Chapter 91. Minimum Standards for Home Health Agencies

§9101. 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*)—the functions or tasks which are 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.

Administrator—a person who is designated in writing as administratively responsible and available in person or by telecommunication at all times for all aspects of an agency's operations.

Advisory Board—a group of persons who meet with agency staff and/or owners as frequently as needed, but at least once every year, to evaluate the overall functions of the agency.

Allied Health Personnel—nursing assistants, licensed practical nurses, licensed physical therapy assistants, and other health care workers who require supervision by other health care professionals.

Branch—an office from which a home health agency provides services within a portion of the total geographic service area served by the parent agency. The *branch* office is part of the parent home health agency; is located within a 50-mile radius of the parent agency; and shares administration and supervision. (See §9117, Operation of Branch Offices.)

Bureau—Bureau of Health Services Financing.

Change of Ownership (CHOW)—the sale or transfer of all or a portion of the assets or other equity interest in a home health agency. Examples of actions that constitute a change of ownership include:

a. unincorporated sole proprietorship. Transfer of title and property of another party constitutes change of ownership;

b. 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;

c. limited liability company. The removal, addition or substitution of a member in a limited liability company does not constitute a change of ownership;

d. 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.

Clinical Note—a written notation of each visit with a patient which shall include the date and time of the visit, services rendered, and the signature of person providing services. The note may also include any pertinent information related to the visit. (See §9129.B Clinical Note.)

Clinical Records—those documents maintained on all patients accepted for care by a home health agency. The records shall be retained in accordance with existing state law.

Controlling Ownership or Controlling Interest—an equity or voting interest possessed by a person or entity that:

a. has a direct or indirect equity interest equal to 5 percent or more in the capital, the stock, or the profits of a home health agency; or

b. is an officer or director of a home health agency which is organized as a corporation; or

c. is a partner in a home health agency which is organized as a partnership; or

d. is a member or manager of a home health agency which is organized as a limited liability company. The term *controlling ownership* is synonymous with the terms *controlling interest* or *control interest* as defined by the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS).

Department—the Department of Health and Hospitals (DHH).

Director of Nurses (DoN)—a person designated in writing to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and be responsible for compliance with regulatory requirements.

Full Licensure—issued only to those agencies that meet all criteria for licensure. It is valid for one year unless specified otherwise (the expiration date is on the license).

Geographic Service Area—area within a 50-statute mile radius of the parent agency.

Governing Body—the person or group of persons who have legal authority for and/or ownership of the corporation of the home health agency and responsibility for agency operations. A governing body assumes full legal authority and responsibility for the operation of the agency.

Home Health Agency—a state-owned and operated agency, or a subdivision of such an agency or organization; or a private nonprofit organization; or a proprietary organization which provides skilled home health care and support services to the public. Skilled home health care is provided under the order of a physician, in the place of residence of the person receiving the care, and includes skilled nursing and at least one of the following services:

a. physical therapy;

b. speech therapy;

c. occupational therapy;

d. medical social services; or

e. home health aide services.

Home Health Agency Premises—the physical site where the home health agency maintains staff to perform administrative functions, and maintains its personnel records, or maintain its patient service records, or holds itself out to the public as being a location for receipt of patient referrals. The home health agency shall be a separate entity from any other entity, business, or trade. If office space is shared with another health related entity, the home health agency must operate independently and have a clearly defined scope of services. The home health agency may not share office space with a nonhealth-related entity.

Home Health Aide—a qualified person who provides direct patient care in the home under the direct supervision of a registered nurse to assist the patient with the activities of daily living.

Home Health Packet—the collection of appropriate forms for licensure that may be obtained from the department for an established fee. This packet is to be completed by all initial applicants before the licensure process can begin.

Jurisdiction—all home health agencies shall be under the jurisdiction of the Department of Health and Hospitals, which promulgates and enforces the rules governing the operation of such agencies or organizations. However, nothing in this Part shall be construed to prohibit the delivery of personal care, homemaker, respite, and other in-home services by a person or entity not licensed under this rule unless provided with other home health services.

Licensed Practical Nurse—a person who works under the supervision of a registered nurse.

Life-threatening—causes or has the potential to cause serious bodily harm or death of an individual.

Physician—a doctor of medicine, a doctor of osteopathy, or a podiatrist who is currently authorized to practice in Louisiana.

Professional Staff—health care providers who are required to possess current licensure and/or board certification and are authorized to supervise other health professionals as indicated.

Provisional License—a license issued to those agencies that do not meet criteria for full licensure. It is issued by the department and is valid for six months or until the termination date.

