be completed as soon as possible.

4. Storage. The facility shall:

a. ensure that there are sufficient and appropriate storage facilities; and

b. secure all potentially harmful materials.

F. Exits

1. Exit doors and routes shall be lighted and unobstructed at all times.

2. There shall be an illuminated "EXIT" sign over each exit. Where the exit is not visible, there shall be an illuminated "EXIT" sign with an arrow pointing the way.

3. Rooms for 50 or more people shall have exit doors that swing out.

4. No door may require a key for emergency exit.

5. In facilities initially licensed after March 20, 2004, at least one window shall be provided in every treatment area.

6. Every building shall have at least two exits that are well separated.

7. Every multiple-story building shall have at least two fire escapes (not ladders) on each story that are well separated. Fire escapes shall:

a. be made of non-combustible material;

b. have sturdy handrails or walls on both sides; and

c. provide a safe route to the ground.

8. Stairs and ramps shall be permanent and have non-slip surfaces.

9. Exit routes higher than 30 inches (such as stairs, ramps, balconies, landings, and porches) shall have full-length side guards.

G. Electrical Systems. All electrical equipment, wiring, switches, sockets and outlets shall be maintained in good order and safe operating condition. All rooms, corridors, stairways and exits within a facility shall be sufficiently illuminated.

1. The facility shall have an illuminating system that provides lighting levels to support tasks performed by staff and the independent functioning of patients without the need for additional lighting.

2. Lighting shall be provided outside the building and in parking lots.

3. Light bulbs shall have shades, wire guards or other shields.

4. Emergency lighting shall illuminate AEXIT≅ routes.

H. Ventilation

1. The facility shall not use open flame heating equipment, floor furnaces, unvented space heaters, or portable heating units.

2. Occupied parts of the building shall be air conditioned and the temperature should remain between 65EF and 85EF.

3. The entire facility shall be adequately ventilated with fresh air. Windows used for ventilation shall be screened.

4. The facility shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of patients and staff.

I. Plumbing. The plumbing systems shall be designed, installed, operated and maintained in a manner that ensures an adequate and safe supply of water for all required facility operations and to facilitate the complete and safe removal of all storm water and waste water.

J. Finishes and Surfaces

1. Lead-based paint or materials containing asbestos shall not be used.

2. Floor coverings must promote cleanliness, must not present unusual problems for the handicapped and have flame-spread and smoke development ratings appropriate to the use area (e.g. patient's room versus exit corridor).

3. All variances in floors shall be easily identified by markings, etc. to prevent falls.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2196 (October 2002), amended LR 30:432 (March 2004).

Subchapter C. Personnel

§8439. General Provisions

A. Administration

1. The administrative staff shall be qualified and adequate to assure adherence to all licensing standards.

2. Qualifications of all facility staff shall meet or exceed those required by federal regulations.

3. Facility compliance with licensing standards shall determine adequacy of available administrative oversight.

4. Facilities shall be organized so that administrative personnel do not perform any clinical duties and/or make clinical decisions, unless the individual is licensed or certified to make clinical decisions.

B. Referrals, Credentials, and Contract Services

1. Facility personnel shall report referral violations of laws, rules, and professional and ethical codes of conduct to

HSS and to appropriate licensing boards when applicable. The facility shall maintain records and have written policies governing staff conduct and reporting procedures that comply with this requirement.

2. The facility administrator is responsible for assuring that all credentials are from accredited institutions, are legal, and have been verified to deter the fraudulent use of credentials.

3. The facility must have formal written agreements with outside professionals or other entities retained to provide contract services. Written agreements shall express the responsibilities between the two parties, be signed by both parties and shall either be time-limited or remain in effect until either party terminates the agreement in writing.

C. Staffing Criteria. Each facility shall develop and implement staffing level criteria to assure compliance with all licensing standards and to provide quality care within the established parameters of current standards of practice.

1. Consideration for determination of adequate nursing staffing levels will include:

a. acuity of patients;

b. physical design of facility;

c. equipment design and complexity; and

d. additional pertinent information as needed.

2. A registered nurse or physician shall be present during and after treatment and until the last patient has left the facility.

3. Any experience used to qualify for any position must be counted by using one year of experience equals 12 months of full-time work.

4. A person may hold more than one position within the facility if that person is qualified to function in both capacities, and the required hours for each job are separate and apart for each position.

5. Social work staffing shall be based on the staffing guidelines developed by the Council of Nephrology Social Workers which addresses the following:

a. treatment setting;

b. number of patients seen or anticipated to be seen in a year;

c. their psychological risk (acuity); and

d. the number of mutually agreed upon social work functions, including, but not limited to:

i. psycho-social evaluations;

ii. casework counseling;

iii. group work;

iv. information and referral;

v. facilitating community agency referral;

vi. team care planning and collaboration;

vii. transfer planning;

viii. pre-admission planning;

ix. discharge planning

x. facilitating use of hospital and/or facility services

xi. patient/family education;

xii. financial assistance;

xiii. staff consultation; and

xiv. community health services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2197 (October 2002), amended LR 30:433 (March 2004).

§8441. Training

A. Each employee shall complete appropriate orientation to the facility and to his/her work responsibilities prior to providing direct patient care/contact. The content of the basic orientation provided to all employees at the time of employment/annual review shall include:

1. policies/procedures and objectives of the facility;

2. duties and responsibilities of the employee;

3. organizational/reporting relationships;

4. ethics and confidentiality;

5. patient's rights;

6. standards of conduct required by the facility;

7. information on the disease process and expected outcomes;

8. emergency procedures including the disaster plan and evacuation procedures;

9. principals and practices of maintaining a clean, healthy and safe environment;

10. specific information as appropriate to the employee's job duties;

11. universal precautions;

12. violent behavior in the workplace;

13. abuse/neglect and exploitation;

14. overview of ESRD licensing standards; and

15. basic emergency care of ill or injured persons until trained personnel can arrive.

B. In-service training is an educational offering that shall assist the direct care/contact workers in providing current treatment modalities, and serve as refresher for subjects covered in orientation. Documentation of attendance for at

least three in-services per quarter is required. Additional educational programs are encouraged.

C. Patient Care Technician (PCT) or Dialysis Technician. Training and orientation shall reflect the American Nephrology Nurses Association (ANNA) standards of clinical practice, including but not limited to:

1. anatomy and physiology of the renal system;

2. principles of water treatment;

3. dialyzer reprocessing;

4. basics of nutrition in renal failure;

5. understanding of ethical issues impacting on nephrology practice;

6. communication and interpersonal skills;

7. standard precautions, as recommended by the Center for Disease Control;

8. concepts and principles of hemodialysis;

9. arteriovenous puncture for dialysis access techniques;

10. use of heparin in dialysis procedures;

11. use of isotonic saline in dialysis;

12. maintenance of the delivery system:

a. integrity of extra corporeal circuit;

b. pressure monitor readings;

c. anticoagulant delivery;

d. blood flow rate;

e. alarm limits and/or conditions;

13. observation and reports of complications to the registered nurse;

14. post-treatment access care guidelines;

15. disposal of supplies in compliance with standard precautions; and

16. agency policy regarding the cleaning of equipment and treatment area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2198 (October 2002).

§8443. Personnel Qualifications and Responsibilities

A. Chief Executive Officer or Administrator

1. Qualifications are as cited in the CFR and designated in writing by the governing body.

2. Responsibilities include:

a. enforcement of local, federal and state requirements;

b. overall management of the facility;

c. annual documented review and appropriate actions taken on all policies, procedures, facility rules, goals, grievances, budget, internal and external evaluations (including all survey findings);

d. implementation and enforcement of codes of conduct to ensure professional, ethical and legal operations; and

e. implementation and enforcement of facility practices that ensure that employees have the necessary administrative support to provide therapeutic milieu for patients (including adequate staff, supplies, and other support).

B. Clinical Nursing Supervisor

1. Qualifications

a. currently licensed as a registered nurse in the state of Louisiana;

b. eighteen months or more of clinical experience as a registered nurse; and

c. six months or more of clinical experience which must include: nursing care of a patient with permanent kidney failure or who is undergoing kidney transplantation, including training in and experience with the dialysis process.

2. Responsibilities include:

a. supervising the clinical nursing functions of the facility;

b. performing the liaison duties between others, including facility staff, physicians and patients;

c. supervising the training and performance of the technicians and non-medical staff in order to ensure safe care;

d. functioning as a patient advocate; and

e. accepting responsibility and accountability for the assessment, planning, intervention, teaching, supervision, and evaluation of care to ensure that the patient receives safe and effective dialysis treatment according to the prescribed treatment plan and in accordance with LAC 46:XLVII.3901-3913.

C. Charge Nurse

1. Qualifications

a. currently licensed as registered nurse in the state of Louisiana;

b. six months or more of clinical experience as a registered nurse; and

c. three months or more of the clinical experience must include nursing care of a patient with permanent kidney failure or who is undergoing kidney transplantation, including training in and experience with the dialysis process.

2. Responsibilities include:

a. accepting responsibility and accountability for the assessment, planning, intervention, teaching, supervision, and evaluation of care to ensure that the patient will receive safe and effective dialysis treatment according to the prescribed treatment plan and in accordance with LAC 46:XLVII.3901-3913;

b. performing initial verification and biannual validation of cannulating skills of dialysis technicians and LPN's;

c. providing supervision and assistance as needed to RN's, LPN's and dialysis technicians; and

d. being on site and available in the treatment area to provide patient care during all dialysis treatments, but may leave the immediate area for meals and breaks. However, during these periods of absence the facility must insure that all necessary care can be delivered by the licensed person on duty.

D. Registered Nurse

1. Qualifications. Possession of a current valid license or be an RN applicant with a temporary permit to practice in Louisiana.

2. Responsibilities include:

a. accepting responsibility and accountability for the assessment, planning, intervention, teaching, supervision, and evaluation of care to ensure that the patient will receive safe and effective dialysis treatment according to the prescribed treatment plan and in accordance with LAC 46:XLVII.3901-3913;

b. conducting admission nursing assessments with each visit prior to delegating any task other than collection of data (vital signs only);

c. reassessing patients as needed to determine a change in the patient's status or at the patient's request;

d. participating in the team review of a patient's progress;

e. recommending changes in treatment based on the patient's current needs;

f. providing oversight and direction to dialysis technicians and LPN's; and

g. participating in continuous quality improvement activities.

3. Registered nurses may perform the duties of the nursing positions cited above for which they are qualified and designated.

E. Dietitian/Nutritionist

1. Qualifications. Possession of a currently valid license with the Louisiana Board of Dietitians/Nutritionists.

2. Responsibilities include:

a. those duties defined in R.S. 37:3081-3094;

b. providing in-service and staff training, consultation to professionals and paraprofessionals, and direct supervision as needed to improve the overall quality of care being provided;

c. conducting individual and/or group didactic and counseling interaction with patients as needed to achieve compliance with dietary restrictions;

d. documenting direct communication with other dietitians who may be involved in the patient's care, such as dietitians at the nursing home, assisted living, etc;

e. providing continuous learning opportunities for patients and/or care givers, including regionally appropriate recipes when possible; and

f. providing adequate knowledge to staff to reinforce patient education.

F. Social Worker

1. Qualifications. Currently licensed by the Louisiana State Board of Social Work Examiners as a Licensed Clinical Social Worker or certified by the board as either a graduate social worker (GSW) or provisional graduate social worker (provisional GSW).

2. Responsibilities include those duties defined in R.S. 37:2701-2723 including, but not limited to:

a. Assessment—identification and evaluation of an individual's strengths, weaknesses, problems, and needs for the development of the treatment plan.

b. Case Management—function in which services, agencies, resources, or people are brought together within a planned framework of action directed toward the achievement of established goals. It may involve liaison activities and collateral contracts with other facilities.

c. Patient Education—function in which information is provided to individuals and groups concerning the disease process and treatment, positive lifestyle changes, and available services and resources. Facility orientation may be included with information given regarding rules governing patient conduct and infractions that can lead to disciplinary action or discharge from the facility, availability of services, costs, and patient's rights.

d. Counseling (Individual/Group)—services to provide appropriate support to the patient and/or family to assist individuals, families, or groups in achieving objectives through:

i. exploration of a problem and its ramifications;

ii. examination of attitudes and feelings;

iii. consideration of alternative solutions; and

iv. decision making and problem solving.

e. Referral—assisting patient and/or family to optimally utilize the available support systems and community resources.

f. Treatment Planning—function in which all disciplines and the patient:

i. identify and rank problems needing resolution;

ii. establish agreed upon immediate objectives and long-term goals; and

iii. decide on a treatment process, frequency, and the resources to be utilized.

G. Medical Director. Every facility shall have a designated medical director.

1. Qualifications

a. the medical director shall have a current, valid license to practice medicine in Louisiana;

b. be board certified in Internal Medicine or Pediatrics, or board eligible, or board certified in Nephrology;

c. have completed an accredited Nephrology training program;

d. have at least 12 months of experience or training in the care of patients at ESRD facilities; and

EXCEPTION: In emergency situations, such as, isolated rural areas, natural disasters, or the death of the qualified director, DHH may approve the interim appointment (for a limited time period) of a licensed physician who does not meet the above criteria.

2. Responsibilities include:

a. providing services as required by the facility to meet the standards;

b. providing oversight to ensure that the facility's policies/procedures and staff conform with the current standards of medical practice;

c. performing liaison duties between others, including facility staff, physicians, and patients;

d. ensuring that each patient at the facility receives medical care and supervision appropriate to his/her needs; and

e. ensuring that each patient is under the care of a physician.

H. Physician Services.

1. Each patient shall be under the care of a physician on the medical staff.

2. At a minimum, each patient receiving dialysis in the facility shall be seen by a physician, physician's assistant, or advanced practice nurse at least once every 30 days; home patients shall be seen at least every three months. There shall be evidence of monthly assessment for new and recurrent problems and review of dialysis adequacy.

3. At a minimum, each patient, whether receiving dialysis in the facility or at home, shall be seen by a physician once every twelve months.

4. If advanced practice nurses or physicians assistants are utilized:

a. there shall be evidence of communication with the treating physician whenever the advanced practice registered nurse or physicians assistant changes treatment orders;

b. the advanced practice nurse or physicians assistant may not replace the physician in participating in patient care planning or in quality management activities; and

c. the treating physician shall be notified and direct the care of patient medical emergencies.

I. Patient Care Technician (PCT) or Dialysis Technician

1. Qualifications include basic general education (high school or equivalent) and dialysis training as specified in §8441.C.

2. Responsibilities include:

a. performing patient care duties only under the direct and on-site supervision of qualified registered nurses;

b. performing only those patient care duties that are approved by facility management and included in the policy and procedure manual; and

c. performing only those patient care duties for which they have been trained and are documented as competent to perform.

J. Reuse Technician

1. Qualifications. Basic general education (high school or equivalent), facility orientation program, and completion of education and training to include the following:

a. health and safety training, including universal precautions;

b. principles of reprocessing, including dangers to the patient;

c. procedures of reprocessing, including pre-cleaning, processing, storage, transporting, and delivery;

d. maintenance and safe use of equipment, supplies, and machines;

e. general principles of hemodialysis and in-depth information on dialyzer processing; and

f. competency certification on a biannual basis by a designated facility employee.

2. Responsibilities. The reuse technician is responsible for the transport, cleaning, processing, and storage of dialyzers to limit the possibility of cross contamination, and to avoid improper care of multiple use dialyzers.

3. Any technician or professional staff who performs reprocessing shall have documented training in the procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2198 (October 2002), amended LR 30:433 (March 2004).

Subchapter D. Patient Care

§8455. Patient's Rights

A. Facilities are required to develop, post, and implement rules and policies that protect the rights of patients and encourage patient responsibility.

1. The facility shall have an operational/documented patient advice process in place that gives feedback to the administration of the facility.

B. Patient's Rights. Each facility shall develop and implement policies that protect the rights of their patients including, but not limited to, the right to:

1. be fully informed of rights, responsibilities and all rules governing conduct related to patient care and services;

2. be fully educated and supported concerning their illness;

3. adequate, safe and efficient dialysis treatment;

4. protection from unsafe and/or unskilled care by any person associated with the facility;

5. protection from unqualified persons providing services under the auspices of treatment;

6. consideration and respect toward the patient, family and visitors;

7. timely resolution of problems or grievances without threat or fear of staff intimidation or retaliation;

8. protection of personal property approved for use by the facility; and

9. protection from retaliation for the exercise of individual rights.

C. Grievance Procedure. The facility must have a grievance process and must indicate who the patient can contact to express a grievance. Records of all grievances, steps taken to investigate them, and results of interventions must be available to surveyors upon request. It is recommended that the facility appoint a grievance committee with patient representation to resolve major or serious grievances.

D. Abuse, Neglect, and Exploitation

1. The facility is responsible for taking necessary action to protect patients from an employee accused of abuse, neglect, or exploitation, for referring any licensed personnel to their respective professional boards, and/or contacting local authorities for investigation when indicated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2201 (October 2002).

§8457. Treatment Services

A. The facility must provide outpatient dialysis services as well as adequate lab, social, and dietetic services to meet the needs of ESRD patients. The facility must provide one or both of the following services.

1. Hemodialysis—a method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream.

2. Peritoneal Dialysis—a procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum (a membrane which surrounds the intestines and other organs in the abdominal cavity).

B. In addition, the following services may be provided by a facility:

1. home training—home visits, teaching, and professional guidance to teach patients to provide self-dialysis;

2. home support—provision of professional support to assist the patient who is performing self-dialysis.

C. Dialyzer Reprocessing. Reuse shall meet the requirements of 42 CFR.§405.2150. Additionally, the facility shall:

1. develop, implement, and enforce procedures that eliminate or reduce the risk of patient care errors including, but not limited to, a patient receiving another patient's dialyzer, or a dialyzer that has failed performance checks;

2. develop procedures to communicate with staff and to respond immediately to market warnings, alerts, and recalls;

3. develop and utilize education programs that meet the needs of the patient and/or family members to make informed reuse decisions; and

4. be responsible for all facets of reprocessing, even if the facility participates in a centralized reprocessing program.

D. Water treatment shall be in accordance with the *American National Standard, Hemodialysis Systems* published by the Association for the Advancement of Medical Instrumentation (AAMI Standards) and adopted by reference 42 CFR. §405.2140.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2201 (October 2002), amended LR 30:433 (March 2004).

§8459. Treatment Requirements

A. Admission

1. Each facility shall develop and implement written criteria to apply when any patient is referred for dialysis treatment or seeks admission, to include:

a. payment guidelines, and alternate resources;

b. exceptions to apply when the patient would have to travel great distances, or suffer undue hardship to be treated at another facility; and

c. consideration of the patient's health and welfare.

2. Each facility shall develop a process that includes:

a. perpetual logging of applicants to assure that all patients are treated equally and offered equal access;

b. referral to appropriate facilities or outside resources;

c. written contracts with those patients who have a history of problems at other facilities, such as disruptive, threatening and abusive behavior to staff or other patients; and

d. professional interaction with other facilities when a patient has financial or behavior problems that cannot be resolved.

B. Patient CareXMiscellaneous

1. Patients must be informed whenever there is an error or incident that exposes them to an infectious illness or the potential for death or serious illness.

2. Facility staff should inform patients of current changes in the dialysis field when those changes could positively or negatively affect the patient.

C. Discharge/Transfer

1. Each facility shall develop and implement written criteria to apply when a patient is discharged without consent to include:

a. reason for discharge (such as, non-compliance or illegal behavior);

b. progressive procedures to assist the patient in making improvements;

c. assistance to aid the patient in finding a new facility; and

e. evaluation of each situation to improve outcomes.

2. A written, patient specific discharge process plan shall be accessible that provides reasonable protection and continuity of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2201 (October 2002), amended LR 30:434 (March 2004).

§8461. Patient Records.

A. The facility is required to maintain a clinical record according to current professional standards for each patient.

1. This record shall:

a. contain all pertinent past and current medical, psychological, social and other therapeutic information, including the treatment plan;

b. be protected from unauthorized persons, loss, and destruction; and

c. be a central location for all pertinent patient information and be easily accessible to staff providing care.

2. Patient records can be copied and/or transferred from one facility to another provided that the patient signs the authorization for transfer of the records and provided that confidentiality of information is strictly enforced.

3. Patient records shall be maintained at the facility where the patient is currently active and for six months after discharge. Records may then be transferred to a centralized location for maintenance in accordance with standard practice and state and federal laws.

4. Confidentiality. Records shall:

a. be inaccessible to anyone not trained in confidentiality, unless they are granted access by legal authority such as surveyors, investigators, etc.; and

b. not be shared with any other entity unless approved in writing by the patient, except in medical emergencies.

5. Record Keeping Responsibility. A person who meets or exceeds the federal requirements, shall be designated as responsible for the patient records.

6. Contents. Patient records shall accurately document all treatment provided and the patient's response in accordance with professional standards of practice. The minimum requirements are as follows:

a. admission and referral information, including the plan/prescription for treatment;

b. patient information/data - name, race, sex, birth date, address, telephone number, social security number, school/employer, and next of kin/emergency contact;

c. medical limitations, such as major illnesses and allergies;

d. physician's orders;

e. psycho-social history/evaluation; and

f. treatment plan. The plan is a written list of the patient's problems and needs based on admission information and updated as indicated by progress or lack of progress. Additionally, the plan shall:

i. contain long and short term goals;

ii. be reviewed and revised as required, or more frequently as indicated by patient needs;

iii. contain patient-specific, measurable goals that are clearly stated in behavioral terms;

iv. contain realistic and specific expected achievement dates;

v. indicate how the facility will provide strategies/activities to help the patient achieve the goals;

vi. be followed consistently by all staff members; and

vii. contain complete, pertinent information related to the mental, physical, and social needs of the patient.

g. diagnostic laboratory and other pertinent information, when indicated;

h. progress notes by all disciplines; and

i. other pertinent information related to the individual patient as appropriate.

7. Computer data storage of pertinent medical information must:

a. meet the above criteria;

b. be easily retrievable and accessible when the patient is receiving dialysis; and

c. be utilized by care givers during dialysis treatment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 40:2117.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2202 (October 2002).

Chapter 85. Intermediate Care Facilities for Persons with Developmental Disabilities

Subchapter A. General Provisions

§8501. Introduction

A. These rules and regulations contain the minimum licensure standards for intermediate care facilities for persons with developmental disabilities (ICF/DD), pursuant to R.S. 40:2180 et seq.

B. Standards are established to ensure minimum compliance under the law, equity among those served, provision of authorized services, and proper disbursement. It is the ICF/DD facility's responsibility to keep these standards current. The standards are the basis for surveys by the state agency, and are necessary for the ICF/DD to remain in compliance with state regulations for licensure.

C. Monitoring of an ICF/DD's compliance with state regulations is the responsibility of Department of Health and Hospitals, Health Standards Section (HSS).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3181 (December 2012).

§8503. Definitions

Administrator—the person appointed by the governing body who is responsible for the day to day functions of the ICF/DD. The administrator can also be called a chief executive officer (CEO).

Bedroom Space—a distinct area used as a sleeping area.

Building Systems-plumbing, mechanical and electrical systems necessary for the complete operations of a facility.

Curator—a person appointed by the court when an individual is interdicted to act as guardian with either limited or full powers over the individual's estate and/or person, depending on the needs of the individual interdicted.

Department—the Louisiana Department of Health and Hospitals (DHH).

Developmental Disabilities (DD)—severe, chronic disabilities which are attributable to mental retardation, cerebral palsy, autism, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation. This condition results in an impairment of general intellectual functioning or adaptive behavior similar to that of mental retardation, and requires treatment or services similar to those required for MR/DD, are manifested before the person reaches age 22 and are likely to continue indefinitely.

Discipline—training that is expected to produce a specified character or pattern of behavior, and especially is expected to produce moral or mental improvement.

Discipline—a field of study, a branch of instruction or learning, or a branch of knowledge or teaching.

Direct Service Management—the act of controlling the various aspects of ICF/DD involving direct services to individuals in order to ensure effective care and treatment.

Direct Service Worker-an employee of an ICF/DD who works directly with individuals as a major function of his/her job.

Existing Licensed Facility—a structure which has been licensed by the department and has received occupancy approval from the local/parish authorities or occupancy approval from Louisiana State Facility Planning and Control and the Office of the State Fire Marshal prior to the effective date of promulgation of these provisions as a final Rule.

Family—the natural or adoptive father, mother, brother, and sister, but may be interpreted broadly to include any person, whether related to the individual by blood or not, who resides in the individual's home and takes part in the individual's family life.

Governing Body—a person or persons with the ultimate responsibility for conducting the affairs of the ICF/DD. The

governing body is responsible for appointing an administrator of the ICF/DD.

Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD)—any 24-hour residential facility, whether public or private, that provides services to individuals that meet the criteria to reside in that facility.

Individual—a person who receives services from an ICF/DD.

Legally Responsible Person—as appropriate, the parent(s) or tutor of a minor or the curator of an interdicted individual.

License—a written certification, whether provisional or regular, of an ICF/DD's authorization to operate under state law.

Living Units—an integral living space utilized by a particular group of individuals who reside in that space.

Major Renovation—any repair or replacement of building materials or equipment which does not meet the definition of *minor alteration*.

Minor Alteration—repair or replacement of building materials and equipment with materials and equipment of a similar type that does not diminish the level of construction beyond that which existed prior to the alteration. This does not include any alteration to the "functionality" or original design of the construction (for example, normal maintenance, re-roofing, painting, wallpapering, asbestos removal, and changes to the electrical and mechanical systems).

Parent—the natural or adoptive mother and father of an individual.

Passive Physical Restraint—the least amount of direct physical contact required on the part of a staff member to prevent an individual from harming himself/herself or others.

Psychotropic Medication—prescription medication given for the purpose of producing specific changes in mood, thought processes, or behavior. They exert specific effects on brain function and can be expected to bring about specific clinically beneficial responses in individuals for whom they are prescribed. The term as used in this policy does not include all drugs which affect the central nervous system, or which may have behavioral effects. For example, the term does not include anticonvulsants or hormones.

Qualified Mental Retardation Professional (QMRP)—the professionally qualified person responsible for overseeing the implementation of an individual's service plan. A QMRP is a person who has specialized training or one year of experience in training or one year of experience in treating or working with the mentally retarded as described in §8579 below.

Qualified Professional (QP)—a psychologist or physician as described in §8579 below.

Re-Establishment Facilities—an existing licensed facility that maintains its license while it has temporarily suspended operation in all or portions of a building due to substantial structural damage.

Replacement Facilities—an existing structure that has obtained substantial structural damage beyond repair and is being totally replaced at another site location or on the same site.

Restraint—the extraordinary restriction of an individual's freedom or freedom of movement.

Service Plan—a comprehensive, time-limited, goal-oriented, individualized plan for care, treatment, and education of an individual in care of an ICF/DD. The *service plan* is based on a current comprehensive evaluation of the individual's needs.

SIP—shelter in place.

Start of Construction—the date the construction permit was issued for new construction, provided that the actual start of construction commenced within 180 days of the permit date. The actual start means either the first placement of permanent construction of a structure on a site, such as the pouring of a slab or footing, the installation of piles, the construction of columns, or any other work beyond the stage of excavation; or the placement of a manufactured home. Permanent construction does not include land preparation such as clearing, grading, or filling; nor does it include excavation of a basement, footings, piers, or foundation or the erection of temporary forms; nor does it include the installation of accessory structures, such as garages or sheds not occupied as dwelling units or not part of the main structure. For substantial repair or substantial improvement, the actual start of construction means the first alteration of any wall, ceiling, floor, or other structural part of a structure, whether or not that alteration affects the external dimensions of the structure.

Structure—any building or other structure.

Substantial Structural Damage—damage of any origin sustained by a structure, whereby the cost of restoration to its pre-damaged condition equals or exceeds 50 percent of its pre-damaged market value, or equals or exceeds a smaller percentage established by the authority having jurisdiction. Evaluation shall be as determined and accepted by the Department of Public Safety, Office of the State Fire Marshal in accordance with RS 40:1574 C-G.

Time-Out Procedure—the isolation of an individual for a period of less than 30 minutes in an unlocked room.

Training—any activity outside the normal routine of the ICF/DD which promotes the development of skills related to individual care, increases the knowledge of the person involved in a related field or fosters the development of increased professionalism.

Treatment Strategy—an orientation or set of clinical techniques informed by a particular therapeutic model and

used to meet a diagnosed need of an individual in care over and above the provisions of basic care.

Tutor—pursuant to Louisiana civil law, a person appointed to have the care of the person of a minor and the administration of his/her estate. There are four types of tutorship.

1. Tutorship by Nature. Upon the death of either parent, the tutorship of minor individuals belongs of right to the other parent. Upon divorce or judicial separation, the tutorship of each minor individual belongs of right to the parent under whose care he/she has been placed.

2. Tutorship by Will. The right of appointing a tutor belongs exclusively to the father or mother dying last. The appointment may be through the surviving parent's will or by declaration in notaries act executed before a notary public and two witnesses. If the parents are divorced or judicially separated, only one with court-appointed custody may appoint a tutor by will or notaries act.

3. Tutorship by the Effect of Law. When a tutor has not been appointed for a minor by the parent dying last, the court shall appoint the nearest ascendant in the direct line of the minor.

4. Tutorship by Appointment of the Judge. When a minor is an orphan and has had no tutor appointed by either parent, or any relation claiming tutorship by effect of law, the court shall appoint a tutor for the minor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3182 (December 2012).

§8505. Licensing Requirements

A. All ICF/DD providers shall be licensed by the Department of Health and Hospitals. An ICF/DD shall not be established, opened, operated, managed, maintained, or conducted in the state without a license issued by DHH. Each ICF/DD shall be separately licensed.

B. DHH is the only licensing authority for ICF/DD providers in the state of Louisiana. It shall be unlawful to operate an ICF/DD provider without possessing a current, valid license issued by the department.

C. Each ICF/DD license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the ICF/DD provider to which it is issued, and only for the specific geographic address of that provider;

3. be valid for one year from the date of issuance, unless revoked, suspended, modified, or terminated prior to that date, or unless a provisional license is issued;

4. expire the last day of the twelfth month after the date of issuance, unless timely renewed by the ICF/DD provider;

5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary;

6. be posted in a conspicuous place on the licensed premises at all times; and

7. specify the maximum number of individuals which may be served by the ICF/DD facility.

D. The licensed ICF/DD provider shall abide by and adhere to any federal, state and local laws, rules, policy, procedure, manual, or memorandums pertaining to ICF/DD provider facilities.

E. A separately licensed ICF/DD provider shall not use a name which is substantially the same as the name of another ICF/DD provider licensed by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3183 (December 2012).

§8507. Initial Licensing Application Process

A. An application packet for licensing as an ICF/DD must be obtained from the department. A completed initial license application packet for the ICF/DD must be submitted to and approved by the department prior to an applicant providing services.

B. An initial applicant must submit a completed licensing packet to DHH, which shall include:

1. a completed ICF/DD licensure application and the non-refundable licensing fee as established by statue;

2. a completed disclosure of ownership and control information form;

3. a copy of a statewide criminal background check, including sex offender registry status, on all owners and administrators;

4. a copy of the approval letter of the architectural facility plans from the Office of the State Fire Marshal and any other office/entity designated by the department to review and approve the facilities architectural plans, if the facility must go through plan review;

5. a copy of the on-site inspection report with approval for occupancy from the Office of the State Fire Marshal;

6. a copy of the health inspection report with approval of occupancy from the Office of Public Health;

7. zoning approval from local governmental authorities; and

8. any other documentation or information required by the department for licensure.