Skilled Care—services provided by an agency for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by licensed professional health care personnel.

Supervision—authoritative procedural guidance by a qualified person who assumes the responsibility for the accomplishment of a function or activity and who provides direction, ongoing monitoring and evaluation of the actual act of accomplishing the function or activity.

Support Services—services provided to assist the ill, disabled or infirmed person with household tasks essential to achieving adequate household and family management. *Support services* may include, but are not limited to, housekeeping, shopping, maintenance of premises, sitter or companion services. Home health agencies that choose to provide *support services* must have written policies and procedures outlining the delivery, training, assignment, supervision and complaint resolution processes for these services. *Support services* are strictly supportive in nature and are not part of the patient's medical plan of care; therefore, a physician's order is not required.

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§9103. Personnel Qualifications and Responsibilities

A. Administrator. The administrator shall be appointed by and answer directly to the governing body of the agency. The administrator and the director of nursing or the alternate director of nursing may be the same individual if dually qualified. If an individual is designated as the administrator for more than one agency, then he/she must designate an alternate who is a full-time, on-site employee of each agency and meets the qualifications for an administrator.

1. Qualifications

a. The administrator must have three years of management experience in the delivery of health care service and meet one of the following criteria:

i. is a licensed physician; or

ii. is a registered nurse; or

iii. is a college graduate with a bachelor's degree; or

iv. has an associate degree; or

v. has had three additional years of documented experience in health care delivery services; or

vi. has had six additional years of documented administrative and managerial experience in a governmental or corporate setting, other than in health care delivery services; supervised at least 20 employees; and handled

administration of the daily operations of the organization, including the budget process. The person shall have held no more than three positions during the six-year time period.

b. In addition to the qualifications listed above, those individuals who meet the qualifications contained in ɔ9103.A.1.a.iii-vi must have one additional year of home health management experience.

2. Responsibilities. The administrator shall:

a. be available in person or by telecommunication at all times for all aspects of agency operation;

b. designate in writing an individual, who meets the qualifications for an administrator, to assume the authority and the control of the agency if the administrator is unavailable;

c. direct the operations of the agency;

d. be responsible for compliance with all regulations, laws, policies and procedures applicable to home health and Medicare (when applicable) issues;

e. employ qualified individuals and ensure adequate staff education and evaluations;

f. ensure the accuracy of public information materials and activities;

g. act as liaison between staff, the group of professional personnel, and the governing body; and

h. implement an ongoing accurate and effective budgeting and accounting system.

B. Advisory Board

1. Qualifications. The advisory board shall be composed of the following individuals:

a. at least three health care professionals of which one must be an RN and one must be a physician; and

b. at least two nonhealth care professionals from the community who are not connected financially or by family to the agency or the governing body; one of these professionals may be a member of a patient's family.

2. Responsibilities. The advisory board shall:

a. conduct an annual documented review of the policies and procedures, the budget, overall program evaluation, statistical information, complaint resolutions and any projected changes;

b. maintain written minutes of meetings with the signatures of all attendees, dates, and times; and

c. receive written notification of any of the following:

i. the agency's administrator or director of nurses is fired, resigns, or becomes incapacitated to the extent that he/she can no longer perform his/her duties;

ii. the agency is surveyed and found to be in violation of the state law, minimum standards, rules, or regulations of the Department of Health and Hospitals;

iii. any other grounds which adversely affect the agency's operation.

C. Director of Nurses

1. Qualifications. The director of nurses (DoN) must be a registered nurse who is currently licensed to practice in the State of Louisiana and has at least three years of experience as a registered nurse. One of these years must consist of full-time experience in providing direct patient care in a home health setting. The DoN must be a full-time employee of only one agency.

NOTE: The director of nurses may never serve more than one agency.

2. Responsibilities. The director of nursing shall:

a. be a full-time employee of only one home health agency;

b. supervise all patient care activities to assure compliance with current standards of accepted nursing and medical practice;

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

d. develop and maintain agency policy and procedure manuals that establish and support the highest possible quality of patient care, cost controls, quality assurance, and mechanisms for disciplinary action for infractions;

e. supervise employee health program;

f. assure compliance with local, state, and federal laws as well as promote the health and safety of employees, patients and the community with 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 to personnel to promote the health and safety of the patient as well as to familiarize staff with regulatory issues and agency policy and procedures;

v. ensure orientation of health care personnel who provide direct patient care;

vi. ensure timely annual evaluation of health care personnel;

vii. assure regularly scheduled appropriate continuing education for all health professionals and home health aides;

viii. assure that the care provided by the health care personnel promotes the health and safety of the patient; and

ix. assure that agency policies are enforced;

g. be on site or immediately available to be on site and available by telecommunications during normal operating hours. The agency shall designate in writing a registered nurse who will assume the responsibilities of the DoN during his/her absence, i.e., on vacation, ill time, at a workshop, etc.