C. Any person convicted of any felony listed below is prohibited from being the owner or administrator of an ICF/DD facility. Any licensing application from such a person shall be rejected by the department.

1. For purposes of this Paragraph, conviction of a felony means:

a. any felony relating to the violence, abuse, or negligence of a person;

b. any felony relating to the misappropriation of property belonging to another person;

c. any felony relating to cruelty to the infirmed, exploitation of the infirmed, or sexual battery of the infirmed;

d. any felony relating to a drug offense;

e. any felony relating to crimes of a sexual nature;

f. any felony relating to a firearm or deadly weapon;

g. any felony relating to Medicare or Medicaid fraud; or

h. any felony relating to fraud or misappropriation of federal or state funds.

D. If the initial licensing packet is incomplete, the applicant shall be notified of the missing information and shall have 90 days from receipt of notification to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ICF/DD provider must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

E. Once the initial licensing application packet has been approved by the department, notification of such approval shall be forwarded to the applicant. Within 90 days of receipt of the approval of the application, the applicant must notify DHH that the ICF/DD is ready and is requesting an initial licensing survey. If an applicant fails to so notify DHH within 90 days, the initial licensing application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ICF/DD provider must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

F. Applicants must be in compliance with all of the appropriate federal, state, departmental, or local statutes, laws, ordinances, rules, regulations, policy, manuals, memorandums and fees before the ICF/DD provider will be issued an initial license to operate by DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3183 (December 2012).

§8509. Initial Licensing Surveys

A. Prior to the initial license being issued to the ICF/DD, an initial licensing survey shall be conducted on site at the facility to assure compliance with the licensing laws and standards.

B. In the event that the initial licensing survey finds that the ICF/DD facility is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

C. In the event the initial licensing survey finds that the ICF/DD facility is non-compliant with any licensing laws or regulations or any other required statutes, law, ordinances, rules or regulations, but the department in its sole discretion determines that the noncompliance does not present a potential threat to the health, safety, or welfare of the individuals receiving services, the department may issue a provisional initial license for a period not to exceed six months. The facility must submit a plan of correction to DHH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. If all such noncompliance or deficiencies are determined to by the department to be corrected on a follow-up survey, then a full license shall be issued. If all such noncompliance or deficiencies are not corrected on the follow-up survey or new deficiencies affecting the health, safety, or welfare of a client are cited, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license packet and fee. However, at the sole discretion of the department the provisional license may be extended for an additional period not to exceed nine days in order for the ICF/DD to correct the noncompliance or deficiencies.

D. In the event that the initial licensing survey finds that the ICF/DD facility is noncompliant with any licensing laws or regulations or any other required statute, law, ordinance, Rule, or regulation, or that present a potential threat to the health, safety, or welfare of the individuals receiving services, the department shall deny the initial license.

E. The initial licensing survey of an ICF/DD provider shall be a scheduled, announced survey. There shall be at least one individual in the ICF/DD facility at the time of the initial licensing survey.

F. Once an ICF/DD provider has been issued an initial license, the department shall conduct licensing surveys at intervals deemed necessary by DHH to determine compliance with licensing regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These licensing surveys shall be unannounced.

1. An acceptable plan of correction may be required from an ICF/DD provider for any survey where deficiencies have been cited. Such plan of correction shall be approved by the department.

2. A follow-up survey shall be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices.

3. If deficiencies have been cited, regardless of whether an acceptable plan of correction is required, the

department may issue appropriate sanctions, including, but not limited to:

a. civil monetary penalties;

b. directed plans of correction; and

c. license revocations.

G. DHH surveyors and staff shall be given access to all areas of the facility and all relevant files during any licensing or other survey. DHH surveyors and staff shall be allowed to interview any provider staff, participant, or person receiving services, as necessary to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3184 (December 2012).

§8511. Types of Licenses and Expiration Dates

A. The department shall have authority to issue the following types of licenses.

1. Full Initial License. In the event that the initial licensing survey finds that the ICF/DD facility is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended or terminated.

2. Provisional Initial License. In the event that the initial licensing survey finds that the ICF/DD facility is non-compliant with any licensing laws or regulations or any other required statutes, laws, ordinances, Rules, regulations or fees, the department is authorized to issue a provisional initial license pursuant to the requirements and provisions of these regulations.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed ICF/DD provider which is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, Rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional Renewal License. The department, in its sole discretion, may issue a provisional license to an existing licensed ICF/DD provider for a period not to exceed six months, for the following reasons:

a. the existing ICF/DD provider has more than five deficient practices or deficiencies cited during any one survey;

b. the existing ICF/DD provider has more than three validated complaints in a 12-month period;

c. the existing ICF/DD provider has been issued a deficiency that involved placing an individual at risk for serious harm or death;

d. the existing ICF/DD provider has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of the follow-up survey; or

e. the existing ICF/DD provider is not in substantial compliance with all of the applicable federal, state, departmental, and local statutes, laws, ordinances, Rules, regulations, and fees at the time of renewal of the license.

5. When the department issues a provisional license to an existing licensed ICF/DD provider, the provider must submit a plan of correction to DHH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license. The department shall conduct an on-site follow-up survey at the ICF/DD provider prior to the expiration of the provisional license. If that on-site follow-up survey determines that the ICF/DD provider has corrected the deficient practices and has maintained compliance during the period of the provisional license, then the department may issue a full license for the remainder of the year until the anniversary date of the ICF/DD license. If that on-site follow-up survey determines that the ICF/DD provider has not corrected the deficient practices, has not maintained compliance during the period of the provisional license, or if new deficiencies that are a threat to the health, safety, or welfare of a client are cited on the follow-up, the provisional license shall expire. However, at the sole discretion of the department the provisional license may be extended by the department, not to exceed 90 days, in order for the ICF/DD provider to correct the non-compliance or deficiencies.

B. If an existing licensed ICF/DD provider has been issued a notice of license revocation or termination, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

1. The denial of the license renewal application shall not affect in any manner the license revocation, suspension, or termination.

C. The renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3185 (December 2012).

§8513. Changes in Licensee Information or Personnel

A. An ICF/DD license shall be valid only for the person or entity named in the license application and only for the specific geographic address listed on the license application.

B. Any changes regarding the ICF/DD's facility name, "doing business as" name, mailing address, phone number, or any combination thereof, shall be reported in writing to the department within five days of the change.

C. Any change regarding the provider's key administrative personnel shall be reported in writing to DHH within five days of the change.

1. Key administrative personnel include the:

a. administrator.

2. The facility's notice to DHH shall include the individual's:

a. name;

b. address;

c. hire date; and

d. qualifications.

D. A change of ownership (CHOW) of the ICF/DD shall be reported in writing to the department within five days of the change of ownership. The license of the ICF/DD is not transferable or assignable; the license of an ICF/DD cannot be sold. In the event of a CHOW, the new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Once all application requirements are completed and approved by the department, a new license shall be issued to the new owner.

1. An ICF/DD provider who is under license suspension, revocation, or termination may not undergo a CHOW.

2. If the CHOW results in a change of geographic address, an on-site survey shall be required prior to the issuance of the new license.

E. If the ICF/DD provider changes its name without a change in ownership, the ICF/DD provider shall report such change to DHH in writing five days prior to the change. The change in the ICF/DD provider name requires a change to the provider's license and payment of the applicable fee.

F. Any request for a duplicate license must be accompanied by the applicable fee.

G. An ICF/DD provider that intends to change the physical address of its geographic location is required to have plan review approval, Office of the State Fire Marshal approval, Office of Public Health approval, compliance with other applicable licensing requirements, and an on-site licensing survey prior to the relocation of the facility. The relocation of the facility's physical address results in a new anniversary date and the full licensing fee shall be paid. Written notice of intent to relocate must be submitted to the licensing section of the department when plan review request is submitted to the department for approval.

H. Any ICF/DD provider who intends to renovate its facility is required to have plan review approval prior to renovation and an on-site licensing survey after renovation of the facility is complete. Written notice of intent to renovate shall be submitted to the licensing section of the department when plan review request is submitted to the department for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3185 (December 2012).

§8515. Renewal of License

A. License Renewal Application. The ICF/DD provider shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;

2. a copy of the current on-site inspection with approval for occupancy from the Office of the State Fire Marshal;

3. a copy of the current on-site inspection report with approval of occupancy from the Office of Public Health;

4. the non-refundable license renewal fee; and

5. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal.

C. Failure to submit to DHH a completed license renewal application packet prior to the expiration of the current license shall result in the voluntary non-renewal of the ICF/DD license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3186 (December 2012).

§8517. Survey Activities

A. The department may conduct annual licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules, and regulations governing ICF/DD providers and to ensure client health, safety and welfare. These surveys may be conducted on-site or as an administrative review.

B. The department shall conduct complaint surveys. Complaint surveys shall be conducted in accordance with R.S. 40:2009.13 et seq.

C. Surveys shall be unannounced surveys.

D. The department may require an acceptable plan of correction from a provider for any survey where deficiencies have been cited, regardless of whether the department takes other action against the facility for the deficiencies cited in the survey. The acceptable plan of correction shall be approved by DHH.

E. A follow-up survey may be conducted for a survey where deficiencies have been cited to ensure correction of the deficient practices.

F. The department may issue appropriate sanctions for noncompliance, deficiencies, and violations of law, rules and regulations. Sanctions include, but are not limited to:

1. civil monetary penalties;

2. directed plans of correction; and

3. license revocation.

G. DHH surveyors and staff shall be given access to all areas of the facility and all relevant files during any complaint survey. DHH surveyors and staff shall be allowed to interview any provider staff or individual receiving services, as necessary or required to conduct the survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3186 (December 2012).

§8519. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to the ICF/DD shall be posted in a conspicuous place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to the ICF/DD provider shall be available for disclosure to the public 30 calendar days after the provider submits an acceptable plan of correction of the deficiencies or 90 calendar days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Unless otherwise provided in statute or in this licensing Rule, a provider shall have the right to an informal reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the deficient practices, of the violation, or of the non-compliance or deficiency shall not be the basis for the reconsideration.

2. The informal reconsideration of the deficiencies shall be requested in writing within 10 calendar days of receipt of the statement of deficiencies, unless otherwise provided in this Rule.

3. The request for informal reconsideration of the deficiencies shall be made to the department’s Health Standards Section. The request for informal reconsideration shall be considered timely if received by the Health Standards Section within 10 calendar days of the provider's receipt of the statement of deficiencies.

4. If a timely request for an informal reconsideration is received, the department shall schedule and conduct the informal reconsideration.

5. The provider shall be notified in writing of the results of the informal reconsideration.

6. Except as provided for in complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this licensing Rule for license denials, revocations, and non-renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

7. Pursuant to R.S. 40:2009.13, et seq., for complaint surveys in which the licensing agency (Health Standards Section) of the department determines that the complaint involves issues that have resulted in, or are likely to result in, serious harm or death, as defined in the statute, the determination of the informal reconsideration may be appealed administratively to the department's Division of Administrative Law or its successor. The hearing before the Division of Administrative Law or its successor is limited only to whether the investigation or complaint survey was conducted properly or improperly. The Division of Administrative Law or its successor shall not delete or remove deficiencies as a result of such hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3186 (December 2012).

§8521. Denial of License, Revocation of License, or Denial of License Renewal

A. The department may deny an application for a license, may deny a license renewal, or may revoke a license in accordance with the provisions of the Administrative Procedure Act.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the ICF/DD facility is non-compliant with any licensing laws or regulations or with any other required statute, laws, ordinances, Rules or regulations that present a potential threat to the health, safety, or welfare of the individuals receiving services.

2. The department shall deny an initial license for any of the reasons a license may be revoked or non-renewed pursuant to these licensing regulations.

C. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary action on the part of the provider.

2. If an ICF/DD fails to timely renew its license, the provider shall immediately cease and desist providing services, unless the provider has individuals in the ICF/DD facility. In which case, the provider shall comply with the following requirements:

a. shall immediately provide written notice to the department of the number of individuals receiving services in the ICF/DD facility;

b. shall immediately provide written notice to the individual, parent, legal guardian, or legal representative of the following:

i. notice of voluntary non-renewal;

ii. notice of closure; and

iii. plans for orderly transition of the individuals receiving services;

c. shall discharge and transition each individual within 15 calendar days of voluntary non-renewal; and

d. shall notify the department of where records will be stored and the contact person for those records.

3. If an ICF/DD provider fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating or owning an ICF/DD facility for a period of two years.

D. Revocation of License or Denial of License Renewal. An ICF/DD's license may be denied renewal or may be revoked for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the ICF/DD licensing laws, rules and regulations or with other required statutes, laws, ordinances, rules or regulations;

2. failure to comply with the terms and provisions of a settlement agreement or education letter with or from the department, the Attorney General's office, any regulatory agency, or any law enforcement agency;

3. failure to uphold resident rights whereby deficient practices may result in harm or injury or death of an individual receiving services;

4. negligent or harmful failure to protect an individual receiving services from a harmful act of an employee or other individual receiving services including, but not limited to:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. an action posing a threat to an individual's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

d. criminal activity;

5. failure to notify the proper authorities, as required by federal or state law or Rule or regulations, of all suspected cases of:

a. mental or physical abuse, neglect, exploitation, or extortion;

b. an action posing a threat to an individual's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. criminal activity;

6. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, client records, or provider records;

d. matters under investigation by the department or the Office of the Attorney General; or

e. information submitted for reimbursement from any payment source;

7. knowingly making a false statement or providing false, forged, or altered information or documentation to DHH employees or to law enforcement agencies;

8. the use of false, fraudulent or misleading advertising;

9. fraudulent operation of an ICF/DD facility by the owner, administrator, manager, member, officer, or director;

10. an owner, officer, member, manager, administrator, director, or person designated to manage or supervise an individual receiving services has plead guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court. For purposes of this paragraph, conviction of a felony means:

a. any felony relating to the violence, abuse, or negligence of a person;

b. any felony relating to the misappropriation of property belonging to another person;

c. any felony relating to cruelty of the infirmed, exploitation of the infirmed, or sexual battery of the infirmed;

d. any felony relating to a drug offense;

e. any felony relating to crimes of sexual nature;

f. any felony relating to a firearm or deadly weapon;

g. any felony relating to Medicare or Medicaid fraud; or

h. any felony relating to fraud or misappropriation of federal or state funds;

11. failure to comply with all reporting requirements in a timely manner as required by the department;

12. bribery, harassment, intimidation, or solicitation of any client designed to cause that client to use or retain the services of any particular ICF/DD;

13. cessation of business or non-operational status;

14. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview provider staff or individuals;

15. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

16. failure to allow or refusal to allow access to provider, facility or client records by authorized departmental personnel;

17. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment; or

18. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department.

E. In the event an ICF/DD's license is revoked or renewal is denied, (other than for cessation of business or non-operational status) any owner, officer, member, director, manager, or administrator of such ICF/DD facility may be prohibited from opening, managing, directing, operating, or owning another ICF/DD facility for a period of two years from the date of the final disposition of the revocation or denial action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3187 (December 2012).

§8523. Notice and Appeal of License Denial, Revocation or Non-Renewal

A. Notice of a license denial, license revocation, or license non-renewal (i.e. denial of license renewal) shall be given to the provider in writing.

B. The ICF/DD has the right to an informal reconsideration of the license denial, license revocation, or license non-renewal. There is no right to an informal reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The ICF/DD provider shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section. The request for informal reconsideration shall be considered timely if received by DHH Health Standards within 15 days from the provider's receipt of the notice.

2. The request for informal reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an informal reconsideration is received by the Health Standards Section, an informal reconsideration shall be scheduled and the provider will receive written notification of the date of the informal reconsideration.

4. The provider shall have the right to appear in person at the informal reconsideration and may be represented by counsel.

5. Correction of a violation of a deficiency which is the basis for the denial, revocation or non-renewal, shall not be a basis for reconsideration.

6. The informal reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the informal reconsideration.

C. The ICF/DD provider has a right to an administrative appeal of the license denial, license revocation, or license non-renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by a provider.

1. The ICF/DD provider shall request the administrative appeal within 30 calendar days of the receipt of the result of the informal reconsideration. The ICF/DD may forgo its rights to an informal reconsideration, and if so, the ICF/DD shall request the administrative appeal within 30 calendar days of the recipient of the notice of license denial, license revocation, or license non-renewal. The request for administrative appeal shall be in writing and shall be submitted to the department's Division of Administrative Law or its successor.

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the Division of Administrative Law or its successor, the administrative appeal of the license revocation or license non-renewal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision. If the department denied an initial license application, the ICF/DD shall discharge any and all individuals receiving services.

a. Notwithstanding the provisions of Paragraph §8523.C.3 above, if the secretary of the department determines that the violations of the facility pose an imminent or immediate threat to the health, welfare, or safety of a participant or individual receiving services, then the imposition of the license revocation or license non-renewal may be immediate and may be enforced during the pendency of the administrative appeal.

b. If the secretary of the department makes such a determination, the facility shall be notified in writing of such determination.

4. Correction of a violation or a deficiency which is the basis for the denial, revocation, or non-renewal, shall not be a basis for the administrative appeal.

D. If an existing ICF/DD provider has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect in any manner the license revocation.

E. If a timely administrative appeal has been filed by the provider on a license denial, license non-renewal, or license revocation, the department's Division of Administrative Law or its successor shall conduct the hearing within 90 days of docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Division of Administrative Law or its successor upon good cause shown.

1. If the final agency action is to reverse the license denial, the license non-renewal, or the license revocation, the provider's license will be re-instated or granted upon the payment of any licensing or other fees due to the department and the payment of any outstanding sanctions due to the department.

2. If the final agency action is to affirm the license non-renewal or the license revocation, the provider shall discharge any and all individuals receiving services according to the provisions of this Rule. Within 10 days of the final agency decision, the provider must notify the department's licensing section in writing of the secure and confidential location of where client records will be stored.

F. There is no right to an informal reconsideration or an administrative appeal of the issuance of a provisional initial license to a new ICF/DD or the issuance of a provisional license to an existing ICF/DD. A provider who has been issued a provisional license is licensed and operational for the term of the provisional license. The issuance of a provisional license to an existing ICF/DD is not considered to be a denial of license, a denial of license nonrenewal, or a license revocation.

1. If a provisional license is issued, the provider shall submit a plan of correction to DHH for approval, and shall be required to correct all noncompliance or deficiencies prior to the expiration of the provisional license.

2. The department shall conduct a follow-up survey, either on-site or by desk review, of the ICF/DD provider prior to the expiration of the provisional license.

3. If the follow-up survey determines that the ICF/DD provider has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the ICF/DD provider.

4. If the follow-up survey determines that all noncompliance or deficiencies have not been corrected, or if new deficiencies that are a threat to the health, safety, or welfare of individuals receiving services are cited on the follow-up survey, the provisional initial license or provisional license shall expire on the date specified on the provisional license. However, at the sole discretion of the department, the provisional license may be extended for an additional period not to exceed 90 days in order for the ICF/DD facility to correct the non-compliance or deficiencies.

5. The department shall issue written notice to the provider of the results of the follow-up survey.

6. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey shall have the right to an informal reconsideration and the right to an administrative appeal as to the deficiencies cited in the follow-up survey.

a. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis for the informal reconsideration or the administrative appeal.

b. The informal reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

c. The provider shall request the informal reconsideration in writing to the DHH Health Standards Section within five calendar days of receipt of the notice of the results of the follow-up survey from the department. The informal reconsideration request shall be considered timely if received by the Health Standards Section within five days from provider's receipt of the notice.

d. The provider must request an administrative appeal within five calendar days of receipt of the notice of the results of the informal reconsideration. The facility may forgo its right to an informal reconsideration, and if so, the facility shall request an administrative appeal within five calendar days of receipt of the notice of the results of the follow-up survey. The request for an administrative appeal shall be in writing and shall be submitted to the department's Division of Administrative Law or its successor.

e. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this section shall cease providing services and discharge clients unless the Division of Administrative Law or its successor issues a stay of the expiration. The stay may be granted by the Division of Administrative Law or its successor upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing, and only upon a showing that there is no potential harm to the client being served by the provider.

f. If a timely administrative appeal has been filed by a provider with a provisional license that has expired or by an existing provider whose provisional license has expired under the provision of this section, the Division of

Administrative Law or its successor shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Division of Administrative Law or its successor upon good cause shown.

i. If the final agency decision is to remove all deficiencies, the provider's license will be reinstated upon the payment of any licensing or other fees due to the department and the payment of any outstanding sanctions due to the department

ii. If the final agency decision is to uphold the deficiencies and affirm the expiration of the provisional license, the provider shall discharge any and all individuals receiving services. Within 10 days of the final agency decision, the provider must notify the department's licensing section in writing of the secure and confidential location of where client records will be stored.

G. Representation at Hearings. An ICF/DD shall, when allowed by law, have a representative present at all judicial, educational, or administrative hearings which address the status of an individual in the care of the ICF/DD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3188 (December 2012).

§8525. Cessation of Business

A. An ICF/DD that intends to close or cease operations shall comply with the following procedures:

1. shall give 30 days advance written notice to the following:

a. the department; and

b. the parent(s) or legal guardian or legal representative;

2. shall notify the department of where records will be stored and the contact person for those records; and

3. shall provide for an orderly discharge and transition of the individuals in the facility.

B. If an ICF/DD provider fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating or owning an ICF/DD for a period of two years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3190 (December 2012).

Subchapter B. Administration and Organization

§8531. Governing Body

A. An ICF/DD shall have an owner or identifiable governing body with responsibility for, and authority over, the policies and activities of the ICF/DD and ultimate authority for:

1. the overall operation of the facility;

2. the adequacy and quality of care;

3. the financial solvency of the facility and the appropriate use of its funds;

4. the implementation of the standards set forth in these regulations; and

5. the adoption, implementation, and maintenance, in accordance with the requirements of state and federal laws and regulations and these licensing standards, of ICFs/DD and administrative policies governing the operation of the facility.

B. An ICF/DD shall have documents identifying the names and addresses of its owners. When an ICF/DD is owned by any type of corporation, partnership, or association it shall identify the names and address of its members and officers and shall have, where applicable, a charter, partnership agreement, articles of association, by laws, or other organizational documents.

C. An ICF/DD shall have documents identifying all members of the governing body; their addresses; their terms of membership; officers of the governing body, and terms of office of all officers, if applicable.

D. When the governing body of an ICF/DD is composed of more than one person, the governing body shall hold formal meetings at least twice a year.

E. When the governing body is composed of more than one person, an ICF/DD shall have written minutes of all formal meetings of the governing body and by-laws specifying the frequency of meetings and the quorum requirements.

F. Responsibilities of a Governing Body. The governing body of an ICF/DD shall:

1. ensure the ICF/DD's continual compliance and conformity with the ICF/DD's charter, bylaws or other organizational documents;

2. ensure the ICF/DD's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

3. ensure that the ICF/DD is adequately funded and fiscally sound;

4. review and approve the ICF/DD's annual budget;

5. ensure the review and approval of an annual external audit;

6. ensure that the ICF/DD is housed, maintained, staffed, and equipped appropriately considering the nature of the ICF/DD's program;

7. designate a person to act as administrator and delegate sufficient authority to this person to manage the ICF/DD;

8. formulate and annually review, in consultation with the administrator, written policies concerning the ICF/DD's philosophy, goals, current services, personnel practices, and fiscal management;

9. annually evaluate the administrator's performance;

10. have the authority to dismiss the administrator;

11. meet with designated representatives of the department whenever required to do so;

12. inform designated representatives of DHH prior to initiating any substantial changes in the program, services or physical plant of the ICF/DD; and

13. ensure statewide criminal background check on all unlicensed persons.

G. The administrator or a person authorized to act on behalf of the administrator shall be accessible to the ICF/DD staff and designated representatives of DHH at all times.

H. An ICF/DD shall have a written statement describing its philosophy and describing both long-term and short-term goals. An ICF/DD shall have a written program plan describing the services and programs offered by the ICF/DD.

I. Administrative File. An ICF/DD shall have an administrative file including:

1. articles of incorporation or certified copies thereof, if incorporated, bylaws, operating agreements, or partnership documents, if applicable;

2. documents identifying the governing body;

3. a list of members and officers of the governing body and their addresses and terms of membership, if applicable;

4. minutes of formal meetings, if applicable;

5. documentation of the ICF/DD's authority to operate under state law;

6. an organizational chart of the ICF/DD, which clearly delineates the line of authority;

7. all leases, contracts and purchase-of-service agreements to which the ICF/DD is a party;

8. insurance policies;

9. annual budgets and audit reports; and

10. copies of all Incident/Accident Reports.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3190 (December 2012).

§8533. Fund Raising and Publicity

A. An ICF/DD shall have a policy regarding participation of individuals in activities related to fund-raising and publicity.

B. Consent of the individual receiving services and, where appropriate, the legally responsible person shall be obtained prior to participation in such activities.

C. An ICF/DD shall have written policies and procedures regarding the photographing and audio or audio-visual recordings of individuals.

D. The written consent of the individual receiving services and, where appropriate, the legally responsible person shall be obtained before the individual is photographed or recorded for research or program publicity purposes. Such consent cannot be made a condition for admission into, remaining in, or participating fully in the activities of the facility. Consent agreements must clearly notify the individual receiving services of his/her rights under this regulation, must specify precisely what use is to be made of the photography or recordings, and are valid for a maximum of one year from the date of execution. Individuals are free to revoke such agreements at any time, either orally or in writing.

E. All photographs and recordings shall be used in a manner which respects the dignity and confidentiality of the individual receiving services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3191 (December 2012).

§8535. Research

A. An ICF/DD shall have written policies regarding the participation of individuals in research projects. These policies shall conform to the National Institute of Mental Health Standards on protection of human subjects.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3191 (December 2012).

Subchapter C. Admission, Transfer, and Discharge Criteria

§8541. Admissions

A. Each ICF/DD shall have written policies and procedures governing the admission, transfer, and discharge of individuals receiving services.

B. Intake and Admissions Policy

1. An ICF/DD shall have a written description of admission policies and criteria. A copy of the admission

policies and criteria shall be provided to the department and shall be available to the legally responsible person for any individual referred for placement. The admission policies and criteria shall include, but is not limited to, the following information:

a. policies and procedures related to intake. Intake policies shall include, at least, due process procedures for admission of minors, and determination before admission of appropriate legal status according to appropriate state laws;

b. the age and sex of individuals receiving services in care;

c. the needs, problems, situations, or patterns best addressed by the ICF/DD's program;

d. any other criterion for admission;

e. criteria for discharge;

f. any placement requirements on the individual, the legally responsible person, the department, or other involved agencies; and

g. procedures for ensuring that placement within the program is the least restrictive alternative appropriate to meet the individual's needs.

2. The ICF/DD shall, when applicable, have policies and procedures governing self-admission. Such policies and procedures shall include procedures for notification, as appropriate, of the legally responsible person.

3. An ICF/DD shall not refuse admission to any individual receiving services on the grounds of race, ethnic origin, or disability.

4. An ICF/DD shall not admit more individuals receiving services into care than the number specified on the ICF/DD's license.

5. An ICF/DD shall not accept any individual receiving services for placement whose needs cannot be adequately met by the ICF/DD's program.

6. An ICF/DD shall assess an individual to determine if they are able to meet the needs of that individual. If the ICF/DD is unable to admit the individual based on that assessment the ICF/DD shall provide a written statement to the designated representative of DHH detailing why they are were unable to meet the needs of that individuals.

7. An ICF/DD shall ensure that the individual receiving services where appropriate, the legally responsible person, and others, as appropriate, are provided reasonable opportunity to participate in the admission process and decisions. Proper consents shall be obtained before admission. Where such involvement of the legally responsible person is not possible, or not desirable, the reasons for their exclusion shall be recorded in the admission study.

C. Intake Evaluation

1. The ICF/DD shall accept an individual into care only when a current comprehensive intake evaluation has been completed, including social, health and family history; and medical, social, psychological and as appropriate, developmental or vocational or educational assessment. This evaluation shall contain evidence that a determination has been made that the individual cannot be maintained in a less restrictive environment within the community.

2. In emergency situations necessitating immediate placement into care, the ICF/DD shall gather as much information as possible about the individual to be admitted and the circumstances requiring placement, formalize this in an "emergency admission note" within two days of admission and then proceed with an intake evaluation as quickly as possible. The intake evaluation shall be completed within 30 days of admission.

D. Clarification of Expectations to Individuals. The ICF/DD shall, consistent with the individual's maturity and ability to understand, make clear its expectations and requirements for behavior and provide the individual referred for placement with an explanation of the ICF/DD's criteria for successful participation in and completion of the program.

E. Placement Agreement

1. The ICF/DD shall ensure that a written placement agreement is completed. A copy of the placement agreement signed by all parties involved in its formulation shall be kept in the individual's record and a copy shall be available to DHH, the individual and, where appropriate, the legally responsible person.

2. An ICF/DD shall not admit any individual into care whose presence will be seriously damaging to the ongoing functioning of the ICF/DD or to individuals already in care.

3. The placement agreement shall be developed with the involvement of the individual, where appropriate, the legally responsible person and DHH. Where the involvement of any of these parties is not feasible or desirable, the reasons for the exclusion shall be recorded. The placement agreement shall include, by reference or attachment, at least the following:

a. discussion of the individual's and the family's expectations regarding:

i. family contact and involvement;

ii. the nature and goals of care, including any specialized services to be provided;

iii. the religious orientation and practices of the individual; and

iv. the anticipated discharge date and aftercare plans;

b. a delineation of the respective roles and responsibilities of all agencies and persons involved with the individual and his/her family;

c. authorization to care for the individual;

d. authorization to obtain medical care for the individual;

e. arrangements regarding visits, vacation, mail, gifts, and telephone calls;

f. arrangements as to the nature and frequency of reports to, and meetings involving, the legally responsible person and referring agency; and

g. provision for notification of the legally responsible person in the event of unauthorized absence, illness, accident or any other significant event regarding the individual.

4. The ICF/DD shall ensure that each individual, upon placement, is checked for illness, fever, rashes, bruises, and injury. The individual shall be asked if he/she has any physical complaints. The results of this procedure shall be documented and kept in the individual's record.

5. The ICF/DD shall assign a staff member to orient the individual, and where available, the family to life at the ICF/DD.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3191 (December 2012).

§8543. Voluntary and Involuntary Transfers and Discharges

A. There are two types of transfers or discharges from an ICF/DD facility:

1. planned or voluntary discharge; or

2. involuntary transfer or discharge.

B. A planned or voluntary transfer or discharge occurs in the following situations:

1. a planned downsizing of a state facility; or

2. a planned transfer or discharge due to client or authorized representative request.

C. The client and/or legal representative(s) must give their written consent to all non-emergency situations, however, written consent by the client and/or legal representative(s) is not required for those situations involving a planned downsizing of a state facility. Notification shall be made to the parents or legal representative(s) as soon as possible, if applicable.

D. Prior to a planned discharge of an individual, the ICF/DD's staff shall formulate an aftercare plan specifying the supports and resources to be provided to the individual. Aftercare plans shall be kept in the individual's record.

E. Prior to discharge, the ICF/DD's staff shall ensure that the individual is aware of and understands his/her aftercare plan and the department's representative shall be notified of the plans.

F. If the client is being discharged to another ICF/DD or provider, representatives from the staff of both the sending and receiving facilities or providers shall confer as often as necessary to share appropriate information regarding all aspects of the client's care and habilitation training. The transferring ICF/DD is responsible for developing a final summary of the client's developmental, behavioral, social, health and nutritional status, and with the consent of the client and/or legal representative, providing a copy to authorized persons and agencies. A copy of the summary shall be included in the client's record and must accompany the client upon discharge to another ICF/DD or provider. This summary shall include:

1. the name and home address of the individual and, where appropriate, the legally responsible person;

2. the name, address, telephone number of the ICF/DD;

3. a summary of services provided during care;

4. a summary of growth and accomplishments during care;

5. the assessed needs which remain to be met and alternate service possibilities which might meet those needs; and

6. a statement of an aftercare plan and identification of who is responsible for follow-up services and aftercare.

G. The ICF/DD shall have a written policy concerning unplanned, involuntary discharge. The policy shall ensure that emergency discharges initiated by the ICF/DD take place only when the health and safety of an individual or other individuals might be endangered by the individual's further placement at the agency.

H. The ICF/DD shall give immediate notice of the client's discharge. The resident and his/her responsible party and/or legal representative or interested family member if known and available, have the right to be notified in writing in a language and manner they understand of the transfer and discharge. The notice must be given no less than thirty days in advance of the proposed action, except that the notice may be given as soon as is practicable prior to the action in the case of an emergency. A copy of the notice must be placed in the client's clinical record and a copy transmitted to:

1. the client;

2. a family member of the client, if known;

3. the client's legal representative and legal guardian, if known;

4. the Community Living Ombudsman Program;

5. DHH, Health Standards Section;

6. the regional office of the Office for Citizens with Developmental Disabilities (OCDD) for assistance with the placement decision;

7. the client's physician; and

8. appropriate educational authorities.

I. The resident, or his legal representative or interested family member, if known and available, has the right to appeal any transfer or discharge to the Department of Health

and Hospitals, which shall provide a fair hearing in all such appeals.

J. The facility must ensure that the transfer or discharge is effectuated in a safe and orderly manner. The resident and his legal representative or interested family member, if known and available, shall be consulted in choosing another facility if facility placement is required.

K. When arranging for placement following an emergency discharge, an ICF/DD shall consult with the receiving ICF/DD and the regional office of OCDD, to ensure that the individual is placed in a program that reasonably meets the individual's needs. The ICF/DD shall have a written report detailing the circumstances leading to each unplanned discharge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3192 (December 2012).

Subchapter D. Service Delivery

§8547. General Provisions

Reserved.

§8549. Individual Service Plan

A. Qualified Mental Retardation Professional (QMRP). An ICF/DD shall ensure that the QMRP, who is an appropriately qualified professional, is assigned to each individual and given responsibility for and authority over:

1. supervision of the implementation of the individual's service plan;

2. integration of the various aspects of the individual's program;

3. recording of the individual's progress as measured by objective indicators;

4. reviewing the individual's service plan, on a quarterly basis;

5. ensuring the timely release, whenever appropriate, of the individual to a less restrictive setting;

6. monitoring any extraordinary restriction of the individual's freedom including use of any form of restraint, any special restriction on an individual's communication with others and any potentially harmful treatment or behavior management techniques applied to the individual; and

7. ensuring the coordination of all care and services.

B. The Service Plan

1. An ICF/DD shall, within 30 days of admitting an individual, ensure that a comprehensive written psychological, social, and as appropriate, educational assessment of the individual has been completed and, based on this assessment, shall develop a comprehensive, time-limited, goal-oriented individual service plan addressing the needs identified by the assessment.

2. The assessment shall identify the individual's strengths and needs, establish priorities to assist in the development of an appropriate plan and conclude with recommendations concerning approaches and techniques to be used.

3. All methods used in assessing an individual shall be appropriate considering the individual's age, cultural background and dominant language or mode of communication.

4. Individual service plans shall be developed by an interdisciplinary team including the QMRP, representatives of the direct service staff working with the individual on a daily basis and other professionals, as indicated.

5. The ICF/DD shall document that, where applicable, the designated representative of DHH and, where appropriate, the legally responsible person have been invited to participate in the planning process and when they do not participate, shall document the reasons, if known, for non-participation.

6. Unless it is clearly not feasible to do so, an ICF/DD shall ensure that the service plan and any subsequent revisions are explained to the individual and, where appropriate, the legally responsible person, in a language or method understandable to the individual.

7. An ICF/DD shall ensure that the service plan for each individual includes the following components:

a. the findings of the assessment;

b. a statement of goals to be achieved or worked towards for the individual and his/her family;

c. a plan for fostering positive family relationships for the individual, when appropriate;

d. specifications for the daily activities, including training, education and recreation, to be pursued by the program staff and the individual in order to attempt achieve the stated goals;

e. specification of any specialized services that will be provided directly or arranged for, and measures for ensuring their proper integration with the individual's ongoing program activities;

f. specification of time-limited targets in relation to overall goals and specific objectives;

g. methods for evaluating the individual's progress;

h. goals and preliminary plans for discharge and aftercare;

i. identification of all persons responsible for implementing or coordinating implementation of the plan; and

j. the completed service plan shall be signed by all team participants.

8. An ICF/DD shall review each service plan at least annually and evaluate the degree to which the goals have been achieved.

9. An ICF/DD shall continuously monitor the individual's service plan and provide revisions as necessary.

10. The ICF/DD shall prepare quarterly status reports on the progress of the individual relative to the goals and objectives of the service plan. These reports shall be prepared by designated staff and reviewed and approved by the QMRP.

11. An ICF/DD shall ensure that all persons working directly with the individual are appropriately informed of the service plan.

C. Education

1. An ICF/DD shall ensure that each individual has access to appropriate educational services consistent with the individual's abilities and needs, taking into account his/her age and level of functioning.

2. All individuals of school age must either be enrolled in a school system or a program approved by the Department of Education.

D. Reports. When the individual is a minor, the administrator of a ICF/DD or his/her designee shall report in writing to the legally responsible person of the individual at least annually, or as otherwise required by law, with regard to the individual's progress with reference to the goals and objectives in the service plan. This report shall include a description of the individual's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3193 (December 2012).

§8551. Food Services

A. An ICF/DD shall ensure that an individual is, on a daily basis, provided with food of such quality and in such quantity as to meet the recommended daily dietary allowances adjusted for age, gender and activity of the Food Nutrition Board of the National Research Council. The ICF/DD shall have an organized system of food service supervised by a qualified dietitian or an appropriately qualified person. This dietitian or person shall be responsible for:

1. menu planning;

2. initiating food orders or requisitions;

3. establishing specifications for food purchases and insuring that such specifications are met;

4. storing and handling of food;

5. food preparation;

6. food serving;

7. maintaining sanitary standards in compliance with state and local regulations; and

8. orientation, training, and supervision of food service personnel.

B. A person designated by the administrator shall be responsible for the total food service of the ICF/DD. If this person is not a professionally qualified dietitian, regularly scheduled consultation with a professionally qualified dietitian shall be obtained.

C. The person responsible for food service shall: maintain a current list of individuals with special nutritional needs, have an effective method of recording and transmitting diet orders and changes, record in the individuals' medical records information relating to special nutritional needs, provide nutrition counseling to staff and individuals and manage and coordinate the resources of the dietary services to achieve effective, efficient and sanitary production. This person shall also ensure that any modified diet for an individual shall be:

1. prescribed by the individual's physician and service plan with a record of the prescription kept on file;

2. planned, prepared, and served by persons who have received adequate training; and

3. periodically reviewed and adjusted as needed.

D. An ICF/DD shall ensure that an individual is provided at least three meals or their equivalent daily at regular times with not more than 14 hours between the evening meal and breakfast of the following day. Meal times shall be comparable to those in a normal home. Meals shall be served to individuals in appropriate quantity, at appropriate temperatures, in a form consistent with the development level of the individual and with appropriate utensils.

E. The ICF/DD shall ensure that the food provided to an individual in care by the ICF/DD is in accord with his/her religious beliefs.

F. An ICF/DD shall develop written menus at least one week in advance.

G. Written menus and records of foods purchased shall be maintained on file for 30 days. Menus shall provide for a sufficient variety of foods and shall vary from week to week.

H. No individual shall be denied a meal for any reason except according to a doctor's order.

I. No individual shall be forced-fed or otherwise coerced to eat against his/her will except by order of a doctor.

J. When meals are provided to staff, an ICF/DD shall ensure that staff members eat substantially the same food served to individuals in care, unless age differences or special dietary requirements dictate differences in diet.

K. An ICF/DD shall ensure that all individuals, including the mobile non-ambulatory, eat or are fed in dining rooms, except where contraindicated for health reasons or by the individual's service plan.

L. Table service shall be provided for all individuals who can and will eat at a table, including individuals in wheelchairs.

M. Dining areas in a facility shall be equipped with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each individual.

N. Dining rooms in a facility shall be adequately supervised and staffed for the direction of self-help dining procedures and to assure that each individual receives an adequate amount of food.

O. Individuals shall be provided with systematic training to develop appropriate eating skills, utilizing adaptive equipment where it serves the development process.

P. Direct-care staff shall be trained in and shall utilize proper feeding techniques.

Q. Individuals shall eat in an upright position unless medically contraindicated.

R. Individuals shall eat in a manner consistent with their developmental needs.

S. An ICF/DD shall purchase and provide to individuals only food and drink of safe quality and the storage, preparation and serving techniques shall ensure that nutrients are retained and spoilage is prevented.

T. Dry or staple food items shall be stored at least twelve inches above the floor, in a ventilated space not subject to sewage or waste water backflow or contamination by condensation, leakage, rodents or vermin.

U. An ICF/DD shall ensure that perishable foods are stored at the proper temperatures to conserve nutritive values.

V. An ICF/DD shall ensure that food served to an individual and not consumed is discarded.

W. An ICF/DD shall show evidence of effective procedures for cleaning all equipment and work areas.

X. Hand washing facilities, including hot and cold water, soap, and paper towels, shall be provided in the food service work areas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3194 (December 2012).

§8553. Health Care Services

A. General Provisions

1. An ICF/DD shall ensure the availability of a comprehensive program of preventive, routine and emergency medical and dental care, as appropriate, for all individuals. The ICF/DD shall have a written plan for providing such care. This plan shall include:

a. ongoing appraisal of the general health of each individual;

b. provisions of health education, as appropriate;

c. establishment of an ongoing immunization program;

d. approaches that ensure that any medical treatment administered will be explained to the individual in language suitable to his/her age and understanding;

e. an ongoing relationship with a licensed physician and dentist to advise the ICF/DD concerning medical and dental care;

f. availability of a physician on a 24-hour a day, seven days a week basis; and

g. the ICF/DD shall show evidence of access to the resources outlined in this plan.

2. An ICF/DD shall have access to psychiatric and psychological resources, on both an emergency and ongoing basis, as appropriate to meet the needs of individuals.

B. Physician Services. An ICF/DD shall arrange a general medical examination by a physician for each individual within a week of admission unless the individual has received such an examination within 30 days before admission and the results of this examination are available to the ICF/DD.

1. This examination shall include:

a. an examination of the individual for physical injury and disease;

b. vision and hearing screening;

c. a current assessment of the individual's general health; and

d. whenever indicated, the individual shall be referred to an appropriate medical specialist for either further assessment or treatment.

2. The ICF/DD shall arrange an annual physical examination of all individuals.

3. Physicians shall participate, when appropriate, in the continuous interdisciplinary evaluation of an individual for the purposes of initiation, monitoring, and follow-up of service plans; and

4. An ICF/DD must ensure that an individual receives timely, competent medical care, in keeping with community standards of medical practice when he/she is ill.

C. Immunizations

1. Individuals receiving services shall have proper immunizations and infection control.

2. The ICF/DD shall ensure:

a. that the individual has received all immunizations and booster shots which are required by the Department of Health and Hospitals within 30 days of his/her admission; and

b. reporting of communicable diseases and infections in accordance with law.

D. Medications

1. An ICF/DD shall ensure that no medication is given to any individual except in accordance with the written order of a physician.

a. There shall be no standing orders for prescription medications.

b. The prescribing physician must be immediately informed of any side-effects observed by staff or any medication errors.

2. An ICF/DD using psychotropic medications on a regular basis shall have a written description of the use of psychotropic medications at the facility including:

a. a description of procedures to ensure that medications are used for therapeutic purposes and in accordance with accepted clinical practice;

b. a description of procedures to ensure that medications are used only when there are demonstrable benefits to the individual unobtainable through less restrictive measures;

c. a description of procedures to ensure continual review of medication and discontinuation of medication when there are no demonstrable benefits to the individual; and

d. a description of an ongoing program to counsel individual's and, where appropriate, their families on the potential benefits and negative side-effects of medication and to involve individuals and, where appropriate, their families in decisions concerning medication.

3. An ICF/DD shall ensure that medications are either self-administered or administered by qualified persons according to state law.

4. A medication shall not be administered to any individual for whom the medication has not been ordered.

5. An ICF/DD shall ensure that medication is used for therapeutic and medical purposes only and are not administered in excessive dosages.

6. Medication shall not be used as a disciplinary measure, a convenience for staff or as a substitute for adequate, appropriate programming.

E. Nursing Services

1. An ICF/DD shall ensure that individuals are provided with nursing services, in accordance with their needs.

2. Nursing services to individuals shall include, as appropriate, registered nurse participation in:

a. the pre-admission study;

b. the service plan and any reviews and revisions of the service plan;

c. the development of aftercare plans;

d. the referral of individuals to appropriate community resources;

e. training in habits in personal hygiene, family life, and sex education (including family planning and venereal disease counseling);

f. control of communicable diseases and infections through identification and assessment, reporting to medical authorities and implementation of appropriate protective and preventive measures; and

g. modification of the nursing part of the service plan, in terms of the individual's daily needs, at least annually for adults and more frequently for children, in accordance with developmental changes.

3. A registered nurse shall participate, as appropriate, in the planning and implementation of training of direct service personnel including training in:

a. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

b. basic skills required to meet the health needs and problems of the individual; and

c. first aid in the event of accident or illness.

4. An ICF/DD shall have available sufficient, appropriately licensed and qualified nursing staff, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. The ICF/DD shall verify that all nursing staff has a current Louisiana license upon hire and at least annually.

5. Nursing service personnel at all levels of experience and competence shall be assigned responsibilities in accordance with their qualifications, delegated authority commensurate with their responsibility and provided appropriate professional nursing supervision.

F. Pharmacy Services

1. An ICF/DD shall ensure that pharmacy services are provided under the direction of a qualified licensed pharmacist.

2. There shall be a formal arrangement for qualified pharmacy services, including provisions for emergency service.

3. The pharmacist shall:

a. receive the original, or a direct copy of the physician's drug treatment order;

b. maintain for each individual an individual record of all medications (prescription and nonprescription) dispensed, including quantities and frequency of refills);

c. participate, as appropriate, in the continuing interdisciplinary evaluation of individuals for the purposes of initiation, monitoring, and follow-up of service plans; and

d. establish quality specifications for drug purchases and ensure that they are met.

4. Qualified pharmacy or medical personnel shall:

a. quarterly review the record of each individual on medication for potential adverse reactions, allergies, interactions, contraindications, rationality and laboratory test modifications; and

b. advise the physician of any recommended changes, stating the reasons for such changes and providing an alternate drug regimen.

5. Poisons, drugs used externally and drugs taken internally shall be stored on separate shelves or in separate cabinets at all locations.

6. Medications that are stored in a refrigerator containing things other than drugs shall be kept in a separate compartment with proper security.

7. If there is a drug storeroom, there shall be an inventory of all drugs kept in such storeroom.

8. Discontinued and outdated drugs, and containers with worn, illegible, or missing labels, shall be removed and returned to the pharmacist for proper disposition.

9. There shall be an effective drug recall procedure that can be readily implemented.

10. There shall be a procedure for reporting adverse drugs to the Federal Food and Drug Administration.

11. An ICF/DD shall have written policies and procedures that govern the safe administration and handling of all drugs developed by the responsible pharmacist, physician, nurse and other professional staff, as appropriate to the ICF/DD.

12. An ICF/DD shall have a written policy governing the self-administration of both prescription and nonprescription drugs.

13. The compounding, packaging, labeling and dispensing of drugs, including samples and investigational drugs, shall be done by the pharmacist or under his supervision, with proper controls and records.

14. Each drug shall be identified up to the point of administration.

15. Whenever possible, drugs that require dosage measurement shall be dispensed by the pharmacist in a form ready to administer to the individual.

16. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

17. All drugs shall be kept under lock and key except when authorized personnel are in attendance.

18. The security requirements for drugs of Federal and State laws shall be satisfied in storerooms, pharmacies, and living units.

G. Dental Services

1. An ICF/DD shall have an organized system for providing comprehensive diagnostic dental services for all individuals which include a complete extra and intra-oral examination, utilizing all diagnostic aids necessary to properly evaluate the individual's oral condition, within a period of 90 days following admission unless such an examination shall be in the individual's case record.

2. An ICF/DD shall have access to comprehensive dental treatment services for all individuals which include:

a. provision for dental treatment;

b. provision for emergency treatment on a 24-hour, seven-days-a-week basis by a qualified dentist; and

c. a recall system that will assure that each individual is re-examined at specified intervals in accordance with his/her needs, but at least annually.

3. An ICF/DD shall have a dental hygiene program that includes imparting information regarding nutrition and diet control measures to individuals and staff, instruction of individuals and staff in living units in proper oral hygiene methods and instructions of family in the maintenance of proper oral hygiene, where appropriate.

4. Dental progress reports shall be entered in the individual's case record.

5. A copy of the permanent dental record shall be provided to an ICF/DD to which an individual is transferred.

6. There shall be available sufficient, appropriately qualified dental personnel and necessary supporting staff to carry out the dental services programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3195 (December 2012).

§8555. Professional and Specialized Programs and Services

A. General

1. An ICF/DD shall have access to the following services in accordance with the needs of individuals:

a. physical and/or occupational therapy;

b. speech pathology and audiology;

c. psychological services;

d. social work services; and

e. training and habilitation services.

2 An ICF/DD shall ensure the following with regard to professional and special services:

a. provide services directly through personal contact with the individual;

b. provide services indirectly through contact with staff members and others working with the individual;

c. develop and record appropriate plans, goals and objectives for the individual and, as appropriate, the individual's family;

d. record all significant contacts with the individual;

e. periodically provide written summaries of the individual's response to the service, the individual's current status relative to the service and the individual's progress to be maintained in the individual's case record;

f. participate, as appropriate, in the development, implementation and review of service plans and aftercare plans and in the interdisciplinary team responsible for developing such plans; and

g. provide services appropriately integrated into the overall program.

3. An ICF/DD shall ensure that any professional or special service provided by the ICF/DD has:

a. adequately qualified and, where appropriate, appropriately licensed or certified staff according to state or federal law;

b. adequate space and facilities;

c. appropriate equipment;

d. adequate supplies; and

e. appropriate resources.

4. An ICF/DD shall ensure that any professional or special service provided by a person or agency outside the ICF/DD meets all relevant requirements contained herein.

B. Physical Therapy and Occupational Therapy

1. Physical therapy and occupational therapy staff shall provide treatment training programs that are designed to:

a. preserve and improve abilities for independent functioning, such as range of motion, strength, tolerance, coordination and activities of daily living;

b. prevent, insofar as possible, irreducible or progressive disabilities, through means such as the use of orthopedic and prosthetic appliances, assistance and adaptive devices, positioning, behavior adaptations and sensory stimulation.

2. The therapist shall function closely with the individual's primary physician and with other medical specialists.

3. Physical and occupational therapy personnel shall be:

a. assigned responsibilities in accordance with their qualifications;

b. delegated authority commensurate with their responsibilities; and

c. provided appropriate professional direction and consultation.

C. Speech Pathology and Audiology

1. Speech pathology and audiology services available to the ICF/DD shall include:

a. screening and evaluation of individuals with respect to speech and hearing functions;

b. comprehensive audiological assessment of individuals as indicated by screening results, to include tests of pure tone air and bone conduction, speech audiometry and other procedures, as necessary, and to include assessment of the use of visual cues;

c. assessment of the use of amplification;

d. provision for procurement, maintenance and replacement of hearing aids, as specified by a qualified audiologist;

e. comprehensive speech and language evaluation of residents, as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;

f. treatment services, interpreted as an extension of the evaluation process, that include:

i. direct counseling with individuals, consultation with appropriate staff for speech improvement and speech education activities;

ii. collaboration with appropriate staff to develop specialized programs for developing the communication skills of individuals in comprehension; and

iii. expression and participation in in-service training programs for direct care and other staff.

2. Adequate, direct and continuing supervision shall be provided to personnel, volunteers or supportive personnel utilized in providing speech pathology and audiology services.

D. Psychological Services

1. An ICF/DD shall provide psychological services, as appropriate, to the needs of the individual, including strategies to maximize each individual's development of:

a. perceptual skills;

b. sensorimotor skills;

c. self-help skills;

d. communication skills;

e. social skills;

f. self direction;

g. emotional stability;

h. effective use of time (including leisure time); and

i. cognitive skills.

2. There shall be available sufficient, appropriately qualified psychological services staff, and necessary supporting personnel, to carry out the following functions:

a. psychological services to individuals, including evaluation, consultation, therapy, and program development; administration and supervision of psychological services; and

b. participation in direct service staff training.

3. Psychologists providing services to the ICF/DD shall have at least a master's degree from an accredited program and appropriate experience or training.

E. Social Work Services

1. Social services as part of an interdisciplinary spectrum of services shall be provided to an individual through the use of social work methods directed toward:

a. maximizing the social functioning of each individual;

b. enhancing the coping capacity of his family; and

c. asserting and safeguarding the human and civil rights of individuals and their families and fostering the human dignity and personal worth of each individual.

2. During the evaluation process, which may or may not lead to admission, social workers shall help the individual and family to consider alternative services and make a responsible choice as to whether and when placement is needed.

3. During the individual's admission to and residence in the ICF/DD or while the individual is receiving services from the ICF/DD, social workers shall, as appropriate, be the liaison between the individual, the ICF/DD, the family, and the community in order to:

a. assist staff in understanding the needs of the individual and his/her family in relation to each other;

b. assist staff in understanding social factors in the individual's day-to-day behavior, including staff-individual relationships;

c. assist staff in preparing the individual for changes in his/her living situation;

d. help the family to develop constructive and personally meaningful ways to support the individual's experience in the ICF/DD through counseling concerned with problems associated with changes in family structure and functioning, and referral to specific services, as appropriate; and

e. help the family to participate in planning for the individual's return to home or other community placement.

4. After the individual leaves the ICF/DD, the ICF/DD's social workers shall provide systematic follow-up to assure referral to appropriate community ICF/DDs.

F. Training and Habilitation Services

1. Training and habilitation services, defined as the facilitation of or preventing the regression of the intellectual, sensorimotor and affective development of the individual, shall be available to all individuals, regardless of chronological age, degree of retardation, or accompanying disabilities or handicaps.

2. Individual evaluations relative to training and habilitation shall:

a. be based upon the use of empirically reliable and valid instruments, whenever such tools are available;

b. provide the basis for prescribing an appropriate program of training experiences for the individual; and

c. identify priority areas to be addressed.

3. There shall be written training and habilitation objectives for each individual that are:

a. based upon complete and relevant diagnostic and prognostic data; and

b. stated in specific behavioral terms that permit the progress of the individual to be assessed.

4. There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every individual.

5. There shall be a functional training and habilitation record for each individual maintained by, and available to, the training and habilitation staff.

6. Appropriate training and habilitation programs shall be provided to individuals with hearing, vision, perceptual or motor impairments, in cooperation with appropriate staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3197 (December 2012).

§8557. Transportation

A. The ICF/DD shall ensure that each individual is provided with the transportation necessary for implementing the individual's service plan.

B. The ICF/DD shall have means of transporting individuals in cases of emergency.

C. The provider shall have documentation of liability insurance coverage for all owned and non-owned vehicles used to transport individuals. Employee’s personal liability insurance shall not be substituted for required coverage.

D. Any vehicle used in transporting individuals in care of the ICF/DD, whether such vehicle is operated by a staff member or any other person acting on behalf of the ICF/DD, shall be properly licensed and inspected in accordance with State law. All vehicles used for the transportation of clients shall be maintained in a safe condition, be operated at a temperature that does not compromise the health, safety, or needs of the individuals, and be operated with all applicable motor vehicle laws.

E. Any staff member of the ICF/DD or other person acting on behalf of the ICF/DD operating a vehicle for the purpose of transporting individuals shall be properly licensed to operate that class of vehicle, according to state law.

F. The ICF/DD shall not allow the number of persons in any vehicle used to transport individuals to exceed the number of available seats with seatbelts in the vehicle.

G. Identification of vehicles used to transport individuals in care of an ICF/DD shall not be of such nature to embarrass or in any way produce notoriety for individuals.

H. The ICF/DD shall ascertain the nature of any need or problem of an individual which might cause difficulties during transportation, such as seizures, a tendency towards motion sickness or a disability. The ICF/DD shall communicate such information to staff transporting clients; any such needs shall be addressed by the provider.

I. The following additional arrangements are required for an ICF/DD serving individuals who use wheelchairs.

1. A ramp device to permit entry and exit of an individual from the vehicle shall be provided for all vehicles normally used to transport persons with disabilities. A mechanical lift may be utilized, provided that a ramp is also available in case of emergency, unless the mechanical lift has a manual override.

2. Wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners.

3. The arrangement of the wheelchairs shall not impede access to the exit door of the vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3199 (December 2012).

Subchapter E. Client Protections

§8565. Client Rights

A. Civil Rights

1. An ICF/DD shall have written policy on individual civil rights and shall post and distribute a copy of those. This policy shall give assurances that:

a. an individual's civil rights are not abridged or abrogated solely as a result of placement in the ICF/DD's program;

b. an individual's civil rights are protected through accessibility of legal counsel; and

c. an individual is not denied admission, segregated into programs or otherwise subjected to discrimination on the basis of race, religion, ethnic background or disability.

2. An ICF/DD accepting any individual who resides in another state shall comply with the terms Compact on Juveniles, the Interstate Compact on the Placement of Children, and the Interstate Compact on Mental Health.

B. Basic Rights

1. All agencies must conform to applicable state laws and DHH policies and procedures relative to consumer rights, including but not limited to, those concerning confidentiality of client information and grievance procedures and client's right to appeal departmental decisions on service eligibility, planning, and delivery.

2. All agencies must conform to applicable state laws and DHH policies and procedures regarding consumer health and safety including but not limited to those concerning transporting individuals and abuse/neglect reporting.

3. There must be written policies and procedures that protect the client's welfare including the means by which the protections will be implemented and enforced.

4. The client, client's family or legal guardian, where appropriate, must be informed of their rights both verbally and in writing in language the consumer is able to understand.

5. The written policies and procedures, at a minimum, must address the following protections and rights:

a. to human dignity;

b. to acceptance of chosen life style;

c. to impartial access to treatment regardless of race, religion, sex, ethnicity, age or disability;

d. cultural access is evidenced through provision of:

i. interpretive services;

ii. translated material;

iii. use of native language and staff when possible; and

iv. staff trained in cultural awareness;

e. access to persons with special needs is evidenced through sign language interpretation and mechanical aids and devices that assist those persons in achieving maximum benefit from services;

f. to privacy;

g. to confidentiality and access to consumer records including:

i. requirement for the consumer's written, informal consent for release of information;

ii. emergency unauthorized release;

iii. internal access to consumer records;

iv. external access to consumer records; and

v. conditions for consumer access to his/her records;

h. to a complete explanation of the nature of services and procedures to be received including risks, benefits and available alternative services;

i. to participate, actively, in services including assessment/reassessment, service plan development, and transition/closure;

j. to refuse specific services or participate in any activity that is against their will and for which they have not given consent;

k. to complaint/grievance procedures;

l. to be informed of the financial aspect of services;

m. to be informed of the need for parental or guardian consent for treatment of services, if appropriate;

n. to manage, personally, financial affairs unless legally determined otherwise;

o. to give informed written consent prior to being involved in research projects;

p. to refuse to participate in any research project without compromising access to services;

q. to protection from harm including any form of abuse, neglect, or mistreatment;

r. to receive services in a safe and humane environment;

s. to receive the least intrusive services appropriate and available;

t. to contact any advocacy resources as needed, especially during grievance procedures; and

u. to be informed of the right to freely choose ICF/DDs from those available.

6. An ICF/DD must ensure that individuals are provided all rights available to them be they interdicted or not.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3199 (December 2012).

§8567. Grievances

A. An ICF/DD shall have a written grievance procedure for individuals designed to allow individuals to make complaints without fear of retaliation.

B. The ICF/DD shall make every effort to ensure that all individuals and their legally responsible person are aware of and understand the grievance procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3200 (December 2012).

§8569. Behavior Management

A. Description of Methods Used

1. The ICF/DD shall have a written description of the methods of behavior management to be used on a facility-wide level. This description shall include:

a. definitions of appropriate and inappropriate behaviors of individuals; and

b. acceptable staff responses to inappropriate behaviors.

2. The description shall be provided to all the ICF/DD's staff.

3. An ICF/DD shall have a clearly written list of rules and regulations governing conduct for individuals in care of the ICF/DD. These rules and regulations shall be made available to each staff member, each individual and, where appropriate, the legally responsible person.

B. Any behavior management plan that limits the rights of the individual shall be approved by the Human Rights Committee and consented to by the client or his/her representative or guardian.

C. Prohibition on Potentially Harmful Responses. An ICF/DD shall prohibit the following responses to individuals by staff members:

1. any type of physical hitting or other painful physical contact except as required for medical, dental or first aid procedures necessary to preserve the individual's life or health;

2. requiring an individual to take an extremely uncomfortable position;

3. verbal abuse, ridicule or humiliation;

4. withholding of a meal, except under a physician's order;

5. denial of sufficient sleep, except under a physician's order;

6. requiring the individual to remain silent for a long period of time;

7. denial of shelter, warmth, clothing or bedding;

8. assignment of harsh physical work;

9. physical exercise or repeated physical motions;

10. denial of usual services; and

11. denial of visiting or communication with family.

D. Time-Out Procedures

1. An ICF/DD with eight beds or less shall not use time out procedures.

2. An ICF/DD using time-out procedures involving seclusion of individuals in an unlocked room for brief periods shall have a written policy governing the use of time-out procedures. This policy shall ensure that time-out procedures are used only when less restrictive measures are not feasible;

3. Written orders by a physician for time-out procedures shall state the reasons for using time-out and the terms and conditions under which time-out will be terminated or extended, specifying a maximum duration of the use of the procedure which shall under no circumstances exceed one hour.

4. Emergency use of time-out shall be approved by the administrator or his/her designee for a period not to exceed one hour. The ICF/DD shall immediately notify the individual’s physician if emergency use of time-out is implemented.

5. When an individual is in time-out, a staff member shall exercise direct physical observation of the individual.

6. An individual in time-out shall not be denied access to bathroom facilities.

7. An ICF/DD shall not use time out on an as needed basis.

E. Restraints

1. The facility may employ physical restraints only:

a. as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applies;

b. as an emergency measure, but only if absolutely necessary to protect the client or others from injury; or

c. as a health related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

2. Authorization to use or extend restraints as an emergency measure must be:

a. in effect no longer than 12 consecutive hours; and

b. obtained as soon as the client is restrained or stable.

3. The facility shall not issue orders for restraint on a standing or as needed basis.

4. A client placed in restraints shall be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

5. Restraints shall be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

6. Opportunity for motion and exercise shall be provided and a record of such activity must be kept.

7. Barred enclosures shall not be more than three feet in height and must not have tops.

F. Human Rights Committee. The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior and persons with no ownership or controlling interest in the facility to:

1. review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

2. insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and

3. review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3200 (December 2012).