D. Home Health Aide

1. Qualifications. A home health aide must meet the following criteria:

a. successfully complete a competency evaluation; and

b. have current nursing assistant certification; or

c. have successfully completed a training program; and

d. exhibit a sympathetic attitude toward the patient, an ability to provide care to the sick, and the maturity 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; and

f. must inform all employers when employed with one or more agencies; cooperate and coordinate to assure highest performance of quality when providing services to the patient.

2. Responsibilities. The home health aide:

a. shall obtain and record vital signs during each visit in addition to notifying the primary registered nurse of deviations according to standard practice;

b. may provide assistance with the following ADL's during each visit: mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, or toileting. 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 ambulation;

v. helping the patient with prescribed exercises which the patient and the health 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;

c. may perform care assigned by a registered nurse if the delegation is in compliance with current standards of nursing practice;

d. may administer over the counter disposable enemas, saline or vinegar douches, and glycerine or Ducolax suppositories; and

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

3. Restrictions. The home health aide shall not:

a. perform any intravenous procedures, procedures involving insertion of feeding tubes or urinary catheters, the administration of tube feedings, or any other sterile or invasive procedures;

b. administer medications to any patient; and

c. perform any of the following tasks which are not home health aide services:

i. transporting the patient;

ii. general housekeeping duties; or

iii. shopping.

4. Training. A home health agency that offers a training program must, at a minimum, include the following in the training program:

a. communication skills;

b. observation, reporting and documentation of patient status and the care or service furnished;

c. reading and recording temperature, pulse, and respiration;

d. basic infection control procedures;

e. basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

f. maintenance of a clean, safe, and healthy environment;

g. recognizing emergencies and knowledge of emergency procedures;

h. the physical, emotional, and developmental needs of the patient and methods for working with the populations served by the agency, including the need to respect the patient, his/her privacy and his/her property;

i. safe transfer techniques and ambulation;

j. appropriate and safe techniques in personal hygiene and grooming that include:

i. bed bath;

ii. sponge, tub, or shower bath;

iii. sink, tub, bed or shampoo;

iv. nail and skin care;

v. oral hygiene; and

vi. toileting and elimination.

k. normal range of motion and positioning;

l. adequate nutrition and fluid intake;

m. any other task, within state regulations, that the agency may choose to have the home health aide perform.

5. Orientation. The content of the basic orientation provided to home health aides shall include the following:

a. policies and objectives of the agency;

b. duties and responsibilities of a home health aide;

c. the role of the home health aide as a member of the health care team;

d. ethics and confidentiality;

e. record keeping;

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

g. information on the emotional problems accompanying illness; and

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

6. Assignment. The home health aide is assigned to a patient by a registered nurse in accordance with the plan of care. Specific written instructions for patient care are prepared by a registered nurse or therapist as appropriate. All personal care services are described to the patient, in writing, by the registered nurse in charge of that patient.

7. Supervision. A registered nurse or licensed therapist shall provide direct supervision to the home health aide as follows.

a. A registered nurse shall supervise and evaluate the home health aide's ability to perform assigned duties, relate to the patient, and work effectively as a member of the health care team.

b. Periodic on-site supervision with the home health aide present shall be established as part of the agency's policies and procedures.

c. If the patient is receiving a skilled service (nursing, physical therapy, occupational therapy, or speech-language pathology), the supervisory visits shall be made to the patient's residence at least once every two weeks (not to exceed 20 days) by the registered nurse or appropriate therapist to assess relationships and determine whether goals are being met.

d. If the patient is not receiving skilled services, a registered nurse must make a supervisory visit to the patient's residence at least once every 62 days. In order to ensure that the aide is properly caring for the patient, the supervisory visit must occur while the home health aide is providing patient care.

e. Documentation of supervision shall include the aide-patient relationships, services provided, and instructions and comments given as well as other requirements of the clinical note.

f. Annual performance review for each aide shall be documented in the individual's personnel record.

8. In-service. The agency must offer a minimum of 12 hours of appropriate in-service training to each home health aide every calendar year. The in-service may be furnished while the aide is providing service to the patient, but must be documented.

a. These in-service sessions should include, but are not limited to:

i. care of the body;

ii. communication;

iii. infection control;

iv. safety and documentation.

b. In-service training may be prorated for employees who only worked a portion of the year; however, part-time employees who work throughout the year must attend 12 hours of in-service training.

c. Documentation should include the outline and length of the in-service training.