Subchapter F. Provider Responsibilities

§8575. General Provisions

Reserved.

§8577. Staffing Requirements

A. An ICF/DD shall have a written plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members.

1. Recruitment. An ICF/DD shall employ qualified persons.

2. Screening

a. An ICF/DD's screening procedures shall address the prospective employee's qualifications, ability, related experience, health, character, emotional stability and social skills as related to the appropriate job description.

b. Prior to employing any person and upon obtaining a signed release and the names of the references from the potential employee, an ICF/DD shall obtain written references or phone notes on oral references from three persons.

3. Orientation. An ICF/DD's orientation program shall provide training for new employees to acquaint them with the philosophy, organization, program, practices and goals of the facility and shall include instruction in safety and emergency procedures and in the specific responsibilities of the employee's job.

4. Training

a. An ICF/DD shall ensure that each direct service worker participates in in-service training each year. Orientation training and activities related to routine supervision of the employee's tasks shall not be considered for the purposes of this requirement.

b. An ICF/DD shall document that all employees receive training on an annual basis in:

i. emergency and safety procedures;

ii. the principles and practices of individual care;

iii. the ICF/DD's administrative procedures and programmatic goals;

iv. individual rights; and

v. procedures and legal requirements concerning the reporting of abuse and critical incidents.

c. Direct service workers shall, in addition, receive training in acceptable behavior management techniques, crisis management and passive physical restraint.

d. An ICF/DD shall train staff to ensure the immediate accessibility of appropriate first aid supplies in the living units of the ICF/DD.

5. Evaluation

a. An ICF/DD shall undertake an annual performance evaluation of all staff members.

b. For any person who interacts with individuals, an ICF/DD's performance evaluation procedures shall address the quality and nature of a staff member's relationship with individuals.

6. Personnel Practices

a. An ICF/DD shall have written personnel policies and written job descriptions for each staff position.

b. An ICF/DD shall have a written employee grievance procedure.

c. An ICF/DD shall have a written policy on abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment whether that abuse or mistreatment is done by another staff member, a family member, a resident or any other person.

B. Number and Qualifications of Staff

1. An ICF/DD shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the responsibilities the ICF/DD undertakes are carried out and to adequately perform the following functions:

a. administrative functions;

b. fiscal functions;

c. clerical functions;

d. housekeeping, maintenance and food service functions;

e. direct service worker functions;

f. supervisory functions;

g. record keeping and reporting functions;

h. social service functions;

i. ancillary service functions; and

j. medication and treatment administration functions.

2. An ICF/DD shall ensure that all staff members are properly certified and/or licensed as legally required.

3. An ICF/DD shall ensure that an adequate number of qualified direct service staff are present with the individuals as necessary to ensure the health, safety and well-being of individuals. Staff coverage shall be maintained in consideration of the time of day, the size and nature of the ICF/DD and the ages and needs of the individuals.

4. An ICF/DD shall not knowingly hire or continue to employ any person whose health, educational achievement, emotional or psychological makeup impairs his/her ability to properly protect the health and safety of the individuals or is such that it would endanger the physical or psychological well-being of the individuals. This requirement is not to be interpreted to exclude continued employment in areas other than direct service capacities of persons undergoing temporary medical or emotional problems.

C. External Professional Services. An ICF/DD shall obtain any required professional services not available from employees of the ICF/DD and shall have documentation of access to such services either in the form of a written agreement with an appropriately qualified professional or a written agreement with the state for required resources.

D. Volunteers/Student Interns. An ICF/DD which utilizes volunteers or student interns on a regular basis shall have a written plan using such resources. This plan shall be given to all volunteers and interns. The plan shall indicate that all volunteers and interns shall:

1. be directly supervised by a paid staff member;

2. be oriented and trained in the philosophy of the facility and the needs of individuals, and methods of meeting those needs;

3. be subject to character and reference checks similar to those performed for employment applicants upon obtaining a signed release and the names of the references from the potential volunteer/intern student; and

4. be aware of and be briefed on any special needs or problems of individuals.

E. Direct Care Staff

1. All non-licensed direct care staff must meet minimum mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179 through R.S. 40:2179.1 or a subsequently amended statute and be screened for eligibility for employment on the Louisiana Direct Service Worker Registry.

2. A provider shall ensure that each direct care staff completes no less than 16 hours of supervised classroom training per year to ensure continuing competence. The training must address areas of weakness as determined by the workers' performance reviews and may address the special needs of clients. Orientation and normal supervision shall not be considered for meeting this requirement.

3. All direct care staff shall be trained in recognizing and responding to medical emergencies of clients.

F. Staff Communications

1. An ICF/DD shall establish procedures to assure adequate communication among staff to provide continuity of services to the individual receiving services. This system of communication shall include:

a. a regular review of individual and aggregate problems of individuals including actions taken to resolve these problems;

b. sharing of daily information noting unusual circumstances and other information requiring continued action by staff; and

c. records maintained of all accidents, personal injuries and pertinent incidents related to implementation of individual's service plans.

2. Any employee of an ICF/DD working directly with individuals in care shall have access to information from individual case records that is necessary for effective performance of the employee's assigned tasks.

3. An ICF/DD shall establish procedures which facilities participation and feedback by staff members in policy-making, planning and program development for individuals receiving services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3201 (December 2012).

§8579. Staffing-Qualified Professional and Qualified Mental Retardation Professional

A. A qualified professional (QP) is:

1. a psychologist with at least a master's degree from an accredited program and specialized training or two years experience in treating mentally retarded, emotionally disturbed or learning disabled children whose condition is similar to the condition of the individuals being served; or

2. a physician licensed under state law to practice medicine or osteopathy and with specialized training or two years experience in treating emotionally disturbed, mentally retarded or learning disabled children whose condition is similar to that of the individuals being served.

B. Qualified mental retardation professional (QMRP) is a professionally qualified person responsible for overseeing the implementation of an individual's service plan. A QMRP is a person who has specialized training or one year of experience in training or one year of experience in treating or working with the mentally retarded and is one of the following:

1. a psychologist with a master's degree from an accredited program;

2. a licensed doctor of medicine or osteopathy;

3. an educator with a degree in education from an accredited program;

4. a social worker shall be:

a. a person with a bachelor's degree in social work from an accredited program;

b. a person who has at least one year of experience working directly with handicapped persons in the appropriate area of handicapping conditions; and is:

i. a physician;

ii. a registered nurse;

iii. an occupational therapist who:

(a). is eligible for certification as an occupational therapist (OTR) by the American Occupational Therapy association; or

(b). is a graduate of an occupational therapist educational program accredited jointly by the American Occupational Therapy association and the committee on allied Health Education and accreditation of the American Medical Association;

iv. an occupational therapy assistant who:

(a). is eligible for certification as a certified occupational therapy assistant (COTA) by the American Occupational Therapy Association; or

(b). is a graduate of an occupational therapy assistant program accredited by the American Occupational Therapy association;

v. a physical therapist that is licensed by the state in which he/she practices;

vi. a physical therapy assistant who is a graduate of a two year college-level program approved by the American Physical Therapy association;

vii. a psychologist who has at least a Master's degree in psychology, from an accredited program;

viii. a social worker who:

(a). is licensed, if applicable by the state in which practicing;

(b). has a degree from a school of social work accredited or approved by the Council on Social Work Education; or

(c). has graduated from a college or university with a Bachelor of Social Work degree accredited or approved by the Council on Social Work Education;

ix. a speech-language pathologist or audiologist who:

(a). is licensed, if applicable, by the state in which practicing; and

(b). is eligible for a certificate of clinical competence in speech and language pathology or audiology granted by the American Speech, Language, and Hearing Association under its requirements in effect on the publication of this provision; or

(c). meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification;

x. a recreation staff member with a bachelor's degree in recreation, or in a specialty area such as art, dance, music or physical education;

xi. a music therapist who:

(a). has a four year undergraduate degree in music therapy;

(b). has at least 6 months experience in the field of music therapy; and

(c). is registered with the National Association for Music Therapy or the American Association for Music Therapy; or

xii. a human services professional with at least a bachelor's degree in a human services field (such as psychology, sociology, special education, rehabilitation counseling, juvenile justice, corrections, etc.); or

c. a person in a field other than social work and at least three years of social work experience under the supervision of a qualified social worker;

5 a physical or occupational therapist as defined in federal regulations;

6. a speech pathologist or audiologist as defined by federal regulations;

7. a registered nurse;

8. a therapeutic recreation specialist who:

a. is a graduate of an accredited program; and

b. is licensed by the state; or

9. a rehabilitation counselor who is certified by the Committee on Rehabilitation Counselor Certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3202 (December 2012).

§8581. Record Keeping

A. Accounting and Record Keeping

1. An ICF/DD shall establish a system of business management and staffing to assure maintenance of complete and accurate accounts, books and records.

2. An ICF/DD shall demonstrate fiscal accountability through regular recording of its finances and an annual external audit.

3. An ICF/DD shall not permit funds to be paid, or committed to be paid, to any person to which any of the members of the governing body, administrative personnel, or members of the immediate families have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the ICF/DD. The ICF/DD shall have a written disclosure of any financial transaction with the facility in which a member of the governing body, administrative personnel, or his/her immediate family is involved.

4. An ICF/DD shall ensure that all entries in records are legible, signed by the person making the entry and accompanied by the date on which the entry was made.

5. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of according to state laws.

6. An ICF/DD shall have sufficient space, facilities and supplies for providing effective record keeping services.

B. Confidentiality and Security of Files

1. An ICF/DD shall have written procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of the records and to whom records may be released. Records shall be the property of the ICF/DD and the ICF/DD, as custodian, shall secure records against loss, tampering or unauthorized use.

2. An ICF/DD shall maintain all individuals' case records in accordance with federal and state law, rule, and regulation regarding confidentiality, privacy and retention. Employees of the ICF/DD shall not disclose or knowingly permit the disclosure of any information concerning the individual receiving services or his/her family, directly or indirectly, to any unauthorized person.

3. When the individual receiving services is of majority age and non-interdicted, an ICF/DD shall obtain the individual's written, informed permission prior to releasing any information from which the individual receiving services or his/her family might be identified except for authorized State and Federal agencies and another ICF/DD with professional interest in the individual.

4. When the individual is a minor or is interdicted, the ICF/DD shall obtain written, informed consent from the parent(s), tutor or curator prior to releasing any information from which the individual receiving services might be identified except for authorized state and Federal agencies and another ICF/DD with professional interest in the individual.

5. An ICF/DD shall, upon request, make available information in the case record to the individual receiving services, the legally responsible person or legal counsel of the individual. If, in the professional judgment of the administration of the ICF/DD, it is felt that information contained in the record would be damaging to an individual receiving services, that information may be withheld from the individual requesting the information except under court order.

6. An ICF/DD may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the ICF/DD's services, or similar educational purposes, provided that

names are deleted and other identifying information is disguised or deleted.

7. Individual records shall be retained in accordance with state and/or federal regulations.

C. Individual's Case Record. An ICF/DD shall have a written record for each individual receiving services, which shall include administrative, treatment, and educational data from the time of admission until the time the individual leaves the ICF/DD. An individual's case record shall include:

1. the name, sex, race, religion, birth date and birthplace of the individual;

2. the individual's history including, where applicable, family data, educational background, employment record, prior medical history and prior placement history;

3. a copy of the individual's service plan and any modifications thereto and an appropriate summary to guide and assist direct service workers in implementing the individual receiving services program;

4. the findings made in periodic reviews of the plan, including a summary of the successes and failures of the individual receiving services program and recommendations for any modifications deemed necessary;

5. monthly status reports;

6. a copy of the aftercare plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

7. when restraint in any form other than passive physical restraint has been used, a signed order for each use of restraint issued by a qualified professional prior to such use;

8. critical incident reports;

9. reports of any individual's grievances and the conclusions or dispositions of these reports;

10. a summary of family visits and contacts; and

11. a summary of attendance and leaves of absence from the ICF/DD.

D. Medical and Dental Records

1. An ICF/DD shall maintain complete health records of an individual receiving services, which shall include:

a. a complete record of all immunizations provided; a record of any medication;

b. records of vision, physical or dental examinations; and

c. a complete record of any treatment provided for specific illness or medical emergencies.

2. Upon discharge, the ICF/DD shall provide a summary of the individual's health record to the person or agency responsible for the future planning and care of the individual receiving services.

3. An ICF/DD shall make every effort to compile a complete past medical history on every individual receiving services. This history shall, whenever possible, include:

a. allergies to medication;

b. immunization history;

c. history of serious illness, serious injury or major surgery;

d. developmental history;

e. current use of prescribed medication;

f. current use of alcohol or non-prescribed drugs; and

g. medical history.

E. Retention of Records. The ICF/DD provider shall retain all client records for a period of six years after the date of the client's discharge, transfer or death.

F. Staff Personnel File

1. An ICF/DD shall maintain a personnel file for each employee. At a minimum, this file shall contain the following:

a. the application for employment and/or resume;

b. a criminal history check, prior to an offer of employment, in accordance with state law;

c. reference letters from former employer(s) and personal references or phone notes on such references;

d. documentation of any state or federally required medical examinations or medical testing;

e. evidence of applicable professional credentials/certifications according to state law;

f. annual performance evaluations;

g. personnel actions, other appropriate materials, reports and notes relating to the individual's employment with the facility;

h. employee's hire and termination dates; and

i. documentation of orientation and annual training of staff.

2. The staff member shall have reasonable access to his/her file and shall be allowed to add any written statement he/she wishes to make to the file at any time.

3. An ICF/DD shall retain the personnel file of an employee for at least three years after the employee's termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3203 (December 2012).

§8583. Client Funds and Assets

A. Money and Personal Belongings

1. An ICF/DD shall permit and encourage an individual to possess his/her own money either by giving an allowance and/or by providing opportunities for paid work, unless otherwise indicated by the individual's service plan and reviewed every 30 days by the QMRP.

2. Money earned, received as a gift or received as allowance by an individual shall be deemed to be that individual's personal property.

3. Limitations may be placed on the amount of money an individual may possess or have unencumbered access to when such limitations are considered to be in the individual's best interests and are duly recorded in the individual's service plan.

4. An ICF/DD shall, as appropriate to the individual's age and abilities, provide training in budgeting, shopping and money management.

5. An ICF/DD shall allow an individual to bring his/her personal belongings to the program and to acquire belongings of his/her own in accordance with the individual's service plan. However, the ICF/DD shall, as necessary, limit or supervise the use of these items while the individual is in care. Where extraordinary limitations are imposed, the individual shall be informed by staff of the reasons, and the decision and reasons shall be recorded in the individual's case record. Reasonable provisions shall be made for the protection of the individual's property.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3205 (December 2012).

§8585. Abuse and Neglect

A. An ICF/DD shall have comprehensive, written procedure concerning individual abuse and neglect including:

1. a description of ongoing communication strategies used by the ICF/DD to maintain staff awareness of abuse prevention, current definitions of abuse and neglect, reporting requirements and applicable laws;

2. a procedure ensuring immediate reporting of any suspected incident to the administrator or his/her designee and mandating an initial written summary on the incident to the administrator or his/her designee within 24 hours;

3. a procedure for ensuring that the individual is protected from potential harassment during the investigation and which accused staff shall be removed from direct care of individuals during the investigation; and

4. a procedure for disciplining staff members who abuse or neglect individuals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3205 (December 2012).

§8587 Abuse/Neglect Reporting

A. An ICF/DD shall have written procedures for the reporting and documentation of deaths of individuals, injuries, fights or physical confrontations, situations requiring the use of passive physical restraints, suspected incidents of abuse or neglect, unusual incident and other situations or circumstances affecting the health, safety or well-being of an individual or individuals.

B. Such procedures shall ensure timely verbal and written reports to the administrator.

C. When an incident involves abuse or neglect of an individual, death of an individual, or entails any serious threat to the individual's health, safety or well-being, an ICF/DD shall:

1. ensure immediate verbal reporting to the administrator or his/her designee and a preliminary written report within 24 hours of the incident;

2. ensure notification to designated representatives of the DHH Health Standards Section within 24 hours of occurrence or discovery of the incident. A final report must be submitted to HSS within five working days. Extensions may be granted on a case by case basis with good cause. The ICF/DD shall utilize the department’s Online Tracking Incident System (OTIS). This requires that the ICF/DD maintain internet access and keeps the department informed of an active e-mail address. Reports to Health Standards Section utilizing OTIS should include the following:

a. abuse and allegations of abuse;

b. neglect and allegations of neglect; and

c. major injuries of unknown source including, but not limited to, fractures, burns, suspicious contusions, head injuries and unanticipated deaths;

3. ensure that other appropriate authorities are notified, according to state law;

4. ensure immediate, documented attempts to notify the legally responsible person of the individual;

5. ensure immediate attempts to notify other involved agencies and parties, as appropriate; and

6. ensure immediate notification of the appropriate law enforcement authority whenever warranted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3205 (December 2012).

§8589. Quality of Life

A. Family Involvement

1. An ICF/DD shall have a written description of strategies used by the ICF/DD's program to foster ongoing positive communication and contact between individuals and their families, their friends and others significant people in their lives.

2. An ICF/DD shall have evidence that the individual's family and, where appropriate, the legally responsible person have been informed of:

a. the philosophy and goals of the ICF/DD;

b. behavior management and disciplinary practices of the ICF/DD;

c. the ICF/DD's arrangements for individuals' participation in religious observances;

d. any specific treatment or treatment strategy employed by the ICF/DD to be implemented for a particular individual;

e. visiting hours, visiting rules and procedures, arrangements for home visits and procedures for communicating with individuals by mail or telephone;

f. a procedure for registering complaints concerning the individual's care or treatment; and

g. the name, telephone number and address of a staff person who may be contacted by the legally responsible person to ask questions or register concerns on an ongoing basis.

B. Community Involvement. An ICF/DD shall have a written plan to foster participation by individuals in normal community activities to the degree possible considering the individual's level of functioning.

C. Communication and Visits. An ICF/DD shall have a written description of rules and procedures concerning telephone communications by individuals, sending and receiving of mail by individuals and visits to and from an individual's family and friends.

1. Telephone Communication

a. An ICF/DD shall allow an individual to receive and originate telephone calls subject only to reasonable rules and to any specific restrictions in the individual's service plan.

b. Any restriction on telephone communication in an individual's service plan must be formally approved by the QMRP and shall be reviewed every 30 days by the QMRP.

2. Mail

a. An ICF/DD shall allow individuals to send and receive mail unopened and unread by staff unless contraindicated by the individual's service plan and reviewed every 30 days by the QMRP.

b. An ICF/DD shall ensure that individuals have access to all materials necessary for writing and sending letters and shall, when necessary ensure that individuals who wish to correspond with others are given any required assistance.

3. Visits

a. An ICF/DD shall allow an individual to visit or be visited by family and friends subject only to reasonable rules and to any specific restrictions in the individual's service plan.

b. Special restrictions shall be imposed only to prevent serious harm to the individual. The reasons for any special restrictions shall be recorded in the individual's service plan. Special restrictions must be reviewed every 30 days by the QMRP and, if restrictions are renewed, the reasons for renewal shall be recorded in the individual's service plan.

D. Clothing

1. An ICF/DD shall ensure that individuals are provided with clean, well-fitted clothing appropriate to the season and to the individual's age, sex and individual needs.

2. Clothing shall be maintained in good repair.

3. All clothing provided to an individual shall go with the individual at discharge.

4. Clothing shall belong to the individual and not be shared in common.

E. Religion

1. An ICF/DD shall have a written description of its religious orientation, particular religious practices that are observed and any religious restrictions on admission. This description shall be provided to the individual, and where appropriate, the legally responsible person and the responsible agency.

2. Every individual shall be permitted to attend religious services in accordance with his/her faith. The ICF/DD shall, whenever possible, arrange transportation and encourage participation by those individuals who desire to participate in religious activities in the community.

3. Individuals shall not be forced to attend religious services.

4. When the individual is a minor, the ICF/DD shall determine the wishes of the legally responsible person with regard to religious observance and instruction at the time of placement and shall make every effort to ensure that these wishes are carried out.

F. Work

1. An ICF/DD shall have a written description of the ICF/DD's approach to involving individuals in work including:

a. a description of any unpaid tasks required of individuals;

b. a description of any paid work assignments including the pay scales for such assignments;

c. a description of the ICF/DD's approach to supervising work assignments; and

d. assurance that the conditions and compensation of such work are in compliance with applicable state and federal laws.

2. An ICF/DD shall demonstrate that any individual work assignments are designed to provide a constructive experience for individuals and are not used as a means of performing vital ICF/DD functions at low cost.

3. All work assignments shall be in accordance with the individual's service plan.

4. An ICF/DD shall assign as unpaid work for individuals only housekeeping tasks similar to those performed in a normal home setting.

5. When an individual engages in off-grounds work, the ICF/DD shall document that:

a. such work is voluntary and in accordance with the individual's service plan;

b. the QMRP approved such work;

c. such work is supervised by qualified personnel;

d. the conditions and compensation of such work are in compliance with applicable state and federal laws; and

e. such work does not conflict with the individual's program.

G. Recreation and Activities Programs

1. An ICF/DD shall have a written plan for providing recreational services based on the individual needs, interests and functioning levels of individuals served. This plan shall ensure that a range of indoor and outdoor recreational and leisure opportunities are provided for individuals.

2. An ICF/DD shall utilize the recreational resources of the community whenever appropriate. The ICF/DD shall arrange the transportation and supervision required for maximum usage of community resources.

3. An ICF/DD shall have sufficient, adequately trained staff to carry out the stated objectives of the ICF/DD's recreation plan.

4. An ICF/DD which has recreation staff shall ensure that recreation staff are apprised of and, when appropriate, involved in the development and review of service plans.

H. Personal Care and Hygiene. An ICF/DD shall establish procedures to ensure that individuals receive training in good habits of personal care, hygiene and grooming.

I. Safety. An ICF/DD shall establish procedures to ensure that individuals receive training in safety and self protection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3205 (December 2012).

Subchapter G. Emergency Preparedness

§8595. Emergency Preparedness Plan

A. The ICF/DD shall incorporate an all hazards risk assessment into the facility's emergency preparedness plan which is designed to manage the consequences of medical emergencies, power failures, fire, natural disasters, declared disasters or other emergencies that disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the residents. The facility shall follow and execute its emergency preparedness plan in the event or occurrence of a disaster or emergency. This plan shall be reviewed, updated and approved by the governing body at least annually. Upon the department's request, a facility shall present its emergency preparedness plan for review.

B. At a minimum the emergency preparedness plan shall include and address the following.

1. The emergency preparedness plan shall be individualized and site specific. All information contained in plan shall be current and correct. The plan shall be made available to representatives of the Office of the State Fire Marshal and the Office of Public Health upon request of either of these offices. The facility's plan shall follow all current applicable laws, standards, rules or regulations.

2. The facility's plan shall contain census information, including transportation requirements for the ICF/DD residents as to the need for:

a. wheelchair accessible or para-transit vehicle transport; or

b. the numbers of ICF/DD residents that do not have any special transport needs.

3. The plan shall contain a clearly labeled and legible master floor plan(s) that indicate the following:

a. the areas in the facility that is to be used by residents as shelter or safe zones during emergencies;

b. the location of emergency power outlets;

c. the locations of posted, accessible, emergency information; and

d. the detail of what will be powered by emergency generator(s), if applicable.

4. The facility's plan shall be viable and promote the health, safety and welfare of facility's residents.

5. The facility shall provide a plan for monitoring weather warnings and watches and evacuation orders from local and state emergency preparedness officials. This plan will include who will monitor, what equipment will be used, and procedures for notifying the administrator or responsible persons.

6. The plan shall provide for the delivery of essential care and services to residents during emergencies, who are

housed in the facility or by the facility at another location, during an emergency.

7. The plan shall contain information about staffing for when the ICF/DD is sheltering in place or when there is an evacuation of the ICF/DD. Planning shall include documentation about staff that have agreed to work during an emergency and contact information for such staff. Plan shall include provisions for adequate, qualified staff as well as provisions for the assignment of responsibilities and duties to staff.

8. The facility shall have transportation or arrangements for transportation for evacuation, hospitalization, or any other services which are appropriate. Transportation or arrangements for transportation shall be adequate for the current census and meet the ambulatory needs of the residents.

9. The plan shall include procedures to notify the resident's family or responsible representative whether the facility is sheltering in place or evacuating to another site. The plan shall include which staff are responsible for providing this notification. If the facility evacuates, notification shall include:

a. the date and approximate time that the facility is evacuating; and

b. the place or location to which the facility is evacuating, including the:

i. name;

ii. address; and

iii. telephone number.

10. The plan shall include the procedure or method whereby each facility resident has a manner of identification attached to his person which remains with him at all times in the event of sheltering in place or evacuation, and whose duty and responsibility this will be; the following minimum information shall be included with him:

a. current and active diagnosis;

b. medications, including dosage and times administered;

c. allergies;

d. special dietary needs or restrictions; and

e. next of kin or responsible person and contact information.

11. The plan shall include an evaluation of the building and necessary systems to determine the ability to withstand wind, flood, and other local hazards that may affect the facility and should also include:

a. if applicable, an evaluation of each generator's fuel source(s), including refueling plans and fuel consumption; and

b. an evaluation of the facility's surroundings to determine lay-down hazards, objects that could fall on facility, and hazardous materials in or around the facility, such as:

i. trees;

ii. towers;

iii. storage tanks;

iv. other buildings;

v. pipe lines;

vi. chemicals;

vii. fuels; and

viii. biologics.

12. For ICF/DDs that are geographically located south of Interstate 10 or Interstate 12, the plan shall include the determinations of when the facility will shelter in place and when the facility will evacuate for a hurricane and the conditions that guide these determinations.

a. A facility is considered to be sheltering in place for a storm if the facility elects to stay in place rather than evacuate when located in the projected path of an approaching storm of tropical storm strength, or a tropical cyclone. The facility has elected to take this action after reviewing all available and required information on the storm, the facility, the facility's surroundings and consultation with the local or parish Office of Homeland Security and Emergency Preparedness (OHSEP). The facility shall accept all responsibility for the health and well being of all residents that shelter with the facility before during and after the storm. In making the decision to shelter in place or evacuate the facility shall consider the following:

i. what conditions will facility shelter for;

ii. what conditions will facility close or evacuate for; and

iii. when will these decisions be made.

b. If the facility shelters in place, the facility's plan shall include provisions for seven days of necessary supplies to be provided by the facility prior to emergency event, to include:

i. drinking water or fluids; and

ii. non-perishable food.

13. The facility's emergency plan shall include a posted communications plan for contacting emergency services and monitoring emergency broadcasts and whose duty and responsibility this will be.

14. The facility's plan shall include how the ICF/DD will notify OHSEP and LDH when the decision is made to shelter in place and whose responsibility it is to provide this notification.

15. The facility shall have a plan for an ongoing safety program to include:

a. continuous inspection of the facility for possible hazards;

b. continuous monitoring of safety equipment and maintenance or repair when needed;

c. investigation and documentation of all accidents or emergencies;

d. fire control and evacuation planning with documentation of all emergency drills (residents can be informed of emergency drills);

e. all aspects of the facility's plan, planning, and drills shall meet the current requirements of the Office of the State Fire Marshal, and the Life Safety Code NFPA 101; and

f. the facility shall inform the resident and/or responsible party of the facility's emergency plan and the actions to be taken.

C. An ICF/DD shall electronically enter current facility information into the department's ESF-8 portal or into the current LDH emergency preparedness webpage or electronic database for reporting.

1. The following information shall be entered or updated before the fifteenth of each month:

a. operational status;

b. census;

c. emergency contact and destination location information; and

d. emergency evacuation transportation needs categorized by the following types:

i. *red*—high-risk residents who will need to be transported by advanced life support ambulance due to dependency on mechanical or electrical life sustaining devices or very critical medical condition;

ii. *yellow*—residents who are not dependent on mechanical or electrical life sustaining devices, but cannot be transported using normal means (buses, vans, cars), may need to be transported by an ambulance; however, in the event of inaccessibility of medical transport, buses, vans or cars may be used as a last resort; and

iii. *green*—residents who do not need specialized transportation may be transported by car, van, bus or wheelchair accessible transportation.

2. An ICF/DD shall also enter or update the facility's information upon request, or as described per notification of an emergency declared by the secretary. Emergency events may include, but are not limited to:

a. hurricanes;

b. floods;

c. fires;

d. chemical or biological hazards;

e. power outages;

f. tornados;

g. tropical storms; and

h. severe weather.

3. Effective immediately, upon notification of an emergency declared by the secretary, all ICFs/DD shall file an electronic report with the ESF-8 portal or into the current LDH emergency preparedness webpage or electronic database for reporting.

a. The electronic report shall be filed, as prescribed by department, throughout the duration of the emergency declaration.

b. The electronic report shall include, but is not limited to, the following:

i. status of operation;

ii. availability of beds;

iii. generator status;

iv. evacuation status;

v. shelter in place status;

vi. mobility status of clients;

vii. range of ages of clients;

viii. intellectual levels/needs of clients; and

ix. any other client or facility related information that is requested by the department.

NOTE: The electronic report shall not be used to request resources or to report emergency events.

D. The facility's plan shall include a process for tracking during and after the emergency/disaster for on-duty staff and sheltered clients.

E. The facility's plan shall also include a process to share with the client, family, and representative appropriate information from the facility's emergency plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3207 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:524 (March 2017).

§8597. Emergency Plan Activation, Review and Summary

A. The facility's emergency plan(s) shall be activated at least annually, either in response to an emergency or in a planned drill. All staff shall be trained and have knowledge of the emergency plan.

B. ICF/DDs must conduct a minimum of 12 fire drills annually with at least one every three months on each shift. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disaster.

1. All staff shall participate in at least one drill annually. Residents shall be encouraged to participate, but the provider may not infringe upon the right of the resident to refuse to participate.

2. The facility shall test at least one manual pull alarm each month of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

C. Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

D. The facility's performance during the activation of the plan shall be evaluated annually by the facility and the findings shall be documented in the plan.

E. The plan shall be revised if indicated by the facility's performance during the emergency event or the planned drill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3208 (December 2012).

§8599. Notification of Evacuation, Relocation, or Temporary Cessation of Operations

A. In the event that an ICF/DD evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state, local or parish OHSEP, the ICF/DD must immediately give notice to the Health Standards Section as well as the Office for Citizens with Developmental Disabilities (OCDD) and OHSEP as directed by filing an electronic report with the ESF-8 portal or into the current LDH emergency preparedness webpage or electronic database for reporting:

1. the date and approximate time of the evacuation; and

2. the locations of where the residents have been placed and whether this location is an ICF/DD or other alternate host site for one or more of the ICF/DD residents.

B. In the event that an ICF/DD evacuates, temporarily relocates or temporarily ceases operations at its licensed location for any reason other than an evacuation order, the ICF/DD must immediately give notice to the Health Standards Section by facsimile or email of the following:

1. the date and approximate time of the evacuation; and

2. the locations of where the residents have been placed and whether this location is an ICF/DD or other alternate host site for one or more of the ICF/DD residents.

C. If there are any deviations or changes made to the locations of the residents that was given to the Health Standards Section, OCDD and OHSEP, then both Health Standards, OCDD and OHSEP shall be notified of the changes within 48 hours of their occurrence.

D. Procedures for emergencies shall specify persons to be notified, process of notification and verification of notification, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating residents, procedures for reentry and recovery, frequency of fire drills, tasks and responsibilities assigned to all personnel, and shall specify medications and records to be taken from the facility upon evacuation and to be returned following the emergency.

E. An ICF/DD shall immediately notify the department and other appropriate agencies of any fire, disaster or other emergency that may present a danger to residents or require their evacuation from the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3208 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:524 (March 2017).

§8601. Authority to Re-open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation

A. In the event that an ICF/DD evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the state, local or parish OHSEP due to a declared disaster or other emergency and that facility sustains damages due to wind, flooding, precipitation, fire, power outages or other causes, the facility shall not be reopened to accept returning evacuated residents or new admissions until surveys have been conducted by the Office of the State Fire Marshal, the Office of Public Health and the Department of Health and Hospitals, Health Standards Section and the facility has received a letter of approval from the department for reopening the facility. The purpose of these surveys is to assure that the facility is in compliance with the licensing standards including, but not limited to, the structural soundness of the building, the sanitation code, staffing requirements and the execution of emergency plans.

B. If an ICF/DD evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the state or parish OHSEP due to a declared disaster or other emergency and the facility does not sustain damages due to wind, flooding, precipitation, fire, power outages or other causes, the facility may be reopened without the necessity of the required surveys. Prior to reopening, the facility shall notify the Health Standards Section in writing that the facility is reopening.

C. The facility shall submit a written initial summary report upon request to the department's Health Standards Section. This report shall be submitted within 14 days from

the date of evacuation which led to the facility having to evacuate, temporarily relocate or temporarily cease operations. The report shall indicate how the facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of the injuries and deaths.

D. If a facility shelters in place at its licensed location during a declared disaster or other emergency, the facility shall submit a written initial summary report upon request to the department's Health Standards Section. The report shall indicate how the facility's emergency preparedness plan was followed and executed. This report shall be submitted within 14 days from the date of the event which caused the facility to shelter in place. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;

2. plan provisions that were not followed;

3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

4. contingency arrangements made for those plan provisions not followed; and

5. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths.

E. Upon request by the department's Health Standards Section, a report that is more specific and detailed regarding the facility's execution of their emergency plan shall be submitted to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3209 (December 2012).

§8603. General Emergency Preparedness Training

A. All employees shall be trained in procedures to be followed in the event of any emergency situations. All employees shall be instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter. The ICF/DD shall instruct all employees on the emergency evacuation procedures. The ICF/DD shall review the procedures with existing staff at least once in each 12 month period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3209 (December 2012).

§8605. Inactivation of License Due to Declared Disaster or Emergency

A. A licensed ICF/DD in an area or areas which have been affected by an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed ICF/DD shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the ICF/DD has experienced an interruption in the provision of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the licensed ICF/DD intends to resume operation as an ICF/DD in the same service area;

c. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;

d. includes an attestation that all clients have been properly transferred to another provider; and

e. provides a list of each client and where that client is discharged or transferred to;

2. the licensed ICF/DD resumes operating as an ICF/DD in the same service area within one year of issuance of the executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the licensed ICF/DD continues to pay all fees and costs due and owed to the department, including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the licensed ICF/DD continues to submit required documentation and information to the department, including, but not limited to cost reports.

B. Upon receiving a completed written request to inactivate an ICF/DD license, the department shall issue a notice of inactivation of license to the ICF/DD.

C. Upon completion of repairs, renovations, rebuilding or replacement of the facility, an ICF/DD which has received notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the ICF/DD must submit a written license reinstatement request to the licensing agency of the department within one year of the executive order or

proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing survey; and

3. the license reinstatement request must include a completed licensing application with appropriate licensing fees.

D. Upon receiving a completed written request to reinstate an ICF/DD license, the department shall conduct a licensing survey. If the ICF/DD meets the requirements for licensure and the requirements under this subsection, the department shall issue a notice of reinstatement of the ICF/DD license. The licensed bed capacity of the reinstated license shall not exceed the licensed bed capacity of the ICF/DD at the time of the request to inactivate the license.

E. No change of ownership in the ICF/DD shall occur until such ICF/DD has completed repairs, renovations, rebuilding or replacement construction and has resumed operation as an ICF/DD.

F. The provisions of the subsection shall not apply to an ICF/DD which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this subsection shall be deemed a voluntary surrender of the ICF/DD license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3209 (December 2012).

Subchapter H. Physical Environment

§8609. Physical Plant

A. Accessibility. An ICF/DD's building, parking lots and facilities shall be accessible to and functional for individuals, staff members and the public, as required by applicable federal and state laws and regulations to include individuals with limited mobility and assistive devices.

B. New Construction or Renovation of Existing Facilities

1. Before beginning renovations or new construction, Health Standards Section must be notified. Plans and specifications must be prepared by a licensed architect or engineer and must be submitted for approval to the Office of State Fire Marshal and any other office/entity designated by the department to review and approve the facility's architectural plans, if the facility must go through plan review, and the Office of Public Health.

2. Health Standards Section, the Office of Public Health, and the Office of State Fire Marshal, shall have the authority to inspect the project at any stage to insure that the approved plans and specifications are being followed. Final approval of the building must be obtained from these agencies after renovation or construction is completed and before it is occupied. A license shall be issued by Health Standards Section only after these final approvals have been obtained.

3. It shall be the responsibility of the ICF/DD to obtain any approvals from local authorities (such as zoning, building, fire, etc), that may be needed in the particular city or parish.

4. All ICF/DDs must be in conformity with the American National Standards Institute (ANSI) standards.

C. Facility Building Codes

1. These requirements shall not apply to facility construction documents approved for new construction, modification, renovation, alteration or repair of structures when:

a. approval of the construction document was acquired prior to promulgation of this rule; and

b. the actual start of construction commenced within 180 days of the construction document's approval and permitting date. The approval and permitting date shall be the date identified as the latest approval date either by the local/parish authorities or the Louisiana State Facility Planning and Control and the Office of State Fire Marshal.

2. All construction of new ICF/DD facilities, including new replacement facilities, and all construction of additions, alterations, reestablishments, refurbishments, and renovations to existing ICF/DD facilities shall comply with the following codes and standards:

a. the minimum standards as described in the Guidelines for Design and Construction of Health Care Facilities, Current Edition, published by the Facility Guidelines Institute (FGI) or any successor publication;

b. the latest editions of the Louisiana State Uniform Construction Codes currently adopted by the Louisiana Department of Public Safety, Louisiana State Uniform Construction Code Council (LSUCCC), LAC 55, Part VI, §301 as follows:

i. International Building Code (IBC);

ii. International Existing Building Code (IEBC);

iii. International Residential Code (IRC);

iv. International Mechanical Code (IMC);

v. The Louisiana Plumbing Code [Part XIV (Plumbing) of the State Sanitary Code];

vi. International Fuel Gas Code (IFGC);

vii. National Electrical Code (NEC);

viii.for all state owned licensed buildings the Louisiana Building Codes in RS 40:1722;

ix. The Advisory Base Flood Elevation (ABFE), published by FEMA; and

x. The National Fire Protection Association (NFPA) Life Safety Code NFPA 101 promulgated by the Louisiana Department of Public Safety and Corrections, Office of the State Fire Marshal.

3. As additional guidance for all construction of new ICF/DD facilities, including new replacement facilities, and all construction of additions, alterations, reestablishments, refurbishments, and renovations to existing ICF/DD facilities, the following design publications may be used, as necessary, to achieve the final product:

a. the Design and Construction Guidance for Community Shelters, published by FEMA, number 361;

b. the Design Guide for Improving Critical Facility Safety from Flooding and High Winds, published by FEMA, number 543;

c. the ICC 500-2008: ICC/NSSA Standard for the Design and Construction of Storm Shelters, published by the International Code Council and National Storm shelter Association, 2008 Edition; and

d. the American Society for Testing and Materials (ASTM), E84.

4. All existing licensed facilities which have sustained damage from an act of God shall be evaluated for re-occupancy and shall have its condition evaluated by a Louisiana registered architect or civil engineer.

a. The owner shall provide a written evaluation report to the department on the condition of the structure, signed and sealed by a licensed Louisiana architect or civil engineer, prior to any reestablishment of occupancy. The evaluation shall be in accordance with the Louisiana State Uniform Construction Codes and acceptable engineering practices and standards. A plan of action to correct any problem shall also be submitted. The report and the plan of action shall be reviewed and accepted by the department prior to proceeding with any proposed modifications. Acceptance by the department will be on a case by case basis.

5. Waivers

a. The secretary of the department may, within his sole discretion, grant waivers to building and construction guidelines. The facility must submit a waiver request in writing to the Office of the State Fire Marshall and any other office/entity designated by the department to review and approve the facility's architectural plans. The facility must demonstrate how patient safety and the quality of care offered are not compromised by the waiver. The facility must demonstrate their ability to completely fulfill all other requirements of the service. The department shall make a written determination of the request. Waivers are not transferable in an ownership change and are subject to review or revocation upon any change in circumstances related to the waiver.

b. The secretary, in exercising his discretion, shall at a minimum, require the applicant to comply with the edition of the building and construction guidelines which immediately proceed the most current edition of the Guidelines for Design and Construction of Health Care Facilities.

6. Any proposed new ICF/DD facility or any existing structure with 50 percent or greater substantial structural damage seeking to be licensed by DHH shall not be constructed or renovated in areas identified to be within the 140 mph or greater wind speed zones as established by the latest Louisiana Department of Public Works, Louisiana State Uniform Construction Code Council, Wind Speed by Parish Data. Links for wind speed data can be found on websites of the LSUCCC or the Office of the State Fire Marshall (OSFM) and any other office/entity designated by the department to review and approve the facility's architectural plans.

7. No new facility or any existing structure with substantial structural damage shall be constructed or renovated in any coastal high hazard area (CHHA) that is subject to high velocity wave action from storms or seismic sources.

8. Any new construction or any replacement structure seeking to be licensed shall comply fully with this rule.

9. No structure shall be converted to ICF/DD use unless it complies with the standards and codes set forth herein including the building systems necessary for full compliance.

10. Separate buildings acquired or constructed for essential use by the facility and included under the ICF/DD facility license, whether on the premises or off, shall comply with the applicable portions of this rule. This requirement includes modular and prefabricated buildings.

11. Any temporary use of an existing building or structure for short term emergency purposes shall be reviewed and approved on a case by case basis for an approved limited time. The temporary use of these facilities shall be approved by the Louisiana Office of Public Health; Department of Public Safety, Office of the State Fire Marshal; and this department.

12. Work must be completed within a compliance time period not to exceed three years from date of acceptance. The department may grant an extension of time to a facility to achieve compliance. A written application requesting an extension must be submitted to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3210 (December 2012).

§8611. Exterior Space

A. An ICF/DD shall ensure that all structures on the grounds of the facility accessible to individuals are maintained in good repair and are free from excessive hazard to health or safety.

B. An ICF/DD shall maintain the grounds of the facility in an acceptable manner and shall ensure that the grounds are free from any hazard to health or safety.

C. Garbage and rubbish which is stored outside shall be stored securely in non-combustible, covered containers and shall be removed on a regular basis. Trash collection receptacles shall be separate from the recreational area and be located as to avoid being a nuisance to neighbors.

D. Areas determined to be unsafe including, but not limited to, steep grades, cliffs, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced off. All fences shall be in good repair.

E. An ICF/DD shall have at least 75 square feet of accessible exterior recreational space for each client. The recreational space shall be enclosed with secure fencing if necessary to protect clients. Recreational equipment, if used, shall be so located, installed and maintained as to ensure the safety of individuals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3211 (December 2012).

§8613. Interior Space

A. Each living unit of an ICF/DD shall contain a space for the free and informal use of individuals. This space shall be constructed and equipped in a manner consonant with the programmatic goals of the ICF/DD. An appropriate variety of interior recreational spaces shall be provided. An ICF/DD shall ensure that there is evidence of routine maintenance and cleaning programs in all areas of the ICF/DD.

B. Dining Areas

1. An ICF/DD shall provide dining areas which permit individuals, staff and as appropriate, guests to eat together at a table, counter or in a manner which accommodates wheelchairs or other assisted devices. As a minimum, the dining area shall provide 15 square feet per person. If usage is by shifts the number of persons in each shift and the number of shifts shall be indicated in the functional program.

2. An ICF/DD shall provide dining areas which are clean, comfortable, home-like, well-lighted, ventilated and attractively furnished.

C. Sleeping Accommodations

1. An ICF/DD shall ensure that each single occupancy bedroom space has a floor area of at least 80-square feet and that each multiple occupancy bedroom space has a floor area of at least 60 square feet for each occupant.

2. An ICF/DD shall not use a room with a ceiling height of less than seven feet six inches as a bedroom space, unless, in a room with varying ceiling height, the portions of the room where the ceiling is at least seven feet six inches allow a usable space with floor areas as required above.

3. An ICF/DD shall not permit more than four individuals to occupy a designated bedroom space.

4. No individual over the age of 5 years shall occupy a bedroom with a member of the opposite sex, unless the persons occupying the bedroom are a married couple or properly documented medical reasons require it.

5. An ICF/DD shall not use any room which does not have an operable window as a bedroom space.

6. Each individual in the care of an ICF/DD shall have his/her own bed. A double bed may be provided for a married couple. An individual's bed shall be no shorter than the individual's height and no less than 30 inches wide and shall have a clean, comfortable, non-toxic, fire-retardant mattress. The bed shall be solidly constructed, include a mattress and box spring and be in good repair.

7. An ICF/DD shall ensure that sheets, pillow and blankets are provided for each individual.

8. Enuretic individuals shall have mattresses with moisture-resistant covers.

9. Sheets and pillow cases shall be changed at least weekly but shall be changed more frequently, if necessary.

10. Cots or other portable beds are not to be used.

11. An ICF/DD shall provide each individual in care with his/her own dresser or other adequate storage space for private use and a designated space for hanging clothing in proximity to the bedroom occupied by the individual.

12. Each individual in care of an ICF/DD shall have his/her own designated area for rest and sleep.

13. The decoration of sleeping areas for individuals shall allow for the personal tastes and expressions of the individuals.

D. Bathrooms

1. An ICF/DD shall have an adequate number of properly equipped bathroom facilities, accommodating individual care needs.

2. Bathrooms shall be so placed as to allow access without disturbing other individuals during sleeping hours.

3. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene.

4. Tubs and showers shall have slip-proof surfaces.

5. An ICF/DD shall provide toilets and baths or showers which allow for individual privacy.

6. An ICF/DD shall ensure that bathrooms have a safe and adequate supply of hot and cold running water. Hot water temperatures shall not exceed 110 degrees F. where individuals are not able to regulate temperature independently.

7. An ICF/DD shall ensure that bathrooms contain mirrors secured to the walls at convenient heights and other

furnishings necessary to meet the individual's basic hygienic needs.

8. An ICF/DD shall ensure that bathrooms are equipped to facilitate maximum self-help by individuals. Bathrooms shall be large enough to permit staff assistance of individuals receiving services, as necessary.

9. Toilets, wash basins, and other plumbing or sanitary facilities in a facility shall, at all times, be maintained in good operating condition and shall be kept free of any materials that might clog or otherwise impair their operation.

E. Kitchens

1. Kitchens used for meal preparations shall be provided with the necessary equipment for the preparation, storage, serving and clean up of all meals for all of the individuals and staff regularly served by such kitchen. All equipment shall be maintained in working order.

2. An ICF/DD shall not use disposable dinnerware at meals on a regular basis unless the facility documents that such dinnerware is necessary to protect the health or safety of individuals in care.

3. An ICF/DD shall ensure that all dishes, cups and glasses used by individuals in care are free from chips, cracks or other defects.

4. All reusable eating and drinking utensils shall be sanitized after a thorough washing and rinsing.

5. Animals shall not be permitted in food storage, preparation, and dining areas.

F. Staff Quarters

1. An ICF/DD utilizing live-in staff shall provide adequate, separate living space with a private bathroom for these staff.

G. Administrative and Counseling Space

1. An ICF/DD shall provide a space which is distinct from individuals' living areas to serve as an administrative office for records, secretarial work and bookkeeping.

2. An ICF/DD shall have a designated space to allow private discussions and counseling sessions between individuals and staff.

H. Furnishings

1. An ICF/DD shall have comfortable customary furniture as appropriate for all living areas. Furniture for the use of individuals shall be appropriately designed to suit the size and capabilities of individuals.

2. An ICF/DD shall replace or repair broken, run-down or defective furnishings and equipment promptly.

I. Doors and Windows

1. An ICF/DD shall ensure that any designated bedroom shall have functional windows that can be opened.

2. An ICF/DD shall provide insect screens for all opened windows. This screening shall be readily removable in emergencies and shall be in good repair.

3. An ICF/DD shall ensure that all closets, bedrooms and bathrooms which have doors are provided with doors that can be readily opened from both sides.

4. Outside doors, windows and other features of the structure necessary for the safety and comfort of individuals shall be secured for safety within 24 hours of being found to be in a state of disrepair. Total repair shall be completed as soon as possible.

J. Storage

1. An ICF/DD shall ensure that there are sufficient and appropriate storage facilities.

2. An ICF/DD shall securely lock storage spaces containing all potentially harmful materials. Keys to such storage spaces shall only be available to authorized individuals.

K. Electrical Systems

1. An ICF/DD shall ensure that all electrical equipment, wiring, switches, sockets and outlets are maintained in good order and safe condition.

2. An ICF/DD shall ensure that any room, corridor or stairway within an ICF/DD shall be sufficiently illuminated.

3. An ICF/DD shall provide adequate lighting of exterior areas to ensure the safety of individuals and staff during the night.

L. Temperature

1. An ICF/DD shall take all reasonable precautions to ensure that heating elements, including exposed hot water pipes, are insulated and installed in a manner that ensures the safety of individuals.

2. An ICF/DD shall maintain the spaces used by individuals at a temperature range of 71-81 degrees F.

3. An ICF/DD shall not use open flame heating equipment.

4. Water. Hot water temperatures shall not exceed 110 degrees F. where individuals are not able to regulate temperature independently.

M. Finishes and Surfaces

1. An ICF/DD shall not utilize any excessively rough surface or finish where this surface or finish may present a safety hazard to individuals.

2. An ICF/DD shall not have walls or ceilings surfaced with materials containing asbestos.

3. An ICF/DD shall not use lead paint for any purpose within the ICF/DD or on the exterior or grounds of the ICF/DD, nor shall the ICF/DD purchase any equipment, furnishings or decoration with lead paint. If an existing facility is to be converted to an ICF/DD, the facility shall be

tested and certified to be free of asbestos or lead paint materials.

4. An ICF/DD which accepts individuals for placement who are under six years of age, mentally retarded or severely emotionally disturbed shall have evidence that the ICF/DD has been found to be free of lead paint hazards.

N. Laundry Space. An ICF/DD shall have a laundry space complete with washer(s) and dryer(s).

O. An ICF/DD shall have a minimum of 60 square feet of interior floor area for each client that is accessible to clients excluding hallways, closets, bathrooms, bedrooms, offices, staff quarters, laundry areas, storage areas and any other areas not accessible to or usable by clients for normal social and recreational activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3212 (December 2012).

§8615. General Facility Safety Practices

A. An ICF/DD shall not maintain any firearm or chemical weapon in the living units of the facility.

B. An ICF/DD shall ensure that all poisonous, toxic and flammable materials are safely stored in appropriate containers labeled as to contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of individuals, staff and visitors.

C. An ICF/DD shall ensure that an appropriately equipped first-aid kit is available in the ICF/DD's buildings and in all vehicles used to transport individuals.

D. An ICF/DD shall ensure that porches, elevated walkways and elevated recreational areas within the facility meet ANSI standards.

E. Every required exit in an ICF/DD's buildings shall be continuously maintained free of all obstructions or impediments to immediate use in the case of fire or other emergency.

F. An ICF/DD shall prohibit the use of candles in sleeping areas of the individuals.

G. Power driven equipment used by an ICF/DD shall be kept in safe and good repair. Such equipment shall be used by individuals only under the direct supervision of a staff member and according to state law.

H. An ICF/DD shall have procedures to prevent insect and rodent infestation.

I. An ICF/DD shall allow individuals to swim only in areas determined to be safe and only under the supervision of a person with a current water safety instructor certificate or senior lifesaving certificate from the Red Cross or its equivalent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3213 (December 2012).

Chapter 87. Adult Brain Injury Facilities Licensing Standards

Subchapter A. General Provisions

§8701. Introduction

A. These rules and regulations contain the minimum licensure standards for adult brain injury facilities, pursuant to R.S. 40:2120.31-40:2120.40. Brain injuries may result in mild, moderate or severe impairments in cognition, physical functioning and psychosocial behavior. Unique care is necessary to rehabilitate and provide for the needs of these individuals in order for them to achieve their fullest capacity. It is the intent of these minimum licensing standards to protect the health, safety, and well-being of the citizens of the state who suffer from brain injuries and are receiving care in an adult brain injury facility. Contained herein are the core requirements for adult brain injury facilities as well as level specific requirements, depending upon the services provided in the following settings:

1. residential level of care;
2. community living level of care; and
3. outpatient level of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2164 (November 2017).

§8703. Definitions

Abuse—the willful infliction of physical or mental injury on an individual by other parties, including but not limited to such means as sexual abuse, exploitation, or extortion of funds or other things of value, unreasonable confinement and/or intimidation to such an extent that his/her health, self-determination or emotional well-being is endangered.

Acquired Brain Injury—an injury to the brain that has occurred after birth and is not hereditary, congenital, or degenerative. The injury commonly results in a change in neuronal activity, which affects the physical integrity, the metabolic activity or the functional ability of the cell. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustments. The term does not refer to brain injuries induced by birth trauma.

Activities of Daily Living (*ADLs*)—activities considered the basic, vital, daily activities for persons and are identified as bathing, grooming, dressing, dining, toileting and ambulation/transfer.

Adult—an individual 18 years of age or older.

Adult Brain Injury (*ABI*) *Facility*—any of the following:

1. *residential level of care*—a facility publicly or privately owned, located at one or more geographic addresses, providing a rehabilitative treatment environment which serves four or more adults who suffer from brain injury and at least one of whom is not related to the operator. Services shall include personal assistance or supervision for a period of 24 hours continuously per day preparing them for community integration. Such services shall be provided by adult brain injury facilities licensed to provide residential level of care services;

2. *community living level of care*—a home or apartment publicly or privately owned, providing a rehabilitative treatment environment which serves one to six adults who suffer from brain injury and at least one of whom is not related to the operator. Services may include personal assistance or supervision for a period of up to 24 hours continuously per day in a home or apartment setting preparing them for community integration:

a. the apartment or home shall contain, at a minimum, a living/dining/bedroom area, kitchen/kitchenette, bathroom and storage space;

b. there shall be no more than three bedrooms in an apartment and no more than six beds per home;

c. such treatment environment shall be provided by adult brain injury facilities licensed to provide community living level of care services;

3. *outpatient level of care*—a facility publicly or privately owned providing an outpatient rehabilitative treatment environment which serves adults who suffer from brain injury, at least one of whom is not related to the operator, in an outpatient day treatment setting in order to advance the individual's independence for higher level of community or transition to a greater level of independence in community or vocational function. Such services shall be provided by adult brain injury facilities licensed to provide outpatient level of care services.

Assistance with Activities of Daily Living—services that provide assistance with activities of daily living. Such assistance may be the actual performance of the task for the individual, providing hands-on assistance with the performance of the tasks, or supervision and prompting to allow the individual to self-perform such tasks.

Behavioral Services—services that identify maladaptive behaviors which interfere with the person's safe integration into the community and the formulation of an inclusive behavior management program to decrease identified maladaptive behaviors.

Brain Injury—an acquired or traumatic injury to the brain. Such term does not include brain dysfunction caused by congenital disorders, degenerative disorders or birth trauma but may include brain injuries caused by anoxia due to trauma.

Cessation of Business—the ABI facility is non-operational and/or has stopped offering or providing services to the community.

Client—an individual receiving care from an ABI facility who is medically stable and does not require an IV, a functioning feeding tube, or other artificial or mechanical supports for life sustaining processes.

Cognitive Rehabilitation—a systematic, functionally oriented service of therapeutic cognitive activities based on an assessment and an understanding of the behavior of a client. Services are directed to achieve functional improvement by either:

1. reinforcing, strengthening or re-establishing previously learned patterns of behavior; or

2. establishing new patterns of cognitive activity or mechanisms to compensate for impaired neurological systems.

Community Integration—the participation in the mainstream of community life and maintaining social relationships with family members, peers and others in the community who do not have brain injuries. Integration also means that clients have equal access to and full participation in community resources and activities available to the general public at the maximum amount of safety and independence as possible.

Department (*LDH*)—the Louisiana Department of Health, formerly known as Department of Health and Hospitals or DHH.

Direct Care Staff—an employee of the facility, either contracted or directly employed, who provides personal care services to the clients. Such services may include, but are not limited to, assistance with ADLs and IADLs.

Director—the person designated by the owner or governing body as responsible for carrying out the day-to-day management, administration, supervision and operation of the facility.

Employed—performance of a job or task for compensation, such as wages or a salary. An employed person may be one who is contracted or one who is hired directly.

Functional Limitations—actual behaviors or mental or physical disabilities exhibited by adults with brain injuries or conditions presented by their environment, or both, that shall be modified or minimized in order for clients to fulfill their potential or maximize their functioning.

Head Injury—a traumatic or acquired brain injury.

Health Standards Section (*HSS*)—the agency or office within the Louisiana Department of Health with the responsibility for the inspection and licensure of adult brain injury facilities.

Impairment—any loss or abnormality of psychological, cognitive, physiological, or anatomical structure or functioning.

Instrumental Activities of Daily Living (*IADLs*)—activities considered to be instrumental, essential activities for persons, but are not usually considered as basic or vital

activities of daily living, and may not be daily activities. Such activities include, but are not limited to:

1. socialization;

2. managing personal affairs;

3 financial management;

4 shopping;

5. housekeeping; and

6. appropriate transportation, correspondence, behavior and health management, etc.

Medication Management Program—a systematic, functionally, oriented program formulated in consultation with the client's primary provider and implemented by staff, either contracted or directly employed, and trained by a nursing director. The program shall be based upon an assessment and understanding of the behaviors of the client and recognition of the unique medical and pharmacological needs of the client. It shall also mean an incorporation of the most appropriate level of assistance necessary to advance towards independence.

Neglect—the failure to provide food, shelter, clothing, medical or other health services, appropriate security and supervision or other personal services necessary for a client's well-being.

Non-Operational—the ABI facility is not open and available for business operation as stated on the licensing application and business location signage.

Nursing Director—a person who meets the legal requirement of a registered nurse (RN) in the state of Louisiana.

Personal Care—services and supports including but not limited to:

1. bathing, hair care, skin care, shaving, nail care, oral hygiene, overall hygiene and activities of daily living;

2. interventions to assist with eating and bowel and bladder management;

3. positioning;

4. care of adaptive personal care devices; and

5. an appropriate level of supervision.

Primary Provider—a provider, board-certified in his/her specialty, who currently holds a valid license in Louisiana and is responsible for overseeing the decision making process for admission and continued stay of clients.

Rehabilitation—the process of providing those comprehensive services deemed appropriate to the needs of a client in a coordinated manner in a program designed to achieve functional objectives of improved health, welfare, maximum physical, cognitive, social, psychological and community functioning.

Rehabilitative Treatment Environment—a rehabilitation setting that provides for all of the following:

1. a provision of a range of choices, with personal preference, self-determination and dignity of risks receiving full respect and consideration;

2. a variety of social interactions that promote community integration;

3. an environment of peer support and mentorship;

4. professional team involvement;

5. a physical environment conducive to enhancing the functional abilities of the client;

6 necessary therapeutic services which may include social work, behavioral services, speech therapy, physical therapy, occupational therapy, vocational services and therapeutic recreational services;

NOTE: All therapeutic providers shall be licensed under state and, if applicable, national boards.

7. a medication management program;

8. cognitive rehabilitation activities; and

9. the identification of functional limitations.

Representative—a person who voluntarily, with the client's written authorization, may act upon the client's direction regarding matters concerning the health and welfare of the client, including having access to personal records contained in the client's file and receiving information and notices about the client's overall care and condition.

1. No member of the governing body, administration or staff, either contracted or directly employed, of an ABI facility or any member of their family may serve as the representative for a client unless they are related to the client by blood or marriage.

2. In the case of an individual that has been interdicted, the representative is the court-appointed curator or his/her designee.

Support—activities, materials, equipment, or other services designed and implemented to assist the client with a brain injury. Examples include, but are not limited to:

1. instruction;

2. training;

3. assistive technology; or

4. removal of architectural barriers.

Therapeutic Recreational Services—services that identify leisure activities and assistance in modifying and adapting identified leisure activities to allow safe participation by the client as a means to improve quality of life and aid in integration into the community.

Traumatic Brain Injury—an insult to the brain, not of a degenerative or congenital nature, caused by an external physical force that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or physical functioning. It can also result

in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functioning disability, or psychosocial maladjustment.

Vocational Services—services provided directly or through cooperating agencies to a client in accordance with his individualized plan and designed to improve or enhance skills and behaviors necessary for successful placement in a volunteer or work setting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2165 (November 2017).

§8705. Licensure Requirements

A. Any entity or person(s) that operates an ABI facility shall have a license issued from the Department of Health (LDH). LDH is the only licensing authority for ABI facilities in the State of Louisiana. It shall be unlawful to establish, open, operate, manage, maintain or conduct services of an ABI facility without possessing a current, valid license issued by LDH. Each facility shall be separately licensed.

B. The department may issue a license to an ABI facility to provide any or all of the following services:

1. residential services (a license is required for each offsite location);

2. community services; and

3. outpatient services.

C. The department may issue multiple licenses to a single facility in accordance with the number of offsite locations operated by such facility.

D. An ABI facility license shall:

1. be issued only to the person or entity named in the license application;

2. be valid only for the entity or person to which it is issued and only for the specific geographic address(es) of each facility owned and operated by the entity or person;

3. be valid for one year from the date of issuance, unless revoked, suspended, modified or terminated prior to that date, or unless a provisional license is issued;

4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the ABI facility;

5. not be subject to sale, assignment, donation or other transfer, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

E. In order for the ABI facility to be considered operational and retain licensed status, the facility shall meet the following conditions:

1. The residential ABI facility shall continuously have at least one employee available by telephone or telecommunications for the ABI facility 24 hours per day, 7 days per week.

2. There shall be staff member(s), either contracted or directly employed, on-site at all times when there are clients present sufficient to meet the needs of the clients.

3. The ABI facility shall have provided services to at least two clients in the preceding 12 months prior to licensure renewal.

F. The licensed ABI facility shall abide by and adhere to any state law, rules, policy, procedure, manual or memorandums pertaining to ABI facilities.

G. A separately licensed ABI facility shall not use a name which is substantially the same as the name of another ABI facility licensed by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2167 (November 2017).