E. Licensed Practical Nurse

1. Qualifications. A licensed practical nurse (LPN) must:

a. be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions;

b. have worked at least one year as an LPN prior to being employed by a home health agency; and

c. inform all employers when employed with one or more agencies and cooperate and coordinate to assure highest performance of quality when providing services to the patient.

2. Responsibilities. The LPN shall:

a. perform skilled nursing services under the supervision of a registered nurse in accordance with the laws governing the practice of practical nursing;

b. observe and report the patient's response to treatment and any changes in the patient's condition to the physician and supervising registered nurse;

c. administer prescribed medications and treatments as permitted by the laws governing the practice of practical nursing;

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

e. perform wound care as ordered in accordance with the plan of care; and

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

3. Restrictions. The LPN shall not:

a. access any intravenous appliance for any reason;

b. perform supervisory visit for a home health aide;

c. develop and/or alter the plan of care;

d. make initial assessment visit;

e. prepare the recertification;

f. make aide assignments; or

g. function as a supervisor of the nursing practice of any registered nurse.

F. Medical Social Services

1. Qualifications. A medical social worker must:

a. be currently licensed by the Louisiana Board of Certified Social Work Examiners; or

b. have a master's degree from a school of social work accredited by the Council on Social Work Education.

2. Responsibilities. The medical social worker shall:

a. assist the physician and other members of the health care team in understanding significant social and emotional factors related to the patient's health problems;

b. assess the social and emotional factors having an impact on the patients health status, and assist in the formulation of the plan of care;

c. provide services within the scope of practice, as defined by state law, in accordance with the plan of care and in coordination with other members of the health care team;

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

e. participate in discharge planning and in-service programs related to the needs of the patient; acts as a consultant to other members of the health care team; and

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

3. Restrictions. An unlicensed medical social worker may not contract directly with the home health agency for clinical services, consultation, supervision or educational services.

G. Nutritional Guidance Services

1. Qualifications. If an agency provides or arranges for nutritional guidance, the staff member or consultant must be a professional dietitian who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association.

2. Responsibilities. The dietitian must:

a. document each visit made to the patient and incorporate notes into the clinical record on a weekly basis;

b. prepare initial nutritional dietary assessment;

c. communicate with the director of nurses, the nurse supervisor and/or the primary nurse assigned to the patient regarding the need for a continuation of services for each patient;

d. evaluate compliance with physician-ordered therapeutic diet and makes recommendations as needed;

e. evaluate patient's socio-economic factors to develop recommendations concerning food purchasing, preparation and storage;

f. train those persons who are responsible for purchasing and storing food;

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

h. participate in all related case conferences with agency staff. Minutes of case conferences are retained in patient's clinical record;

i. prepare a written discharge summary and ensure that a copy is retained in patient's clinical record and a copy is forwarded to the attending physician;

j. assess and evaluate the food and nutritional needs of the patient in accordance with the plan of treatment and the Recommended Daily Dietary Allowances established by the Food and Nutrition Board, National Academy of Sciences-National Research Council;

k. participate in discharge planning and in-service training programs related to the needs of the patient and acts as a consultant to the other members of the health care team; and

l. ensure that a current diet manual (within five years of publication) is readily available to agency staff where applicable.

H. Occupational Therapist

1. Qualifications. An occupational therapist must be registered by the American Occupational Therapy Association, and currently licensed by the Louisiana Board of Medical Examiners.

2. Responsibilities. The occupational therapist shall:

a. assist the physician in evaluating the patient's functional status and occupational therapy needs, and assist in the development of the plan of care;

b. provide services within the scope of practice as defined by the state laws governing the practice of occupational therapy, in accordance with the plan of care, and in coordination with other members of the health care team;

c. observe and report the patient's response to treatment and any changes in his/her condition to the physician and the supervising registered nurse;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the plan of care, functional limitations and progress towards goals;

e. prepare clinical and/or progress notes for each visit and incorporate them into the clinical record at least weekly;

f. when occupational therapy services are discontinued, submit a written summary of services

provided, including an assessment of patient's current status, for retention in the patient's clinical record; and

g. provide supervision of the occupational therapy assistant (OTA) as follows:

i. be readily available to the OTA by telecommunications;

ii. assess the competency and experience of the OTA;

iii. establish the type, degree and frequency of supervision that is required for an OTA in a home health setting; and

iv. conduct a face-to-face patient care conference with each OTA once every two weeks, or once every four to six treatment sessions, to review progress and modification of treatment programs for all patients.