§8707. Initial Licensure Application Process

A. An initial application for licensing as an ABI facility shall be obtained from the department. A completed initial license application packet for an ABI facility shall be submitted to, and approved by, LDH prior to an applicant providing adult brain injury services. An applicant shall submit a completed initial licensing packet to LDH, which shall include:

1. a completed ABI facility licensure application and the non-refundable licensing fee as established by statute;

2. the type of facility or facilities the applicant intends to operate (residential, community or outpatient);

3. a copy of the approval letter of the architectural facility plans from the entity/office designated by the department to review and approve healthcare facilities' architectural and licensing plans (residential);

4. a copy of the on-site inspection report with approval for occupancy by the Office of the State Fire Marshal (OSFM) (residential and outpatient only);

5. a copy of the health inspection report with approval of occupancy from the Office of Public Health (OPH) (residential and outpatient only);

6. a copy of a statewide criminal background check conducted by the Louisiana State Police, or its authorized agent, on all owners;

7. proof of financial viability as evidenced by one of the following:

a. verification of sufficient assets equal to $100,000 or the cost of three months of operation, whichever is less; or

b. a letter of credit issued from a federally insured, licensed lending institution in the amount equal to $100,000 or the cost of three months of operation, whichever is less;

8. proof of general and professional liability insurance of at least $300,000;

9. proof of worker's compensation insurance;

10. if applicable, clinical laboratory improvement amendments (CLIA) certificate;

11. disclosure of ownership and control information;

12. a readable 11x17 minimum copy floor sketch of the premises to be licensed, including room usage and dimensions (residential and outpatient only);

13. the days and hours of operation (outpatient only);

14. a copy of the articles of organization or articles of incorporation;

15. any other documentation or information required by the department for licensure.

B. If the initial licensing packet is incomplete, the department will notify the applicant of the missing information and the deadline to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days of notification, the application will be closed. Once an initial licensing application is closed, an applicant who is still interested in becoming an ABI facility shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application has been approved by LDH, the ABI facility applicant shall notify LDH of readiness for an initial survey. If an applicant fails to notify LDH of readiness for an initial survey within 90 days of approval of the application, the application will be closed.

1. After an initial licensing application is closed, an applicant who is still interested in becoming an ABI facility shall submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

D. Applicants shall be in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the department will issue the ABI facility an initial license to operate.

E. When issued, the initial ABI facility license shall specify the number of beds, if applicable (residential facility only) and the type(s) of service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2167 (November 2017).

§8709. Initial Licensure Surveys

A. Prior to the initial license being issued to the ABI facility, an initial licensing survey shall be conducted on-site at the ABI facility to assure compliance with the ABI facility licensing standards. The initial licensing survey of an ABI facility shall be an announced survey.

B. No client shall be provided services by the ABI facility until a license is issued to the ABI facility by the LDH.

C. Once an ABI facility has been issued an initial license, the department shall conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other applicable statutes, laws, ordinances, rules and regulations. These surveys shall be unannounced.

1. A plan of correction may be required from an ABI facility for any survey where deficiencies have been cited. Such plan of correction shall be submitted to LDH for approval within the prescribed timeframe.

2. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices.

3. The department may issue appropriate sanctions, including, but not limited to, civil fines, directed plans of correction, provisional licensure and license revocation for deficiencies and non-compliance with any survey.

4. Pursuant to applicable state law, rules and regulations, monies collected from the imposition of civil fines shall be used for the benefit of clients in adult brain injury facilities.

D. The department's surveyors and staff shall be:

1. given access to all areas of the facility and all relevant files during any licensing or other survey; and

2. allowed to interview any facility staff, participant, or person receiving services, as relevant and necessary to conduct a survey or investigation.

E. The department shall issue written notice to the facility of the results of any survey in a statement of deficiencies, along with notice for a plan of correction, if appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2168 (November 2017).

§8711. Complaint Investigations

A. The department shall conduct complaint investigations in accordance with R.S. 40:2009.13 et seq.

B. Complaint investigations shall be unannounced.

C. Upon request by the department, an acceptable plan of correction shall be submitted by the facility for any complaint investigation where deficiencies have been cited. Such plan of correction shall be submitted within the prescribed timeframe.

D. A follow-up survey may be conducted for any complaint investigation where deficiencies have been cited to ensure correction of the deficient practices.

E. The department may issue appropriate sanctions, including but not limited to, civil fines, directed plans of correction, provisional licensure, denial of license renewal and license revocation for non-compliance with any state law or regulation.

F. The department's surveyors and staff shall be:

1. given access to all areas of the ABI facility and all relevant files during any complaint investigation; and

2. allowed to interview any facility staff or resident, as necessary or required to conduct the investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2168 (November 2017).

§8713. Statement of Deficiencies

A. The following statements of deficiencies issued by the department to an ABI facility shall be displayed in a prominent place in the facility premises:

1. the most recent annual survey statement of deficiencies; and

2. any subsequent complaint survey statement of deficiencies.

B. Any statement of deficiencies issued by the department to an ABI facility shall be available for disclosure to the public 30 calendar days after the facility submits an acceptable plan of correction of the deficiencies or 90 calendar days after the statement of deficiencies is issued to the facility, whichever occurs first.

C. Unless otherwise provided in statute or in this Chapter, a facility shall have the right to an informal reconsideration for any deficiencies cited as a result of a survey or investigation.

1. Correction of the deficient practice, the violation, or the noncompliance shall not be the basis for the reconsideration.

2. The informal reconsideration of the deficiencies shall be submitted in writing within 10 calendar days of receipt of the statement of deficiencies, unless otherwise provided for in these provisions.

3. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this Chapter for license denials, revocations and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. The facility shall be notified in writing of the results of the informal reconsideration.

6. The request for an informal reconsideration of any deficiencies cited as a result of a survey or investigation does not delay submission of the required plan of correction within the prescribed timeframe.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2168 (November 2017).

§8715. Types of Licenses

A. In the event that the initial licensing survey finds that the ABI facility is compliant with all licensing laws and regulations, and is compliant with all other applicable required statutes, laws, ordinances, rules, regulations and fees, the department shall issue a full license to the facility. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, or suspended.

B. In the event that the initial licensing survey finds that the ABI facility is non-compliant with any licensing laws or regulations or any other applicable required statutes, laws, ordinances, rules or regulations, but the department in its sole discretion determines that the non-compliance does not present a threat to the health, safety or welfare of the participants or persons receiving services, the department may issue a provisional initial license for a period not to exceed six months.

1. The facility shall submit a plan of correction to LDH for approval and shall be required to correct all such non-compliance or deficiencies prior to the expiration of the provisional license.

a. If all such non-compliance or deficiencies are determined by the department to be corrected on a follow-up survey, a full license will be issued.

b. If all such non-compliance or deficiencies are not corrected on the follow-up survey, or if new deficiencies that are a threat to the health, safety or welfare of the client(s) are cited on the follow-up, the provisional license will expire.

i. If the applicant still wishes to operate as an ABI facility, it shall begin the initial licensing process again by submitting a new initial license application packet and fee.

C. The department may renew the license of an existing licensed ABI facility that is in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked or suspended.

D. The department, in its sole discretion, may issue a provisional license to a licensed ABI facility for a period not to exceed six months, for any one of the following reasons:

1. the ABI facility has more than five deficient practices or deficiencies cited during any one survey;

2. the ABI facility has more than three validated complaints in one licensed year period;

3. the ABI facility has been issued a deficiency that involved placing a participant at risk for serious harm or death;

4. the ABI facility has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey;

5. the ABI facility is not in substantial compliance with all applicable federal, state, departmental and local statutes, laws, ordinances, rules, regulations and fees at the time of renewal of the license; or

6. there is documented evidence that a representative of the facility has, with or without the knowledge or consent of facility's owner, medical director and/or administrator/director, bribed, harassed, offered, paid for or received something of economic value for the referral of an individual to use the services of a particular brain injury facility.

E. When the department issues a provisional license to a licensed ABI facility, the department may conduct an on-site follow-up survey at the ABI facility prior to the expiration of the provisional license. The existing facility with a provisional license is required to correct all non-compliance or deficiencies at the time the follow-up survey is conducted.

1. If the on-site follow-up survey determines that the ABI facility has corrected the deficient practices and has maintained compliance during the period of the provisional license, the department may issue a full license for the remainder of the year until the anniversary date of the ABI facility license.

2. If the on-site follow-up survey determines that the ABI facility has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional license shall expire.

a. If this occurs, the facility shall coordinate and arrange for discharge or transfer of the clients, as appropriate.

F. If a licensed ABI facility has been issued a notice of license revocation, suspension or modification, and the facility's license is due for annual renewal, the department shall deny the license renewal. The denial of the license renewal does not affect the license revocation, suspension or modification, or any other sanction imposed by the department for violations prior to the denial of the renewal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2169 (November 2017).

§8717. Changes in Licensee Information or Key Personnel

A. A license shall apply only to the location stated on the application and such license, once issued, shall not be transferable from one place to another or from one person to another.

B. Any change in the facility regarding the following shall be reported in writing to the department no less than five days prior to the change:

1. entity name;

2. doing business as (dba) name;

3. geographic address;

4. mailing address and/or electronic address; and

5. telephone number(s) and fax number(s).

C. For a change in facility address, a new license with a new license number will be issued upon receipt by the department of a new completed application and the licensing fee required for a change of address. The anniversary date shall be changed to reflect the date of issuance of the new license.

D. Any change regarding the ABI facility's key administrative personnel shall be reported in writing to the department within five days of the change. Key administrative personnel include the facility director and the nursing director. The facility's notice to the department shall include the individual's name, address, hire date and qualifications.

E. Any request for a duplicate license shall be accompanied by the required fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2169 (November 2017).

§8719. Change of Ownership

A. The license of an ABI facility is not transferable or assignable and cannot be sold.

B. A change of ownership (CHOW) of the facility shall be reported in writing to the department within five days of the change of ownership.

C. A CHOW of a facility shall not be submitted at time of the annual renewal of the facility's license.

D. Before an initial license can be issued to the new owner, all licensing application requirements in accordance with the provisions of this Chapter shall be met.

E. The applicant shall submit to the department, pursuant to §8707 above, the following licensing requirements, including but not limited to:

1. the completed facility license application and non-refundable fee;

2. the disclosure of ownership documentation;

3. a copy of a statewide criminal background check conducted by the Louisiana State Police, or its authorized agent, on all owners;

4. proof of financial viability as evidenced by one of the following:

a. verification of sufficient assets equal to $100,000 or the cost of three months of operation, whichever is less; or

b. a letter of credit issued from a federally insured, licensed lending institution in the amount equal to $100,000 or the cost of three months of operation, whichever is less;

5. proof of general and professional liability insurance of at least $300,000;

6. proof of worker's compensation insurance;

7. if applicable, CLIA certificate of waiver;

8. disclosure of ownership and control information;

9. the days and hours of operation (outpatient only);

10. a copy of the articles of organization or articles of incorporation; and

11. any other documentation or information required by the department for licensure.

F. An ABI facility may not undergo a CHOW if any of the following conditions exist:

1. an ABI facility whose licensure is provisional, is under revocation or is in denial of renewal;

2. an ABI facility is in a settlement agreement with the department; and/or

3. an ABI facility has ceased to operate and does not meet operational requirements to hold a license.

G. The department may deny approval of the CHOW for any of the reasons a license may be revoked or denied renewal pursuant to these licensing provisions.

H. If the CHOW results in a change of geographic address, an on-site survey shall be required prior to issuance of the new license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2170 (November 2017).

§8721. Renewal of License

A. License Renewal Application

1. In order to renew a license, the ABI facility shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license.

2. The license renewal application packet shall include:

a. the license renewal application;

b. a current fire inspection and a current health inspection, if applicable;

c. the license renewal fee; and

d. any other document required by the department.

3. Upon receipt of the completed license renewal application packet, the department shall determine if the ABI facility continues to meet the statutory and regulatory requirements for ABI facilities. The department may perform an on-site survey upon annual renewal at intervals deemed necessary by the department to determine compliance.

4. Failure to submit to the department a completed license renewal application packet prior to the expiration of the current license will result in the voluntary surrender of the ABI facility license.

a. There is no right to an informal reconsideration or an administrative appeal of a voluntary surrender of a license by the facility.

B. The renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2170 (November 2017).

§8723. Denial of License, Revocation of License, License Suspension and Denial of License Renewal

A. The department may deny an application for a license, may deny a license renewal, may suspend a license or may revoke a license in accordance with the provisions of the Administrative Procedure Act (APA).

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the ABI facility is non-compliant with any licensing laws or regulations that present a potential threat to the health, safety, or welfare of the clients or persons receiving services.

2. The department shall deny an initial license in the event that the initial licensing survey finds that the ABI facility is non-compliant with any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety or welfare of the clients or persons receiving services.

3. The department shall deny an initial license for any of the reasons that a license may be revoked or denied renewal.

C. Revocation of License, Suspension of License or Denial of License Renewal. An ABI facility license may be revoked, suspended, or denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the ABI facility licensing laws, rules and regulations;

2. failure to be in substantial compliance with other applicable statutes, laws, ordinances, rules or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. failure to uphold client rights whereby deficient practices may result in harm, injury or death of a client;

5. failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation; or

e. harassment;

6. failure to notify the proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof.

7. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical, client or facility records;

d. matters under investigation by the department or the Office of the Attorney General;

e. information submitted for reimbursement from any payment source;

8. knowingly making a false statement or providing false, forged or altered information or documentation to LDH employees or to law enforcement agencies;

9. the use of false, fraudulent or misleading advertising;

10. fraudulent operation of an ABI facility by the owner, director/administrator or manager;

11. an owner, officer, member, manager, director/administrator or person designated to manage or supervise participant care has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court;

NOTE: For purposes of this paragraph, conviction of a felony means a felony relating to the violence, abuse or negligence of a person, or to the misappropriation of property belonging to another person.

12. failure to comply with all reporting requirements in a timely manner as required by the department;

13. submission of non-sufficient funds for any payment to the department;

14. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview facility staff or participants;

15. failure to allow or refusal to allow access to authorized departmental personnel to records; or

16. bribery, harassment, or intimidation of any participant designed to cause that participant to use the services of any particular ABI facility.

E. If the secretary of the department determines that violations of the facility pose an imminent or immediate threat to the health, welfare or safety of a participant or person receiving services, the secretary may suspend the license. A license suspension is immediate and shall be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the facility will be notified in writing of such determination.

F. In the event an ABI facility license is revoked, suspended or renewal is denied, any owner, officer, member, manager and director/administrator of such ABI facility is prohibited from owning, managing, directing or operating another ABI facility for a period of two years from the date of the final disposition of the revocation, suspension or denial action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2170 (November 2017).

§8725. Notice and Appeal of License Denial, License Revocation, License Suspension and Denial of License Renewal

A. Notice of a license denial, license revocation, license suspension or denial of license renewal shall be given to the facility in writing.

B. The ABI facility has a right to an administrative reconsideration of the license denial, license revocation, license suspension or denial of license renewal.

1. The ABI facility has 15 calendar days from the receipt of the notice of the license denial, license revocation or denial of license renewal to request an administrative reconsideration. The request for administrative reconsideration shall be in writing and shall be forwarded to the department's Health Standards Section.

2. The request for administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received by the Health Standards Section, an administrative reconsideration shall be scheduled; the facility shall be notified in writing of the scheduled date.

4. The facility shall have the right to appear in person at the administrative informal reconsideration; the facility may be represented by counsel at the administrative reconsideration.

5. Correction of a violation or deficiency which is the basis for the denial, revocation, suspension or denial of license renewal shall not be a basis for reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The facility will be notified in writing of the results of the administrative reconsideration.

C. The ABI facility has a right to an administrative appeal of the license denial, license revocation, license suspension or denial of license renewal.

1. The ABI facility has 30 days from receipt of the notice of the results of the administrative reconsideration of the license denial, license revocation, license suspension or denial of license renewal to request an administrative appeal.

a. The ABI facility may forego its rights to an administrative reconsideration, and if so, shall request the administrative appeal within 30 calendar days of the receipt of the written notice of the initial license denial, license suspension, revocation or non-denial of license renewal.

b. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law (DAL) or its successor.

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal of a license revocation or denial of license renewal is made, then the license revocation or denial of license renewal action shall be suspensive during the pendency of the appeal. The facility shall be allowed to continue to operate and provide services until such time as the department issues a final administrative decision.

4. A license suspension is immediate and shall be enforced during the pendency of the administrative appeal.

5. Correction of a violation or deficiency which is the basis for the denial, revocation or denial of license renewal shall not be a basis for the administrative appeal.

D. If a timely administrative appeal has been filed by the facility on an initial license denial, denial of license renewal or license revocation, the DAL, or its successor, shall conduct the hearing in accordance with the APA.

1. If the final agency decision is to reverse the initial license denial, denial of license renewal or license revocation, the facility's license will be re-instated or granted upon the payment of any licensing fees, outstanding sanctions or other fees due to the department.

2. If the final agency decision is to affirm the denial of license renewal or license revocation, the facility shall discharge any and all clients receiving services according to the provisions of this Chapter.

a. Within 10 calendar days of the final agency decision, the facility shall notify HSS, in writing, of the secure and confidential location where the client records will be stored and the name and contact information of the person(s) responsible for the client records.

E. There is no right to an informal reconsideration or an administrative appeal of the issuance or expiration of a provisional license.

F. A facility with a provisional license that expires due to deficiencies cited at the follow-up survey shall have the right to an informal reconsideration and the right to an administrative appeal only as to the validity of such cited deficiencies.

1. The correction of any deficiency after the follow-up survey shall not be the basis for the informal reconsideration or for the administrative appeal.

2. The informal reconsideration and the administrative appeal are limited to the whether the deficiencies were properly cited at the follow-up survey.

3. The facility shall request the informal reconsideration within five days of receipt of the notice of the results of the follow-up survey from the department.

4. The facility shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department.

5. A facility with a provisional license that expires under the provisions of this Subsection shall cease providing services unless the DAL issues a stay of the expiration. The stay may be granted by the DAL upon application by the facility at the time the administrative appeal is filed and only after a contradictory hearing and only upon a showing that there is no potential harm to the clients being served by the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2171 (November 2017).

§8727. Cessation of Business

A. A cessation of business or closure is deemed to be effective the date on which the facility stops providing services to the community or clients.

1. Except as provided in §8729 (Temporary Inactivation of a License Due to a Declared Disaster or Emergency) and §8731 (Inactivation of License due to Non-Declared Emergency or Disaster) of these licensing regulations, a license shall be immediately null and void if an ABI facility ceases to operate.

B. A cessation of business is considered to be a voluntary action on the part of the facility. As such, there is no right to an informal reconsideration and no right to an administrative appeal of a cessation of business or voluntary closure.

C. Upon the cessation of business, the facility shall immediately return the original license to the department.

D. A facility that intends to close or cease operations shall comply with the following procedures:

1. give 30 days advance written notice to:

a. the department;

b. clients; and

c. attending physicians; and

2. provide for an orderly discharge and transition of all clients admitted to the facility.

E. In addition to the 30 days advance written notice, the facility shall submit a written plan for the disposition of client services-related records for approval by the department. The plan shall include the following:

1. the effective date of the closure;

2. provisions that comply with federal and state laws on storage, maintenance, access and confidentiality of the closed facility's client services-related records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing facility, at least 15 days prior to the effective date of closure.

F. If a facility fails to follow these procedures, the owners, managers, officers, directors and administrators may be prohibited from opening, managing, directing, operating or owning an ABI facility for a period of two years.

G. Once the facility has ceased doing business, the facility shall not provide services until the facility has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2172 (November 2017).

§8729. Inactivation of a License Due to a Declared Disaster or Emergency

A. A facility licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the facility shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the facility has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the facility intends to resume operation as an ABI facility in the same service area;

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

d. includes an attestation that all clients have been properly discharged or transferred to another facility; and

e. provides a list of each client and where that client is discharged or transferred;

2. the facility resumes operating as an ABI facility in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766;

3. the ABI facility continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the ABI facility continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate an ABI facility license, the department shall issue a notice of inactivation of license to the ABI facility.

C. Upon completion of repairs, renovations, rebuilding or replacement, the ABI facility which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The ABI facility shall submit a written license reinstatement request to the licensing agency of the department at least 15 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening, and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The facility resumes operating as an ABI facility in the same service area within one year.

D. Upon receiving a completed written request to reinstate an ABI facility license, the department may conduct a licensing survey. If the ABI facility meets the requirements for licensure and the requirements under this Section, the department will issue a notice of reinstatement of the ABI facility license.

1. The licensed capacity of the reinstated license shall not exceed the licensed capacity as approved by the OSFM.

E. No change of ownership in the ABI facility shall occur until such ABI facility has completed repairs,

renovations, rebuilding or replacement construction, and has resumed operations as an ABI facility.

F. The provisions of this Section shall not apply to an ABI facility which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the ABI facility license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2173 (November 2017).

§8731. Inactivation of License due to Non-Declared Emergency or Disaster

A. An ABI facility in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

1. the ABI facility shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

a. the ABI facility has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

b. the ABI facility intends to resume operation as an ABI facility in the same service area;

c. the ABI facility attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

d. the ABI facility's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility;

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

2. the ABI facility continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil fines; and

3. the ABI facility continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to temporarily inactivate an ABI facility license, the department shall issue a notice of inactivation of license to the ABI facility.

C. Upon the ABI facility's receipt of the department's approval of request to inactivate the ABI facility's license, the ABI facility shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility to the OSFM and the OPH as required.

D. The ABI facility shall resume operating in the same service area within one year of the approval of renovation/construction plans by the OSFM and the OPH as required.

EXCEPTION: If the ABI facility requires an extension of this timeframe due to circumstances beyond the ABI facility's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the ABI facility's active efforts to complete construction or repairs and the reasons for request for extension of the ABI facility's inactive license. Any approvals for extension are at the sole discretion of the department.

E. Upon completion of repairs, renovations, rebuilding or replacement of the facility, an ABI facility which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the ABI facility shall submit a written license reinstatement request to the licensing agency of the department;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing or physical environment survey; and

3. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

F. Upon receiving a completed written request to reinstate an ABI facility license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the ABI facility has met the requirements for licensure including the requirements of this Subsection.

NOTE: The licensed capacity of the reinstated license shall not exceed the licensed capacity as approved by the OSFM.

G. No change of ownership of the ABI facility shall occur until such facility has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as an ABI facility.

H. The provisions of this Section shall not apply to an ABI facility which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the ABI facility license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2173 (November 2017).

§8733. Operating Without a License or in Violation of Departmental Regulations, Fines and Injunctive Relief

A. In accordance with applicable state laws, rules and regulations, the department shall fine any ABI facility that operates without a valid license issued by the department, or operates in violation of departmental regulations. Such fines

are not to exceed two hundred fifty dollars for each day of such offense.

B. Any such fines levied and collected by the department, subject to applicable law, shall be used for the benefit of clients in ABI facilities and shall be distributed in accordance with criteria promulgated by rules of the department.

C. Notwithstanding the provisions of this Section, the department may impose a fine(s) pursuant to R.S. 40:2199 and the regulations promulgated thereunder.

D. The facility may request an administrative reconsideration and/or an administrative appeal of a fine in accordance with the delay, notice and other procedures set forth in R.S. 40:2199 and the regulations promulgated thereunder.

E. If any ABI facility operates without a valid license issued by the department, or in violation of departmental regulations, the department may cause a civil suit to be instituted in a district court in the parish in which the facility is located for injunctive relief, including a temporary restraining order, to restrain the institution, society, agency, corporation, person or persons or any group operating the facility from continuing the violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2174 (November 2017).

§8735. Fees

A. Any remittance submitted to the department in payment of a required fee shall be in the form of a company or certified check or money order made payable to the "Louisiana Department of Health".

B. Fee amounts shall be determined by the department.

C. Fees paid to the department are not refundable.

D. A fee is required to be submitted with:

1. an initial application;

2. a renewal application;

3. a change of controlling ownership;

4. a change of name or physical address; and

5. each offsite residential location.

E. Submission of fees that are returned for non-sufficient funds may result in the license being denied, either initially or at time for renewal, revoked or suspended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2174 (November 2017).

Subchapter B. Organization and Administration

§8741. Governing Body

A. Governing Body. The ABI facility shall have an identifiable governing body which has the responsibility and authority for the policies and procedures of the facility.

1. The governing body shall be designated in writing.

2. When the governing body of a facility is comprised of more than one person, the governing body shall hold formal meetings at least twice a year. There shall be written bylaws specifying frequency of meetings and quorum requirements. There shall be written minutes of all meetings.

3. When the governing body is composed of only one person, this person shall assume all responsibilities of the governing body.

B. Responsibilities of the Governing Body. The governing body of an ABI facility shall:

1. ensure the facility's compliance and conformity with the facility's policies and procedures;

2. ensure the facility's continual compliance and conformity with all relevant federal, state and local laws and regulations;

3. ensure that the facility is adequately funded and fiscally sound;

4. review and approve the facility's annual budget;

5. designate a person to act as director and delegate sufficient authority to this person to manage the facility (a sole owner may be the director);

6. formulate and annually review, in consultation with the director, written policies concerning the facility's philosophy, goals, current services, personnel practices, job descriptions and fiscal management; and

7. annually evaluate the director's performance (if a sole owner is not acting as director).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2174 (November 2017).

§8743. Governing Body Responsibilities

A. An ABI facility shall comply with all federal, state and local laws, rules and regulations in the development and implementation of its policies and procedures. The governing body shall ensure all of the following requirements are met.

B. Policies and Procedures. The facility shall have:

1. written policies and procedures approved by the governing body that address the following:

a. confidentiality of client information and security of client files;

b. advertising;

c. personnel;

d. client's rights;

e. a grievance procedure to include documentation of grievances, investigation, resolution and response to complainant in a timely manner, time frame in which facility will respond, and an appeals process for grievances;

f. safekeeping of personal possessions, if applicable;

g. clients' funds, if applicable;

h. emergency and evacuation procedures;

i. abuse, neglect and exploitation, and documentation and reporting of same;

j. incidents and accidents and documentation of same;

k. admissions and discharge procedures;

l. medication administration; and

m. safety of the client while being transported by an agency employee, either contracted or staff, that includes a process for evaluation of the employee's driver's license status inquiry report which may prohibit an employee from transporting clients;

2. minutes of formal governing body meetings;

3. organizational chart of the facility; and

4. written leases, contracts and purchase-of-service agreements (including all appropriate credentials) to which the facility is a party.

C. Organizational Communication

1. A facility shall establish procedures to assure written communication among personnel to provide continuity of services to all clients.

2. Direct care staff shall have access to information concerning clients that is necessary for effective performance of the employee's assigned tasks.

D. Confidentiality and Security of Records. The facility shall ensure the confidentiality of client records, including information in a computerized medical record system, in accordance with applicable federal privacy laws and any state laws and regulations which provide a more stringent standard of confidentiality than the applicable federal privacy regulations and laws.

1. Information from, or copies of, records may be released only to authorized individuals, and the facility shall ensure that unauthorized individuals cannot gain access to or alter client records.

2. Original medical records shall not be released outside the facility unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster.

E. Clinical Records

1. A facility shall maintain a separate record for each client. Such record shall be current and complete and shall be maintained in the facility or in a central administrative location readily available to facility staff and to the department.

2. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of in accordance with state laws.

3. Each record shall include but not be limited to at least the following information:

a. identifying information to include at least client's name, marital status, date of birth and gender;

b. dates of admission and discharge;

c. client's written authorization and contact information of the representative or responsible person;

d. name and 24-hour contact information for the primary physician and any other physician involved in the client's care;

e. the admission assessment;

f. individual service plan, updates and quarterly reviews;

g. progress notes of care and services received and response to treatment;

h. a record of all personal property and funds which the client has entrusted to the facility; and

i. written acknowledgements that the client has received verbal and written notice of client's rights, grievance procedures and client's responsibilities.

4. Storage of any client information or records may be maintained electronically or in paper form.

a. If stored electronically, documents shall be viewable and reproducible as necessary and relevant.

F. Advertising. A facility shall have written policies and procedures regarding the photographing and audio or audiovisual recordings of clients for the purposes of advertising.

1. No client shall be photographed or recorded without the client's or representatives' prior informed written consent.

a. Such consent cannot be made a condition for admission into, remaining in, or participating fully in the activities of the facility.

b. Consent agreements shall clearly notify the client of his/her rights under this regulation and shall specify precisely what use is to be made of the photograph or recordings.

c. Consents are valid for a maximum of one year from the date of execution.

d. Clients are free to revoke such agreements at any time, either orally or in writing.

2. All photographs and recordings shall be used in a way that respects the dignity and confidentiality of the client.

G. Personnel Policies. A facility shall have written personnel policies that include:

1. orientation, ongoing training, development, supervision and performance evaluation of personnel members;

2. written job descriptions for each position, including volunteers;

3. requirements for a health assessment of personnel prior to employment. These policies shall, at a minimum, require that the individual has no evidence of active tuberculosis and is re-evaluated as recommended by the Office of Public Health;

NOTE: Policies shall be in accordance with state rules, laws and regulations for employees, either contracted or directly employed, and volunteers.

4. abuse prevention and reporting procedures that include what constitutes abuse, how to prevent it and requirement that all personnel report any incident of abuse or neglect to the director or his/her designee, whether that abuse or neglect is done by another staff member, either contracted or directly employed, a family member, a client or any other person;

5. criteria for determining employment based on the results of a statewide criminal background check conducted by the Louisiana State Police, or its designee, which shall be conducted upon hire, rehire and in accordance with facility policy for any unlicensed facility personnel:

a. the facility shall have documentation on the final disposition of all charges that bars employment pursuant to applicable state law; and

6. clarification of the facility's prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media and include, at a minimum, ensuring confidentiality of client information and preservation of client dignity and respect, including protection of client privacy and personal and property rights.

H. Orientation

1. A facility's orientation program shall include training in the following topics for all personnel:

a. the policies and procedures of the facility, including but not limited to the prohibited use of social media;

b. emergency and evacuation procedures;

c. client's rights;

d. abuse and neglect prevention and requirements concerning the reporting of abuse and neglect of clients;

e. procedures for reporting of incidents and accidents; and

f. instruction in the specific duties and responsibilities of the employee's job and a competency evaluation of those duties and responsibilities.

2. Orientation for direct care staff, either contracted or directly employed, shall include the following:

a. training in client care services (ADLs and IADLs) provided by the facility;

b. infection control to include universal precautions;

c. any specialized training to meet clients' needs; and

d. a new employee shall not be given sole responsibility for the implementation of a client's program plan until this training is documented as successfully completed.

3. All direct care staff shall receive and/or have documentation of certification in basic life support and general first aid procedures within the first 30 days of employment. Direct care staff, either contracted or directly employed, shall have this training prior to being assigned sole responsibility for a client's care.

4. In addition to the topics listed above, orientation for direct care staff, either contracted or directly employed, shall include an evaluation to ensure competence to provide ADL and IADL assistance.

5. A new direct care staff employee shall not be assigned to carry out a client's care until competency has been demonstrated and documented.

I. Annual Training

1. A facility shall ensure that each direct care staff participates in required training each year. Routine supervision of direct care staff shall not be considered as meeting this requirement.

2. The facility shall document that direct care staff, either contracted or directly employed, receive training on an annual basis in:

a. facility's policies and procedures;

b. emergency and evacuation procedures;

c. client's rights;

d. abuse and neglect prevention and requirements concerning the reporting of abuse and neglect and incidents and accidents;

e. client care services (ADLs and IADLs);

f. infection control to include universal precautions; and

g. any specialized training to meet clients' needs.

3. All direct care staff, either contracted or directly employed, shall have documentation of current certification in basic life support and general first aid.

J. Evaluation. An employee's annual performance evaluation shall include his/her interaction with clients, family, and other employees.

K. Personnel Files

1. A facility shall maintain a separate personnel record for each employee. At a minimum, this file shall contain the following:

a. the application for employment including the applicant's education, training and experience;

b. a statewide criminal background check conducted by the Louisiana State Police, or its designee, prior to an offer of employment for any unlicensed personnel:

i. the facility shall have documented disposition of any charges, if applicable;

c. evidence of applicable professional credentials;

d. documentation of required health assessment as defined in the facility's policies;

e. annual performance evaluation;

f. employee's hire and termination dates;

g. documentation of orientation and annual training;

h. documentation of competency evaluations for duties assigned, including, but not limited to, safety in transporting clients;

i. documentation of a current, unrestricted driver's license (if driving or transporting clients);

j. documentation of a current driver's license status inquiry report available on-line from the state Office of Motor Vehicles for staff, either contracted or directly employed, who are required to transport clients as part of their assigned duties; and

k. comply with the provisions of R.S. 40:2179-2179.2 and the rules regarding the direct service worker registry.

2. A facility shall not release an employee's personnel file without the employee's written permission, except as required by state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2175 (November 2017).

§8745. Required Staffing

A. Each ABI facility shall be staffed to sufficiently safeguard the health, safety and welfare of the clients, as required by these regulations.

B. At a minimum, the following staff positions are required; however, one person may occupy more than one position.

1. Director

a. Each facility shall have a qualified director who is an employee of the facility. Responsibilities include the day-to-day management, supervision, operation of the facility and ensuring the individual service plan is implemented and carried out.

i. It is the responsibility of the director to contact the client's representative, if applicable, and request assistance to help the client in adjusting to the facility at the first indication of an adjustment problem.

b. During periods of temporary absence of the director, there shall be a responsible staff person designated to be in charge that has the knowledge and authority to handle any situation that may occur.

c. Director Qualifications. The director shall, at least, meet one of the following criteria upon date of hire:

i. a bachelor's degree from an accredited university or college plus two years of experience in the fields of health, social services, geriatrics, management or administration; or

ii. a master's degree from an accredited university or college in geriatrics, health care administration, or in a human service related field or their equivalent; or

iii. in lieu of a degree, six years of experience in health, social services, geriatrics, management, administration or a combination of undergraduate education and experience for a total of six years.

d. The director shall be at least 21 years of age.

2. Nursing Director. The nursing director or an equally qualified RN shall be available by telecommunications or able to be on-site as needed 24 hours/day.

a. Qualifications. Each facility shall have a nursing director who is currently licensed as a registered nurse in Louisiana without restrictions.

b. Responsibilities. The responsibilities of a nursing director are to advance community integration through:

i. overseeing the medication management program, including staff training to implement the program;

ii. assisting the client in the restoration and maintenance of maximal health;

iii. consulting the primary physician to advance the client with their medication management program;

iv. advancing understanding of their unique medical and pharmacological needs;

v. improving the client's quality of life; and

vi. ensuring nursing care is provided in accordance with the client's individual service plan.

3. Designated Recreational/Activity Staff. There shall be an individual designated to organize and oversee the recreational and social program(s) of the facility.

4. Direct Care Staff

a. An ABI facility shall have staff sufficient in number and qualifications on duty at all times to meet the needs of clients.

b. An ABI facility that operates on a 24-hour basis shall have staff on duty 24 hours a day, 7 days a week.

c. Direct care staff may include care assistants, social workers, activities personnel or other staff who provide direct care services to clients on a regular basis. If employed at more than one facility, direct care staff shall notify each facility of employment and shall ensure their schedule does not overlap.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2177 (November 2017).

Subchapter C. Client Protection

§8751. Client Rights

A. The facility shall have a written policy regarding client's rights. The policy shall assure the client has the right to:

1. not be deprived of civil or legal rights;

2. not be denied admission, segregated or otherwise subjected to discrimination on the basis of race, sex, handicap, creed, national background or ancestry; a facility that is a religious organization may limit admissions to its own adherents;

3. live within the least restrictive environment possible in order to retain their individuality and personal freedom; staff shall knock and request entrance before entering any bedroom;

4. be treated as individuals and with dignity, be assured choice and privacy and the opportunity to act autonomously, take risks to enhance independence and share responsibility for decisions;

5. be allowed to participate, and have family participate, if desired, in the planning of activities and services;

6. receive or refuse care and services that are adequate, appropriate and in compliance with conditions of residency, relevant federal and state laws, rules and regulations;

7. be free from mental, emotional and physical abuse and neglect and assured that no chemical restraints will be used;

8. have records and other information about the client kept confidential and released only with a client's expressed written consent;

9. have a service animal for medical reasons;

10. have visitors of their choice, as long as the rights of others are not infringed upon;

11. have access to private telephone communication;

12. send and receive mail promptly and unopened;

13. furnish their own rooms and use and maintain personal clothing and possessions as space permits;

14. manage his or her personal funds unless such authority has been delegated to another.

NOTE: If authority to manage personal funds has been delegated to the facility, the client has the right to examine the account during business hours;

15. have freedom to participate in accessible community activities and in social, political, medical, and religious activities and to have freedom to refuse such participation;

16. arrange for third-party services at their own expense, that are not available through the facility as long as the client remains in compliance with the conditions of residency;

17. to be informed of grievance process or procedures and receive response to grievances without fear of reprisal and to voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of reprisal or other retaliation;

18. be given written notice of not less than 30 days prior to discharge from the facility, except in life-threatening emergencies and when the client is a danger to himself/herself or to others;

19. remain in the current facility, foregoing a recommended transfer to obtain additional services, if a mutually agreed upon risk agreement is signed by the client, the responsible representative (if any) and the facility as long as it does not place the facility in conflict with these or other laws or regulations;

20. receive at least a 24-hour notice prior to a change in room/unit, be informed of the reason for the move and the right to be informed when their roommate is being changed;

21. live in a physical environment which ensures their physical and emotional security and well-being;

22. retain the services of his/her own personal physician, dentist or other health care provider;

23. confidentiality and privacy concerning his/her medical and dental condition and treatment; and

24. select the pharmacy or pharmacist of their choice.

B. Each client shall be fully informed of these rights and of all rules and regulations governing clients' conduct and responsibilities, as evidenced by written acknowledgement, prior to or at the time of admission and when changes occur. Each client's file shall contain a copy of the written acknowledgement which shall be signed and dated by the director/designee, client and/or representative.

C. A copy of these rights shall be posted conspicuously in the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2177 (November 2017).

§8753. Client Association

A. The facility shall provide a formal process and structure by which clients, in representative groups and/or as a whole, are given the opportunity to advise the director regarding client services and life at the facility. Any client request, concerns or suggestions presented through this process will be addressed by the director within a reasonable time frame, as necessitated by the concern, request or suggestion. The facility shall have policies and procedures addressing the following:

1. the times and frequency of use of the public or communal telephone;

2. visitors;

3. hours and volume for viewing and listening to television, radio, and other media;

4. movement of clients in and out of the home;

5. use of personal property; and

6. care of pets.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2178 (November 2017).

§8755. Grievance Procedure

A. The facility shall establish and have written grievance procedures to include, but are not limited to:

1. a formal process to present grievances;

2. a formal appeals process for grievances; and

3. a process to respond to client requests and/or client grievances in a timely manner, and the time frames in which the facility shall respond.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2178 (November 2017).

§8757 Personal Possessions

A. The facility may, at its discretion, offer to clients the service of safekeeping of valuable possessions. The facility shall have a written statement of its policy.

1. If the facility offers such a service, a copy of the written policy and procedures shall be given to a client at the time of his/her admission.

2. The facility shall give the client a receipt listing each item that it is holding in trust for the client. The facility shall maintain a copy of the receipt.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2178 (November 2017).

§8759. Client Funds

A. If a facility offers the service of safekeeping and/or management of clients' personal funds, the facility's admission agreement shall include the client's rights regarding personal funds and list the services offered and charges, if any. Any charges assessed shall not exceed the actual cost incurred by the facility for the provision of the services.

B. There is no obligation for a client to deposit funds with the facility or have the facility manage his/her funds, and the facility may not require the client to deposit his/her funds with the facility. If a facility offers the service of safekeeping and if a client wishes to entrust funds, the facility shall:

1. obtain written authorization from the client and/or his/her representative to safekeeping of funds;

2. provide each client with a receipt listing the amount of money the facility is holding in trust for the client;

3. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction; and

4. not accept more than $300 of a client's money.

C. If a facility offers the service of safekeeping and/or management of clients' personal funds, the facility shall purchase a surety bond or otherwise provide assurance satisfactory to the secretary to assure the security of all personal funds of clients deposited with the facility. In addition, if a client wishes the facility to assist with the management of all their funds, the facility:

1. shall receive written authorization to manage the client's funds from the client and the representative, if applicable;

2. shall only manage a client's money when such management is mandated by the client's service plan; and

3. shall keep funds received from the client for management in an individual account in the name of the client.

D. When a client is discharged, the facility shall refund the balance of the client's personal funds to the client or representative, if applicable, on the date of discharge or no later than the last day of the month of the month of discharge.

E. In the event of the death of the client, the facility shall refund the balance of the client's personal funds to the executor of the client's estate. If there is no executor, the

facility shall refund the balance to the representative or responsible party for the client. The refund shall be made within three months of the date of death.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2179 (November 2017).

§8761. Emergency and Evacuation Procedures

A. Disaster and emergency plans shall be developed by the governing body, and updated annually, which are based on a risk assessment using an all hazards approach for both internal and external occurrences. Disaster and emergency plans shall include provisions for persons with disabilities.

B. The facility shall develop and implement policies and procedures based on the emergency plan, risk assessment, and communication plan which shall be reviewed and updated at least annually. Such policies shall include a system to track on duty staff and sheltered clients, if any, during the emergency.

C. The facility shall develop and maintain an emergency preparedness communication plan that complies with both federal and state laws. Client care shall be well-coordinated within the facility, across health care providers and with state and local public health departments and emergency systems.

D. Additional Requirements

1. The ABI facility shall have continuously available telephone service on a 24-hour basis.

2. The ABI facility shall either post telephone numbers of emergency services, including the fire department, police department, medical services, poison control and ambulance or show evidence of an alternate means of immediate access to these services.

3. The ABI facility shall have a detailed written plan and procedure including the evacuation of residences or sheltering in place as appropriate to meet all potential emergencies and disasters such as fire, severe weather and missing clients. The ABI facility shall implement this plan in the event that an emergency or disaster occurs. These emergency and evacuation procedures shall include:

a. an agreement with a host or receiving facility, transportation, medications, food and necessary items to be evacuated with clients to safe or sheltered areas. Plans that family may evacuate the client when possible;

b. means for an ongoing safety program including continuous inspection of the facility for possible hazards, continuous monitoring of safety equipment and investigation of all accidents or emergencies;

c. fire prevention and evacuation plan and this plan shall be posted in each facility in a conspicuous place and kept current;

d. fire drills shall be documented for each shift at least quarterly;

NOTE: The drills may be announced in advance to the clients.

e. shelter in place when appropriate;

f. transportation arrangements for hospitalization or any other services which are appropriate;

g. maintenance of a first aid kit for emergencies; and

h. any emergency equipment appropriate for the ABI facility's client population.

E. The ABI facility shall develop and maintain training and testing programs, including initial training in policies and procedures and demonstrate knowledge of emergency procedures. Such training shall be provided at least annually.

F. The ABI facility shall immediately notify the department and other appropriate agencies of any fire, disaster or other emergency that may present a danger to clients or require their evacuation from the facility.

G. At any time that the ABI facility has an interruption in services or a change in the licensed location due to an emergency situation, the facility shall notify HSS no later than the next stated business day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2179 (November 2017).

§8763. Incidents/Accidents

A. The ABI facility shall have written procedures for the reporting and documentation of unusual incidents and other situations or circumstances affecting the health, safety or well-being of a client or clients. (i.e., death of unnatural causes, injuries, fights or physical confrontations, situations requiring the use of passive physical restraints, suspected incidents of abuse or neglect).

1. Such procedures shall ensure timely verbal reporting to the director or designee and a preliminary written report within 24 hours of the incident.

2. Incidents or accidents shall be documented in the client record. An incident report shall be maintained by the facility.

B. Incident/Accident Report. When and if an incident occurs, a detailed report of the incident shall be made. At a minimum, the incident report shall contain the following:

1. circumstances under which the incident occurred; names of clients, staff and others involved;

2. date and time the incident occurred;

3. where the incident occurred (bathroom, bedroom, street, lawn, etc.);

4. immediate treatment and follow-up care;

5. name and address of witnesses and their statements;

6. date and time family or representative was notified;

7. symptoms of pain and injury discussed with the physician; and date and time physician was notified; and

8. signatures of the staff completing the report, client and director.

C. Critical Incidents. When an incident results in death of a client, involves abuse or neglect of a client, or entails any serious threat to the client's health, safety or well-being the facility shall:

1. immediately report verbally to the director and submit a preliminary written report within 24 hours of the incident;

2. immediately notify the department and local law enforcement agency according to state law, with written notification to the above agencies to follow within 24 hours of the suspected incident;

3. immediately notify the family or representative of the client;

4. provide follow-up written reports of the completed investigation to all the above persons and agencies;

5. take appropriate corrective action to prevent future incidents; and

6. document its compliance with all of the above procedures for each incident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2180 (November 2017).

§8765. Abuse and Neglect

A. The ABI facility shall develop, implement and comply with facility-specific written policies and procedures related to compliance with this Section, including, but not limited to policies and procedures that include provisions for:

1. protect clients from abuse/neglect and/or injury inflicted by other clients, staff or third parties;

2. ensure that the client and/or reporter of the abuse is protected from potential harassment during the investigation;

3. ensure training and maintaining staff awareness of abuse prevention, current definitions of abuse and neglect, reporting requirements and applicable laws;

4. ensure that procedures for reporting critical incidents involving abuse and neglect are followed; and

5. ensure that the director completes an investigation report within five working days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2180 (November 2017).

Subchapter D. Admissions, Transfers and Discharges

§8771. Admission

A. Admission Criteria

1. The ABI facility shall have a clear and specific written description of admission policies and procedures. This written description shall include, but is not limited to:

a. the application process and the possible reasons for the rejection of an application;

b. types of clients suitable to the ABI facility; and

c. services offered and allowed in the ABI facility.

2. An ABI facility may accept or retain clients in need of additional care beyond routine personal care provided that:

a. the client or the representative, if applicable, and the facility agree that acceptance or retention of the client is appropriate; and

b. the facility has the capability of meeting the needs of the client.

B. Admissions Agreement

1. The ABI facility shall complete and maintain individual written admission agreements with all persons admitted to the facility or with their representative. The facility contract/admissions agreement shall specify:

a. clear and specific occupancy criteria and procedures (admission, transfer and discharge);

b. basic services to be made available;

c. optional services which are available;

d. payment provisions, including the following:

i. covered and non-covered services; and

ii. payor or funding source;

e. client's code of conduct for participation in the program and client's agreement to abide by the same;

f. the facility shall notify the client or representative at least 30 days prior to rate changes;

g. refund criteria;

h. that the department has the authority to examine clients' records as part of the evaluation of the facility;

i. division of responsibility between the facility, client, family or others (e.g., arranging for or overseeing medical care, purchase of essential or desired supplies, emergencies, monitoring of health, handling or finances);

j. clients' rights;

k. explanation of the grievance procedure and appeals process; and

l. the development of a service plan specific to the individual client, including participation of the client and/or representative in the development of the plan.

2. The admissions agreement shall be signed by the director and by the client and the representative, if applicable.

C. At the time of admission the ABI facility shall:

1. obtain from the client or the client's family or representative, their plan for both routine and emergency medical care to include the name of physician(s) and provisions and authorization for emergency medical care;

2. document that the client and/or representative was informed of the ABI facility's emergency and evacuation procedures; and

3. if the client has executed a medical power of attorney or an advanced directive, the facility shall maintain a copy of these documents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2180 (November 2017).

§8773. Transfer or Discharge

A. The director shall, in consultation with the client and the representative, if applicable, assist in planning and implementing the transfer or discharge of the client when:

1. the client's adjustment to the ABI facility is not satisfactory as determined by the director in consultation with the client or his/her representative;

2. the client is in need of services that the facility cannot provide or obtain for the client; or

3. the client or representative has failed to pay all fees and costs stated in the admission agreement or otherwise materially breached the admission agreement.

B. When a discharge or transfer is initiated by the facility, the director shall provide the client, and his/her representative, if applicable, with 30 days prior written notice citing the reason for the discharge or transfer, except shorter notice may be given in cases where the client is a danger to self or others.

C. At the request of the client or representative and receiving facility, copies of all pertinent information shall be given to the director of the licensed facility to which the client is transferred.

D. The following discharge information shall be recorded in the client's record:

1. date of discharge;

2. transfer facility;

3. reason(s) for discharge; and

4. condition upon discharge.

E. Client records shall be retained for at least six years from the date of discharge.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2181 (November 2017).

Subchapter E. Participation Requirements

§8777. Services

A. Assessment, Service Coordination, and Monitoring

1. Within seven days of admission, the facility shall complete an assessment to determine the needs and preferences of the client. The assessment shall include but is not limited to:

a. review of physical health, psycho-social status and cognitive status and determination of services necessary to meet those needs;

b. a summary of the client's health needs, if any, including medication, treatment and special diet orders obtained from professionals with responsibility for the client's physical or emotional health;

c. a written description of the activities of daily living and instrumental activities of daily living for which the client requires assistance, if any, obtained from the client, the client's physician, family or representative;

d. the client's interests, likes and dislikes;

e. recreational and social activities which are suitable or desirable;

f. a plan for handling special emergency evacuation needs; and

g. additional information or documents pertinent to the client's service planning, such as guardianship papers, power of attorney, living wills, do-not-resuscitate orders, or other relevant medical documents.

2. Within 30 days after admission, the facility, with input from the client, and/or his/her representative shall develop and implement a service plan using information from the assessment. The service plan shall include:

a. the client's needs;

b. the scope, frequency and duration of services and monitoring that will be provided to meet the client's needs;

c. staff responsible for providing the services inclusive of third-party providers;

d. current medication list from the client's primary care physician; and

e. identification of the level of assistance that the client requires.

3. The facility shall have a reporting procedure in place for notifying appropriate individuals of any changes in a client's condition.

4. The client's service plan shall be revised when a client's condition or preferences change and signed by the client and the representative, if applicable, and the designated facility staff.

5. The service plan shall be monitored on an ongoing basis to assess its appropriateness and to identify when a client's condition or preferences have changed.

6. A documented review of the client's service plan shall be made at least every three months.

7. All plans and reviews shall be signed by the client, facility staff and the representative, if applicable.

B. Personal and Supportive Services

1. The facility shall provide adequate services and oversight/supervision, including adequate security measures, continuously as needed for any client.

2. The facility shall provide or coordinate services, to the extent needed or desired by clients.

3. The client may participate in these services as written in his/her service plan. The following services are required to be offered:

a. assistance with all ADLs and IADLs;

b. at least three nutritious, varied, and palatable meals a day, seven days a week, that take into account client's dietary requirements, preferences and needs in residential facilities:

i. nourishing snacks, such as fruits and beverages, shall be available to residents at all times; and

ii. the ABI facility shall furnish medically prescribed diets to all clients for which it is designated in the service plan;

c. basic personal laundry services in residential facilities;

d. opportunities for individual and group socialization and to utilize community resources to create a normal and realistic environment for community interaction within and outside the facility (i.e. barber/beauty services, social/recreational opportunities);

e. services for clients who have behavior problems requiring ongoing staff support, intervention, and supervision to ensure no danger or infringement of the rights of other clients or individuals;

f. household services essential for the health and comfort of client (e.g. floor cleaning, dusting, bed making, etc.) in residential facilities;

g. assistance with self-administration of medications; and

h. a program of recreational activities.

C. Medication Management. The ABI facility shall have a medication management program. The medication management program shall be formulated in consultation with the client's primary physician and overseen by the nursing director.

1. The facility shall have written policies and procedures for the implementation of the medication management program.

2. The facility shall assist clients in the self-administration of prescription and non-prescription medication as agreed to in their contract or service plan, as allowed by state statute/regulations and overseen by the nursing director. Only clients who have awareness of their medication regime shall be provided assistance by direct care staff with self-administration of medications.

3. Assistance with self-administration of medications shall be limited to the following:

a. the client may be reminded to take his/her medication;

b. the medication regimen, as indicated on the container may be read to the client;

c. the dosage may be verified by staff, according to the container label; and

d. staff may physically assist the client in pouring or handling medications, including opening the medicine container (i.e. bottle, mediset, blister pak, etc.), if the client lacks the ability to open the container.

4. If the client has been assessed as able to utilize a pill organizer box, such pill organizer box may be filled by the nursing director or designee, the client with supervision or the client's representative.

5. The facility shall thoroughly review the medication administration staff's ability to follow policy and procedures regarding assisting with medication administration.

6. An employee that provides assistance with the self-administration of medications to a client shall have documented training on the policies and procedures for medication assistance including the limitations of this assistance.

a. Documentation of training shall include the signature of the employee.

b. Training shall be repeated at least annually.

c. Training for direct care staff assisting with medication management shall include but not be limited to the following:

i. legal aspects of medication assistance;

ii. understanding roles and responsibilities in medication assistance;

iii. definitions of medical terminology;

iv. classifications of medications;

v. identification of medication;

vi. dosing and measurement of medications;

vii. mechanism of action, therapeutic effects of drugs, and response to medications;

viii. education on side effects, observation, reporting and documentation of side effects; and

ix. care and safe handling of medications.

7. Direct care staff assisting with medication management shall meet the following:

a. be a minimum of 18 years of age;

b. able to read, write and comprehend the English language; and

c. have no current evidence of drug use, drug abuse or diversion of drugs and no record of conviction of a felony.

8. Limitations. Medication assistance is limited to assistance with oral medication, inhalant medication, topical applications, suppository medication, eye and ear drops as prescribed and documented in the service plan.

a. Direct care staff providing medication assistance shall not assist with any intramuscular, intravenous or subcutaneous medications.

b. Direct care staff providing medication assistance shall not receive or assume responsibility for writing oral or telephone orders from a physician.

c. Direct care staff providing medication assistance shall not alter medication dosages, as delivered from the pharmacy, without being instructed to do so by the nursing director, in accordance with prescribed medication orders.

9. The facility shall ensure that a client's medications shall be securely stored by the client in the client's own bedroom or stored in a secure central location in the facility, as appropriate for each individual client.

D. Transportation

1. The facility shall have the capacity to provide or to arrange transportation as necessary for the following:

a. medical services, including ancillary services for medically related care (e.g., physician, pharmacist, therapist, podiatrist);

b. personal services, including barber/beauty services;

c. personal errands; and

d. social/recreational opportunities.

2. The facility shall ensure and document that any vehicle used in transporting clients, whether such vehicles are operated by a staff member or any other person acting on behalf of the facility, is inspected, licensed and insured in accordance with state law.

3. When transportation services are provided by the facility, whether directly or by third party contract, the facility shall document and ensure that drivers have a valid driver's license and that drivers have a current insurable driving recordas evidenced by a driver's license status inquiry report available on-line from the Office of Motor Vehicles.

4. When transportation services are provided by the ABI facility, the facility shall ensure that drivers are trained and experienced in assisting a resident being transported, in accordance with the individual client's needs and service plan.

5. Vehicles used for transporting clients shall be handicapped accessible and sufficiently equipped to safely meet the needs of the clients served.

E. Meals (Residential Facilities)

1. A facility shall ensure that a client is provided at least three meals, or their equivalent, daily and at regular times.

a. There shall not be more than 14 hours between the evening meal and breakfast of the following day, unless there is a nourishing snack served and/or available between the evening and morning meal.

b. Meal times shall be comparable to those in a normal home.

2. The facility shall make reasonable accommodations to:

a. meet religious and ethnic preferences;

b. meet the temporary need for meals delivered to the client's room;

c. meet clients' temporary schedule changes as well as clients' preferences (e.g. to skip a meal or prepare a simple late breakfast); and

d. make nutritious snacks, fruits and beverages available to clients when requested.

3. All food preparation areas (excluding areas in clients' units) shall be maintained in accordance with state and local sanitation and safe food handling standards.

4. Staff shall be available in the dining area to serve the food and to give individual assistance as needed.

5. Written reports of inspection by the OPH, Sanitarian Services shall be kept on file in the facility.

6. Specific times for serving meals shall be established and posted.

7. Meals shall be prepared and served in a way that assures that they are appetizing, attractive and nutritious and promotes socialization among the clients.

8. Food shall be palatable, sufficient in quantity and quality and properly prepared by methods that conserve the nutritive value, flavor and appearance.

9. The facility shall have kitchens and dining rooms that are appropriately and adequately furnished to serve the number of clients residing in the facility in a comfortable environment.

a. Dining room(s) may be sized to accommodate clients in either one or two settings.

b. The facility shall have a central kitchen or a warming kitchen.

c. The facility's kitchen(s) and dining room(s) shall meet applicable sanitation and safety standards and shall be well lighted and ventilated.

F. Menus (Residential Facilities)

1. Menus shall be planned and written at least one week in advance and dated as served. The current week's menu shall be posted in a conspicuous place in the facility.

2. The facility shall furnish medically prescribed diets to clients in accordance with their service plan and shall be planned or approved by a licensed dietician.

3. Records of all menus as served shall be kept on file for at least 30 days.

4. All substitutions made on the master menu shall be recorded in writing.

G. Food Supplies

1. All food in the facility shall be labeled as safe for human consumption.

2. Grade "A" pasteurized fluid milk and fluid milk products shall be used or served. Dry milk products may not be used, except for cooking purposes.

H. Food Protection

1. If food is prepared in a central kitchen and delivered to separate facilities, provision shall be made for proper maintenance of food temperatures and a sanitary mode of transportation.

2. Facility's refrigerator(s) shall be maintained at a temperature of 45 degrees Fahrenheit or below.

3. Freezers shall be maintained at a temperature of 0 degrees Fahrenheit or below.

4. Thermometers shall be required for all refrigerators and freezers.

5. Food stored in the refrigerator shall be covered.

6. Pets are not allowed in food preparation and serving areas.

I. Ice and Drinking Water

1. The water supply shall be adequate, of a safe sanitary quality and from an approved source.

2. Clean sanitary drinking water shall be available and accessible in adequate amounts at all times.

3. The ice scoop shall be maintained in a sanitary manner. The handle of the ice scoop shall at no time come in contact with the ice.

J. Recreation

1. The facility shall have a range of indoor and outdoor recreational and leisure opportunities to meet the needs and preferences of clients.

2. The facility shall provide and/or coordinate access to community-based activities.

3. There shall be a monthly posted list of recreational and leisure activities in the facility and the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2181 (November 2017).

Subchapter F. Quality Enhancement Plan

§8781. Quality Enhancement

A. An ABI facility shall develop, implement and maintain a quality enhancement (QE) plan that:

1. ensures that the facility is in compliance with federal, state, and local laws;

2. meets the needs of the facility's clients;

3. is attaining the goals and objectives established by the facility;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual client outcomes and individual client satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan; and

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QE plan shall include:

1. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients of the facility receiving services, that include, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

2. a process to review and resolve individual client issues that are identified;

3. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above;

4. a process to correct problems that are identified through the program that actually or potentially affect the health and safety of the clients; and

5. a process of evaluation to identify or trigger further opportunities for improvement in identification of individual client care and service components.

C. The QE program shall hold bi-annual committee meetings to:

1. assess and choose which QE plan activities are necessary and set goals for the quarter;

2. evaluate the activities of the previous quarter; and

3. implement any changes that protect the clients from potential harm or injury.

D. The QE plan committee shall:

1. develop and implement the QE plan; and

2. report to the director any identified systemic problems.

E. The facility shall maintain documentation of the most recent 12 months of the QE plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2183 (November 2017).

Subchapter G. Physical Environment

§8785. General Provisions

A. Interior Space

1. The facility shall be designed, constructed, equipped and maintained to meet the accessibility needs of the clients in accordance with applicable federal and state laws, rules and regulations for persons with disabilities.

2. Handrails and sufficient lighting shall be integrated into public areas as appropriate to assist clients in ambulation.

3. Sufficient lighting shall be provided for general lighting and reading in bedrooms and common areas.

4. Night lights for corridors, emergency situations and the exterior shall be provided as needed for security and safety.

5. Windows used for ventilation to the outside and exterior doors used for ventilation shall be screened, intact and operable.

6. The facility shall be kept free of hazards.

7. The facility shall have sufficient and separate storage space for administration records, cleaning supplies (janitorial), food service (supplies), lawn maintenance (equipment) and locked areas for medications.

8. Poisonous and toxic materials shall be identified, and stored in a separate cabinet used for no other purpose.

9. There shall be evidence of routine maintenance and cleaning programs in all areas of the facility. The facility shall replace or repair broken, worn or defective furnishings and equipment promptly.

10. The facility shall have an effective pest control program.

11. The facility shall have a system in place to control water temperature to prevent burns and ensure client safety.

12. The facility shall be maintained at a comfortable seasonal temperature (65 to 80 degrees Fahrenheit) in all indoor public and private areas.

13. The facility shall be furnished according to the activities offered. Furniture shall be clean, safe, operable, where applicable and appropriate for the functional program. Furniture shall be available to facilitate usage by the number of clients in the facility.

B. Exterior Space

1. A facility shall ensure that the grounds and any structure thereon shall be maintained in operating condition and free from any reasonably foreseeable hazard to health and safety.

a. Garbage and rubbish stored outside shall be secured securely in noncombustible, covered containers and shall be removed on a regular basis.

b. Trash collection receptacles and incinerators shall be separate from outdoor recreational space.

c. Areas determined to be unsafe, including but not limited to steep grades, cliffs, open pits, swimming pools, high voltage boosters or high speed roads shall be fenced off or have natural barriers to protect clients.

d. Fences shall be in good repair and constructed in such a way as to provide safety and security.

2. A facility shall provide clients access to safe, suitable outdoor space designated for recreational use.

3. The parking lot shall not double as recreational space.

4. If a facility accepts clients that have dementia or other conditions that may cause them to leave or walk away from the home/facility, an enclosed area shall be provided adjacent to the home/facility so that the clients may go outside safely.

5. Signage. The facility's address or name shall be displayed so as to be easily visible from the street.

6. The facility shall ensure that exterior areas are well lit at night.

C. Common Space

1. A facility shall not share common living, or dining space with another facility licensed to care for individuals on a 24 hour basis.

2. The facility shall provide common areas to allow clients the opportunity for socialization.

3. Common areas for leisure shall be at least 60 square feet per licensed capacity.

4. Dining rooms and leisure areas shall be available for use by clients at appropriate times to provide periods of social and diversified individual and group activities.

5. Outpatient facilities and 24 hour facilities shall provide public restrooms of sufficient number and location to serve clients and visitors.

6. The facility's common areas shall be accessible and maintained to provide a clean, safe and attractive environment for the clients.

7. Space used for administration, sleeping or passage shall not be considered as dining or leisure space.

D. Laundry

1. The facility shall have provisions to provide laundry services that are adequate to handle the needs of the clients, including those with bladder and/or bowel incontinence.

2. On-site laundry facilities, if provided, shall be located in a specifically designated area and there shall be adequate space for sorting, processing and storage of soiled material.

3. Laundry rooms shall not open directly into client common areas or into food service areas.

4. Domestic washers and dryers which are for the exclusive use of clients may be provided in client areas, provided they are installed in such a manner that they do not cause a sanitation problem, offensive odors or safety concerns.

5. Universal precautions shall be followed in all laundry areas. Hand cleaning facilities shall be available in or near any laundry area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2184 (November 2017).

§8787. Residential Facilities

A. The ABI facility shall ensure that each single occupancy bedroom has a floor area of at least 100 net square feet, exclusive of bathrooms, closets or storage space and that each multiple occupancy bedroom has a floor area of at least 70 net square feet for each client. There shall be no more than two clients per bedroom. The facility shall strive to maintain a home-like environment.

B. A facility shall not use a room with a ceiling height of less than 7 feet, 6 inches as a bedroom, unless, in a room with varying ceiling heights, the portions of the room where the ceiling is at least 7 feet, 6 inches allow a usable floor space.

C. A facility shall not use as a bedroom any room which does not have a window opening to the outside.

D. Each client in the facility shall have his/her own bed. Cots, bunk beds or portable beds are prohibited.

E. A facility shall ensure that sheets, pillows and pillow cases, bedspreads and blankets are provided for each client as needed. Linens that are torn, worn or frayed shall not be utilized.

F. Each client shall be provided with individual space, in the bedroom, for personal possessions or clothing such as dressers, chest of drawers, etc.

G. Clients shall be allowed to decorate their own bedrooms with personal effects, such as pictures, etc.

H. Each bedroom shall have a closet which opens directly into the room and be of sufficient size to serve the occupants of the bedroom.

1. If the bedroom does not have a closet opening into the room, there shall be a moveable closet or armoire available in the bedroom.

2. If a moveable closet or armoire is used, this space shall not be counted in the net floor space.

I. There shall be adequate, gender segregated, toileting, bathing and hand washing facilities, in accordance with LAC Title 51, *Public Health—Sanitary Code*.

J. One bathroom shall serve no more than four beds and shall contain wash basins with hot and cold water, flush toilets and bath or shower facilities with running hot and cold water.

K. Each bathroom shall be located so that they open into a hallway, common area or directly into the bedroom. If the bathroom only opens directly into a bedroom, it shall be for the sole use of the occupants of that bedroom only.

L. Each bathroom shall be properly equipped with toilet paper, towels, soap and other items required for personal hygiene, unless clients are individually given such items. Tubs and showers shall have slip-proof surfaces.

M. A facility shall provide toilets, baths and showers which allow for individual privacy, unless clients require assistance for care.

N. A facility's bathrooms shall contain mirrors secured to the walls at convenient heights and other furnishings necessary to meet the client's basic hygienic and grooming needs.

O. A facility's bathrooms shall be equipped to facilitate maximum self-help by clients. Grab bars, shower chairs, toilet extensions and other handicap aides are to be provided as needed in bathrooms.

P. Toilets, wash basins and other plumbing or sanitary areas in a facility shall continuously be maintained in operable condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2185 (November 2017).

§8789. Community Living

A. General. Community living facilities shall provide a home or apartment setting, or efficiency/studio apartments providing a rehabilitative treatment environment. The community living facility shall be equipped in a manner to help ensure clients their privacy, dignity and independence while preparing them for community integration. There shall be no more than three bedrooms per apartment or six beds per home. Each shall strive to maintain a home-like environment and shall be furnished for living. Each home/apartment shall include at a minimum:

1. a food preparation area consisting of a sink with hot and cold running water, electrical outlets in compliance with applicable laws and regulations, mini refrigerator, cooking appliance, food storage cabinets and counter space;

2. a bathroom that is shared by no more than four individuals which includes a toilet, sink and shower or tub with hot and cold running water, shall be equipped with functional aides and shall be accessible to the individual(s) using it and electrical outlets shall be in compliance with applicable laws and regulations;

3. dining/sitting/bedroom area;

4. sufficient storage/closet space;

5. an operating emergency call system (wired or wireless) is required for those clients that live alone without 24-hour on-site supervision and shall be easily accessible to those clients that live alone, in the event of an emergency and shall register at a location that is monitored at all hours of the day and night;

6. a lockable front door that can be controlled by the client;

7. heating, ventilation and air conditioning (HVAC) thermostats that can be individually controlled by the client, with a locking mechanism provided, if required to prevent harm to a client;

8. at least one operating telephone available 24 hours/day; and

9. the ABI facility shall ensure that any living situation that is selected by the client is:

a. accessible to and functional for the inhabitants of the living space, considering any handicapping condition or other disability of the clients;

b. free from any hazard to the health or safety of the clients;

c. properly equipped with useable facilities for sleeping, food storage and preparation, sanitation, bathing, personal hygiene and household cleaning;

d. accessible to transportation; and

e. accessible to any services as required by the client's plan of services or individual program, and in compliance with applicable health, safety and sanitation codes.

B. A client may reside in an efficiency/studio apartment that shall have a minimum of 250 net square feet of floor space, excluding bathrooms and closets.

C. Homes or apartments with separate bedrooms shall have a living area (living/dining/kitchenette) of at least 190 net square feet, excluding bedroom, bathroom and closets. Each separate bedroom shall have a minimum of 100 net square feet, excluding bathroom and closet or wardrobe space.

D. Homes or apartments with a bedroom designed for two individuals shall have a minimum of 200 net square feet excluding bathrooms and closet or wardrobe space. Clients sharing a two person bedroom shall agree, in writing, to this arrangement. No bedrooms shall accommodate more than two clients.

E. Bedrooms shall contain an outside window. A room where access is through a bathroom or another bedroom is prohibited for use as a client's bedroom.

F. There shall be at least 60 net square feet of common space for each home or apartment.

G. Bathrooms shall be located so that they open into a hallway, common area or directly into the bedroom.

1. If the bathroom only opens directly into a bedroom, it shall be for the sole use of the occupants of that bedroom only.

2. Non-skid surfacing or strips shall be installed in all showers and bathing areas. Grab bars shall be installed in all showers and bathing areas if determined to be necessary for the client(s) residing in this space.

3. Hot and cold water faucets shall be easily identifiable.

4. Bathrooms shall not be utilized for storage or purposes other than those indicated by this Subsection.

H. The facility shall have a written plan for providing support and supervision to the clients in supervised living situations. The plan shall ensure:

1. regular contact between the facility personnel and the client at a minimum of three times a week or as specified in the client's service plan; and

2. provisions for emergency access by clients to an appropriate facility staff member on a 24-hour basis.

I. A facility shall, through routine visits by staff to the home or apartment, determine and document that:

1. there is no reasonable cause for believing that the client's mode of life or living situation presents any risks to the client's health or safety;

2. the living situation is maintained in a clean and safe condition;

3. the client is receiving required medical care; and

4. the current plan of services provides appropriate and sufficient services to the client.

J. Staff may have and utilize pass keys to apartments or homes as may be necessary for services or emergencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2185 (November 2017).

§8791. Outpatient Services

A. General. The ABI facility that elects to provide the outpatient level of care shall do so in a facility that meets the following space requirements.

1. At a minimum, one therapy room shall be provided within the treatment space. Use of this room for evaluations and private communication with client and/or family as well as therapy requiring privacy or seclusion shall be permitted.

2. A therapy room shall have a minimum clear floor area of 70 square feet.

3. Size requirements shall be based upon the types of services provided and the equipment used for therapeutic treatment. Sufficient space shall be provided to allow access to the equipment by the client and the therapist when in use.

4. At least one hand-washing station shall be provided within the treatment area.

5. Designated work space shall be provided for therapists and/or other staff.

6. There shall be a secure area for storage of client treatment records.

7. There shall be an administrative area available and designated for office equipment.

8. There shall be a separate toilet room for clients and staff/visitors.

9. The outpatient facility shall be in compliance with federal, state and local rules, laws and regulations applicable to persons with disabilities.

10. There shall be a waiting area for clients with sufficient seating for numbers of clients served.

B. Exterior Space. There shall be parking spaces sufficient to meet the numbers of clients served, with a covered space for drop off and pick up, maintained well-lit as needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2120.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2186 (November 2017).

Chapter 88. Nurse Licensure Compact

§8801. Definitions

Department—the Louisiana Department of Health (LDH), the department.

Health Standards Section (HSS)—the section in LDH responsible for licensing health care facilities and agencies, certifying facilities and agencies applying for participation in the Medicaid (title XIX) and Medicare (title XVIII) programs, and conducting surveys and inspections.

Home State—the party state which is the nurse's primary state of residence.

Licensing Board—a party state's regulatory body responsible for issuing nurse licenses.

Multi-State License—a license to practice as a registered nurse (RN) or a licensed practical nurse/licensed vocational nurse (LPN/LVN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multi-state licensure privilege.

Multi-State Licensure Privilege—a legal authorization associated with a multistate license permitting the practice of nursing as either an RN or LPN/LVN in a remote state.

Nurse—registered nurse (RN) or licensed practical nurse/licensed vocational nurse (LPN/LVN), as defined by each party state's practice laws.

Nurse Licensure Compact (NLC)—Part V of Chapter 11 of Title 37 of the Louisiana Revised Statutes of 1950, comprised of R.S. 37:1018 through 1020.

Party State—any state that has adopted the Nurse Licensure Compact.

Remote State—a party state other than the home state.

Single-State License—a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multi-state licensure privilege to practice in any other party state.

State—a state, territory or possession of the United States and the District of Columbia.

State Practice Laws—a party state's laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice and create the methods and grounds for imposing discipline. State practice laws do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1018-1020.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:45 (January 2019).

§8803. General Administration

A. Pursuant to R.S. 37:1018-1020 et seq., all health care entities licensed and/or certified by the Health Standards Section of LDH including, but not limited to, those specified in §8803.B.1-25 shall:

1. register with the National Council of State Boards of Nursing's (NCSBN) Nursys e-Notify system; and

2. provide required nurse data for collection of aggregate data from employees on the number and geographic representation of registered nurses (RNs) and

licensed practical nurses/licensed vocational nurses (LPNs/LVNs) employed in Louisiana practicing pursuant to a multi-state or single state license, as determined by the Louisiana State Board of Nursing (LSBN) and the Louisiana State Board of Practical Nurse Examiners (LSBPNE).

B. Once registered, the licensed facility/agency, the LSBN and the LSBPNE shall have real-time access to nurse licensure verification including expirations, upcoming renewals and discipline from all nurse licensure compact states. The real-time notifications shall be delivered to employer inboxes automatically and immediately available to the requisite nursing boards prior to an RN or LPN/LVN furnishing any such services in one or more of the following licensed and/or certified health care facilities and agencies:

1. nursing facilities (NF);

2. home health agencies (HHA);

3. hospice agencies;

4. emergency medical transportation services (EMTS);

5. behavioral health services (BHS) providers;

6. home and community-based services (HCBS) providers;

7. adult day health care (ADHC) providers;

8. intermediate care facility for people with developmental disabilities (ICF-DD);

9. adult residential care providers (ARCP);

10. hospitals;

11. rural health clinics (RHC);

12. outpatient physical therapy (OPT) clinics;

13. comprehensive outpatient rehabilitation facilities (CORF);

14. pediatric day health care (PDHC) facilities;

15. end stage renal disease (ESRD) clinics;

16. federally qualified health centers (FQHC);

17. forensic supervised transitional residential and aftercare (FSTRA) facilities;

18. psychiatric residential treatment facilities (PRTF);

19. therapeutic group homes (TGH);

20. ambulatory surgical centers (ASC);

21. outpatient abortion facilities (OAF);

22. support coordination agencies (SCA);

23. adult brain injury (ABI) facilities;

24. community mental health centers (CMHC); and

25. portable x-ray providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1018-1020.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:45 (January 2019).

§8805. Licensed Facility and Agency Requirements

A. In accordance with federal, state and local laws, rules and regulations, agencies and facilities licensed by the department shall comply with state nurse licensure laws to ensure the health and safety of the public.

B. The governing body of the health care facility or agency licensed by the department shall be responsible for registering with the NCSBN's Nursys e-Notify system (or other system as designated by the state board of nursing).

C. Facilities and agencies licensed by the department as health care providers shall report data to the applicable state nurse licensing board on the number and geographic representation of RNs and LPNs/LVNs employed by the licensed health care facility or agency practicing pursuant to a multi-state license, as determined by the respective licensing board.

D. The report shall be completed prior to an RN or LPN/LVN furnishing any nursing services in this state. Failure of an employer to submit this data to the board shall not be a basis for disciplinary action against or restriction of the multi-state license of any RN or LPN/LVN.

E. The governing body of the licensed health care facility or agency shall be responsible for the development, implementation and enforcement of policies and procedures related to §8805.A-D, as applicable to the facility or agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1018-1020.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:46 (January 2019).

Chapter 89. Crisis Intervention

§8901. Purpose

A. The overall purpose of these regulations is the protection of the health, safety and well-being of persons served by crisis care providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1261 (November 1995).

§8903. Procedures

A. Initial Application. Before beginning operation, it is mandatory to obtain a license from the Department of Social Services. To do so, the following steps should be followed:

1. Secure an application form issued by: Department of Social Services Bureau of Licensing, P. O. Box 3078, Baton Rouge, LA 70821-3078. Phone: (504) 922-0015

2. A license will be issued on an initial application when the licensure inspection verifying compliance is completed and verification is received by the Bureau of Licensing.

3. When a Provider changes location, it is mandatory to notify the Bureau of Licensing and program offices as appropriate. Additionally the provider must submit the processing fee to the bureau.

4. When a provider changes ownership, a new application and fee are required.

5. A license is valid for the period for which it is issued but may be revoked if the provider falls below minimum standards.

6. The department is authorized to determine the period during which the license shall be effective. A license is not transferable to another person or location.

7. If a director or member of his immediate family has had a previous license revoked or refused, upon re-application, applicant shall provide satisfactory evidence that the reason for such revocation no longer exists.

B. Fees

1. An application processing fee of $25 is required to be submitted with all initial applications. This fee is to be paid by all providers. All fees are nonrefundable.

2. Other licensure fees:

a. $25 replacement fee for any provider replacing a license when changes are requested by the provider, i.e. change in provider location, name change, age range change.

b. $5 processing fee for issuing a duplicate provider license with no changes.

C. Relicensing. The relicensing survey is similar to the original licensing inspection. The provider will have an opportunity to review any licensing deficiencies with the licensing specialist before it is submitted to the State Office.

1. A license is issued for a period of no more than one year. Provider is totally responsible for applying for license renewal on an annual basis. Failure to reapply will result in nonrenewal of license.

2. If the licensure inspection reveals that the provider is not substantially meeting minimum requirements, a new license may not be issued.

3. The Department of Social Services shall be notified before changes are made which might have an effect upon the license (for example, changes in age range, changes in location).

D. Inspections

1. It shall be the duty of the Department of Social Services through its duly authorized agents, to inspect at regular intervals not to exceed one year, or as deemed necessary by the department, and without previous notice, all crisis care/intervention service providers.

2. Whenever the department is advised or has reason to believe that any person or agency or organization is operating a crisis intervention service without a license, the department shall make an investigation to ascertain the facts.

E. Waivers

1. The office of the Secretary of the Department of Social Services shall have the authority to waive any of these standards for just cause provided the health and safety of the clients and/or staff are not in jeopardy. If it is determined that the provider or agency is meeting or exceeding the intent of a standard or regulation, the standard or regulation may be deemed to be met.

F. Denial, Revocation, or Nonrenewal of License

1. An application for a license may be denied for any of the following reasons:

a. failure to meet any of the minimum standards for licensure.

b. conviction of a felony, as shown by a certified copy of the record of the court of conviction of the applicant;

i. or if the applicant is a firm or corporation, of any of its members or officers;

ii. or of any staff providing the crisis intervention or supervision of the clients.

2. A license may be revoked, or renewal thereof, denied, for any of the following reasons:

a. cruelty or indifference to the welfare of the children and adults;

b. violation of any provision of the minimum standards, rules, regulations, or orders of the Department of Social Services promulgated thereunder;

c. disapproval from any agency whose approval is required for licensure;

d. non payment of application processing fee or failure to submit a licensure application;

e. any validated instance of client abuse, corporal punishment, physical punishment, cruel, severe, or unusual punishment may result in revocation, denial or nonrenewal of the license if the owner is responsible or if the staff member who is responsible remains in the employment of the provider.

G. Appeal Procedure. If the license is refused or revoked because the provider does not meet minimum requirements for licensure, the procedure is as follows:

1. the Department of Social Services, by certified letter, shall advise the provider of the reasons for denial or revocation, and its right of appeal;

2. the provider/owner may appeal this decision by submitting a written request with the reasons to the Secretary of the Department of Social Services. Write to Department of Social Services, Appeals Section, P.O. Box 2994, Baton Rouge, LA 70821-9118. This written request must be post-marked within 30 days of the director/owner's receipt of the above notification in 8903.G.1;

3. the Appeals Bureau of the Department of Social Services shall set a hearing;

4. an appeal hearing officer of the Department of Social Services shall conduct the hearing. The Department of Social Services shall advise the appellant by certified letter of the decision, either affirming or reversing the original decision. If the license is denied or revoked, the provider shall terminate operation immediately;

5. if the provider continues to operate without a license, the Department of Social Services may file suit in the district court in the parish in which the provider is located for injunctive relief.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1261 (November 1995).

§8905. Organization and Administration

A. General Requirements

1. A provider shall allow designated representatives of DSS in the performance of their mandated duties to inspect all aspects of a provider's functioning which impact on clients and to interview any staff member or client (if the client agrees to said interview).

2. A provider shall make any information which the Provider is required to have under the present requirements and any information reasonably related to assessment of compliance with these requirements available to DSS.

B. Governing Body

1. A provider shall have an identifiable governing body with responsibility for and authority over the policies and activities of the program/agency.

2. A provider shall have documents identifying all officers and members of the governing body, their addresses, and terms of membership.

3. When the governing body of a provider is comprised of more than one person, the governing body shall hold formal meetings at least twice a year.

4. When the governing body is composed of more than one person, a provider shall have written minutes of all formal meetings of the governing body and by-laws specifying frequency of meetings and quorum requirements.

C. Responsibilities of a Governing Body. The governing body of a provider shall:

1. ensure the provider's compliance and conformity with the provider's charter;

2. ensure the provider's continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;

3. ensure that the provider is adequately funded and fiscally sound;

4. review and approve the provider's annual budget;

5. ensure the review and approval of an annual external audit;

6. designate a person to act as chief administrator and delegate sufficient authority to this person to manage the provider agency;

7. formulate and annually review, in consultation with the chief administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;

8. annually evaluate the chief administrator's performance;

9. have the authority to dismiss the chief administrator;

10. meet with designated representatives of DSS whenever required to do so;

11. inform designated representatives of DSS prior to initiating any substantial changes in the services provided by the provider.

D. Accessibility of Executive. The chief administrator or a person authorized to act on behalf of the chief administrator shall be accessible to staff and designated representatives of DSS at all times.

E. Documentation of Authority to Operate. A private provider shall have documentation of its authority to operate under state law.

F. Administrative File. A provider shall have an administrative file including:

1. documents identifying the governing body;

2. list of members and officers of the governing body and their addresses and terms of membership;

3. minutes of formal meetings and by-laws of the governing body, if applicable;

4. documentation of the provider's authority to operate under state law;

5. organizational chart of the provider;

6. all leases, contracts and purchase-of-service agreements to which the provider is a party;

7. insurance policies: every provider shall maintain in force at all times a comprehensive general liability insurance policy. this policy shall be in addition to any professional liability policies maintained by the provider and shall extend coverage to any staff member who provides transportation for any client in the course and scope of his/her employment;

8. annual budgets and audit reports;

9. master list of all contractors used by the provider.

G. Accounting

1. A provider shall establish a system of business management and staffing to assure maintenance of complete and accurate accounts, books and records, in keeping with generally accepted accounting principles.

2. A provider shall demonstrate fiscal accountability through regular recording of its finances and annual external audit.

3. A provider shall not permit public funds to be paid, or committed to be paid, to any person or organization to which any of the members of the governing body, administrative personnel, or members of the immediate families of members of the governing body or administrative personnel have any direct or indirect financial relationship or interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the provider. The provider shall have a written disclosure of any financial transaction between the provider and other business entities in which a member of the governing body, administrative personnel, or his/her immediate family is involved.

H. Confidentiality and Security of Files

1. A provider shall have written procedures for the maintenance, security, and confidentiality of records. This shall include specifying who shall supervise the maintenance of records, and who shall have custody of records. This procedure shall also state to whom records can be released and the procedure for doing so. Records, including client as well as administrative, shall be the property of the provider and the provider, as custodian, shall secure records against loss, tampering, or unauthorized use.

2. Staff members of the provider shall not disclose or knowingly permit the disclosure of any information concerning the agency, the clients or his/her family, directly or indirectly, to any unauthorized person.

3. When the client is of majority age and noninterdicted, a Provider shall obtain the client's written, informed permission prior to releasing any information from which the client or his/her family might be identified.

4. When a client is a minor or is interdicted, a provider shall obtain written, informed consent from the legally responsible person prior to releasing any information from which the client or his/her family might be identified.

5. A provider shall, upon written authorization from the client or his legal representative, make available information in the case record to the client, his counsel, or the client's legally responsible person. If, the provider reasonably concludes that knowledge of the information contained in the record would be injurious to the health or welfare of the client, or could reasonably be expected to endanger the life or safety of any other person, that provider may deny access to the record. The provider may charge a reasonable fee for copying the records.

6. A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, provided that names are deleted and other similar identifying information is disguised or deleted.

7. A provider shall not release a personnel file without the staff member's written permission except in accordance with state law.

I. Records - Administrative and Client

1. A provider shall ensure that all entries in records are legible, signed by the person making the entry and accompanied by the date on which the entry was made.

2. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of in accordance with state laws and requirements of the funding sources.

3. A provider shall have sufficient space, facilities and supplies for providing effective record keeping services.

4. A provider shall have a written record for each client which shall include:

a. The name, sex, race, birth date of the client, home address, address of crisis location.

b. Other identification data including court status and/or legal status, name of parent or legal guardian, as appropriate.

c. The names, addresses and phone numbers of other persons or providers involved with the client's plan/case. This shall include the client's physician.

d. A provider shall document:

i. client's presenting problem, any known DSM IV diagnosis and medications;

ii. any other known serious health condition and medication.

e. information and documentation of interventions used and case disposition, including progress notes as required in 8907.D.1.b.

f. information and documentation concerning any injuries (regardless of cause), any violations of client safeguards, any suspected incidents of abuse/mistreatment/neglect, or any client grievances.

5. A provider shall have a written record for each staff member which includes:

a. the application for employment and/or resume's;

b. references (three);

c. any required medical examinations;

d. all required documentation of appropriate status which includes:

i. valid driver's license for operating provider vehicles or transporting clients;

ii. professional credentials/certification required to hold the position.

e. periodic, at least annual, performance evaluations;

f. staff member's starting and termination dates along with salary paid;

g. staff member shall have reasonable access to his/her file and shall be allowed to add any written statement he/she wishes to make to the file at any time;

h. documentation of criminal records check;

i. any reports or internal investigations concerning the staff member's involvement in any suspected abuse/mistreatment/neglect, violation of client safeguards, or violation of client rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1262 (November 1995).

§8907. Program and Services

A. Program Description

1. A provider shall have a written program description describing:

a. the overall philosophy of the provider;

b. the long-term and short-term goals of the provider;

c. the types of clients best served by the provider;

d. there shall be written eligibility criteria for each of the services/programs provided;

e. the services provided directly or through subcontract by the provider;

f. a schedule for any fees for services which will be charged the client.

2. A provider shall make every effort to ensure that service and program planning for each client is a comprehensive process involving appropriate provider staff, representatives of other agencies, the client, and where appropriate the legally responsible person, and any other person(s) significantly involved in the client's care on an ongoing basis.

3. A provider shall perform crisis assessments to determine, as a minimum, the mental status of the individual and their danger to self or others. Appropriate short term follow-up shall be included as part of the intervention. Documentation of this intervention shall be kept in the client's record.

4. There shall be written policies and procedures to assure the following client care safeguards:

a. crisis workers shall not participate in discipline or punishment procedures;

b. crisis workers shall not subject clients to verbal remarks which belittle or ridicule them, their families, or others;

c. seclusion, defined as the placement of a client alone in a locked room, shall not be employed;

d. passive physical restraint shall be employed only as a therapeutic intervention to protect the client from physical injury to self or others;

e. restraining devices shall not be used in crisis interventions.

5. The provider shall have written policies and procedures to assure that any suspected violations of these safeguards are internally investigated and, where abuse or neglect is suspected, that immediate reports are made to the public agency statutorily authorized to investigate such alleged incidents.

B. Transportation

1. A provider shall ensure and document that any vehicle used by provider staff to transport clients is inspected and licensed according to state laws and carries a sufficient amount of current liability insurance.

2. Any staff member or the provider using a vehicle to transport clients shall be properly licensed to operate that vehicle according to state laws.

C. External Professional Service. A provider shall have a written policy which mandates that, when necessary, clients be given assistance in obtaining any required professional services not available from staff members of the provider.

D. Organizational Communication

1. A provider shall establish procedures to assure adequate communication among staff to provide continuity of services to the client, including:

a. establishing procedures to assure periodic staff meetings with supervisory staff, professional staff, and direct line workers;

b. crisis workers doing one-to-one monitoring with a client will keep progress notes every half hour detailing the behavior of the client subsequent to the last entry. Progress notes will become part of the client's record. The client's record will be shared with the client's treating clinician, if applicable;

c. establishing a mechanism to assure the crisis worker's access to emergency services and/or an agency supervisor.

2. A provider shall establish procedures which facilitate participation and feedback from clients and families.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1263 (November 1995).

§8909. Personnel

A. Staff Plan. A provider shall have a written plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members.

B. Nondiscrimination. A provider shall have a written policy to prevent discrimination and shall comply with all state and federal employment and service delivery laws and regulations pertaining to nondiscrimination.

C. Recruitment. A provider shall actively recruit and, whenever possible, employ qualified persons of both sexes representative of the cultural and racial groups served by the provider. This shall include the hiring of qualified persons with disabilities.

D. Education and Experience Requirements. Provider shall establish requisite education and experience qualifications for the crisis worker doing one-to-one Intervention, which shall include:

1. a bachelor's degree in a human service related field (social work, psychology, counseling, criminal justice, education) and one year successful paid work experience with clients with emotional disorders; or,

2. a high school diploma with two years successful paid work experience with clients with emotional disorders; however,

3. the provider may elect to permit applicants who are parents of children with emotional disorders to substitute their year(s) of successful parenting experience for the requisite years of work experience.

4. provider shall establish requisite education and experience qualifications for crisis workers responsible for mental health assessments, which shall include:

a. A bachelor's degree in a human service related field (social work, psychology, counseling, criminal justice, education); and

b. two years successful paid work experience with clients with emotional disorders.

5. provider shall establish requisite education and experience qualifications for crisis workers responsible for clinical supervision of staff which shall include:

a. a valid Louisiana license in a mental health/counseling profession (board certified social worker, licensed professional counselor, licensed psychologist, physician, registered nurse); and

b. successful work experience with clients with emotional disorders.

E. Screening

1. Provider shall maintain documentation of satisfactory criminal record check, as required by R.S. 15:587.1, or documentation that an application for criminal record check has been made if no response has been received. A criminal records check shall be requested by the Provider prior to the employment of any person who will have supervisory or disciplinary authority over clients.

2. Provider shall have a résumé or a record of employment history on each staff member.

3. Prior to employing any person, and upon obtaining a signed release and the names of the references from the applicant, a provider shall obtain three written references for each prospective staff member or telephone notes from contact with said references.

4. A provider's screening procedures shall address the prospective staff member's qualifications, ability, related experience, health, character, emotional stability and social skills as related to the appropriate job description. Documentation shall be maintained in the personnel file.

F. Orientation. A provider's orientation shall provide a minimum of 18 hours of training for all crisis workers before direct contact with clients will begin. The training will include:

1. Twelve hours of training in crisis de-escalation and management of aggressive behavior, including passive physical restraints and acceptable and prohibited responses. Documentation of pre-service crisis training shall consist of a signed statement of the date(s), hours, method and content of curriculum trained and confirmation of the staff member's participation.

2. Six hours of orientation in provider's emergency and safety procedures, universal precautions, state law on client abuse and client rights, and provider's policies and procedures, including prohibited disciplinary responses. Documentation shall consist of a signed statement of the date(s), hours, and topics of the orientation and confirmation of the staff member's participation.

G. Training

1. A provider shall ensure that each crisis worker completes at least 40 hours of training per year. Orientation may be considered in meeting this requirement during the staff member's first year of employment. Routine supervision shall not be considered for meeting this requirement. This requirement may be fulfilled through documented individual consultation as well as group training sessions.

2. Direct service delivery staff members' annual training shall be documented by signed statements consisting of the dates, hours and content of the training, and confirmation of the staff members' participation. Curricula shall include:

a. crisis de-escalation and aggression control management, including physical restraint;

b. signs and symptoms of reactions to medication, especially psychotropic medication;

c. psychotropic medications;

d. major mental disorders of population served by program; description of disorders and treatment;

e. universal precautions, HIV, and Hepatitis B;

f. CPR course appropriate to client population, or yearly recertification in same;

g. first aid and emergency medical procedures;

h. client rights, mental health law, orders for protective custody, judicial commitments;

i. mandated reporting of child/adult abuse per state law.

H. Evaluation. A provider's performance evaluation procedures shall address the nature, quality and effectiveness of a crisis worker's interactions with clients, family and other providers. Evaluations shall be completed at least annually.

I. Personnel Practices

1. A provider shall have written personnel practices and written job descriptions for each staff position including volunteers.

2. A provider shall have an employee grievance procedure which complies with federal and state law.

J. Abuse Reporting. A provider shall have abuse reporting procedures which require all staff members to report any incidents of suspected abuse or mistreatment whether that abuse or mistreatment is done by another staff member or professional, family member, the client, or any other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1264 (November 1995).

§8911. Client Rights and Grievance Procedure

A. A provider shall ensure that clients are provided all rights available to them, be they interdicted or not, and shall document same.

B. A provider shall make every effort to ensure that a client understands his/her rights in matters such as access to services, appeal, grievance, and protection from abuse.

C. A provider shall have a written grievance procedure for clients designed to allow clients to make complaints without fear of retaliation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1265 (November 1995).

§8913. Glossary of Terms

Crisis—the subjective reaction to a stressful life experience that compromises the individual's and/or family's stability and ability to cope or function.

Crisis Assessment—exploration of the precipitating factors, description of current manifestations, identification of available resources, and development of a crisis response plan.

Crisis De-escalation—techniques for reduction in crisis manifestations and implementation of the crisis response plan.

Crisis Intervention—treatment which alleviates the impact of a crisis and helps mobilize the resources and improve the coping skills of those affected.

Crisis Intervention Service—services which provide assessment, de-escalation and referrals to those in emotional/behavioral crisis. This may include one-to-one intervention to prevent harm to self or others. These services may be available 24 hours a day, seven days a week and are usually staffed by crisis clinicians, social workers, and trained paraprofessionals.

Crisis Worker—professional or paraprofessional worker engaged in direct services delivery or in supervision of direct services delivery.

DSM IV—fourth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

One-to-one Intervention—provision of staff, trained in verbal de-escalation and passive physical restraint, to a person in crisis characterized by continuous visual contact, at a minimum, for a specified amount of time, for the purpose of preventing harm to self or others. These staff do not function as alternative care givers or supplant the existing care giver relationships.

Passive Physical Restraint—the least amount of direct physical contact required on the part of a staff member to prevent a client from harming self or others, and specifically excludes use of restraining devices.

Staff Member—staff members include the wage and hourly workers (consistent with Department of Labor guidelines) and independent contractors paid by the provider. Staff may be either administrative and clerical support workers or professional and paraprofessional workers engaged in direct service delivery. Due to the unpredictable nature of the demand for crisis services, crisis providers may need to employ independent contractors as staff members on an as-needed basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:51.

HISTORICAL NOTE: Promulgated by Department of Social Services, Office of the Secretary, LR 21:1265 (November 1995).