I. Occupational Therapy Assistant

1. Qualifications. The occupational therapy assistant (OTA) must:

a. be currently 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

b. have, at a minimum, two years experience as a licensed OTA before starting a home health caseload.

J. Physical Therapist

1. Qualifications. The physical therapist must be currently licensed by the Louisiana State Board of Physical Therapy Examiners and have graduated from a school with a physical therapy curriculum approved by:

a. the American Physical Therapy Association; or

b. the Council on Medical Education and Hospitals of the American Medical Association; or

c. the Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

2. Responsibilities. The physical therapist shall:

a. assist the physician in evaluating the patient's functional status and physical therapy needs, and assist in the development of the plan of care;

b. provide services within the scope of practice as defined by the state laws governing the practice of physical therapy, in accordance with the plan of care, and in coordination with other members of the health care team;

c. observe and report the patient's reaction to treatment and any changes in his/her condition to the physician and the supervising registered nurse;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the plan of care, functional limitations and progress towards goals;

e. prepare clinical and/or progress notes for each visit and incorporate them into the clinical record at least weekly;

f. when physical therapy services are discontinued, prepare a written discharge summary and ensure that a copy is retained in the patient's clinical record and a copy is forwarded to the attending physician;

g. may supervise home health aides in lieu of a registered nurse if physical therapy is the only skilled service being provided;

h. provide supervision to a physical therapy assistant (PTA) as follows:

i. be readily accessible by telecommunications;

ii. evaluate and establish a written treatment plan on the patient prior to implementation of any treatment program;

iii. treat and reassess the patient on at least every sixth visit, but not less than once per month;

iv. conduct a face-to-face patient care conference once a week with each PTA to review progress and modification of treatment programs for all patients; and

v. assess the final treatment rendered to the patient at discharge and write a discharge summary.

K. Physical Therapy Assistant

1. Qualifications. The physical therapy assistant (PTA) must be currently licensed by the Louisiana State Board of Physical Therapy Examiners and be supervised by a licensed physical therapist. The PTA must have, at a minimum, one year of experience as a licensed PTA before assuming responsibility for a home health caseload.

2. Restrictions. The PTA's duties shall not include interpretation and implementation of referrals or prescriptions, performance evaluations, or the determination or major modifications of treatment programs.

L. Registered Nurse

1. Qualifications. The registered nurse (RN) must be currently licensed by the Louisiana State Board of Registered Nurse Examiners without restrictions and have, at a minimum, one year of clinical experience as a registered nurse. This requirement may be waived for a registered nurse with recent clinical experience as a LPN or an RN currently working for a home health agency at the time this rule takes effect.

a. Special Qualifications. In addition to the above qualifications, a RN must have one of the following credentials in order to provide psychiatric nursing services. Work experience must have been obtained within the last five years. If experience is not within the five-year time period, then documentation must be provided to support either psychiatric retraining, classes, or CEUs to update psychiatric knowledge:

i. a master's degree in psychiatric or mental health nursing; or

ii. a bachelor's degree in nursing and one year of work experience in an active treatment unit in a psychiatric or mental health facility or outpatient mental health clinic; or

iii. a diploma or associate degree and two years of work experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic.

2. Responsibilities. The registered nurse shall:

a. provide or supervise skilled nursing services in accordance with physicians orders;

b. assess and regularly re-evaluate the nursing needs of the patient;

c. develop, initiate, implement, and update the plan of care as needed or at least every 62 days, or as needed;

d. provide specialized nursing services, which may include treatments and diagnostic and preventive procedures;

e. initiate preventive and rehabilitative nursing procedures as appropriate for the patient's care and safety;

f. coordinate services and inform the physician and other personnel of changes in the patient's condition and needs;

g. teach, supervise and counsel the patient, family members and other members of the health care team regarding the nursing care needs and other related problems of the patient at home;

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

i. observe and report the patient's response to treatment and any changes in his/her condition to the physician and supervising registered nurse;

j. conduct on-site supervisory evaluations at least every six months of each licensed practical nurse while he/she is providing care and document such supervision in the LPN's personnel file;

k. conduct on-site supervision of patient care provided by the home health aide; and

l. function as patient advocate in all medical decisions affecting the patient.

3. Restrictions. A registered nurse applicant may not work in the home health setting as a registered nurse.

M. Speech Pathology Services

1. Qualifications. The speech pathologist must be currently licensed by the Louisiana State Board of Examiners of Speech Pathology and Audiology and certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised (as directed by the state agency certifying body) work experience required for certification.

2. Responsibilities. The speech pathologist shall:

a. assist the physician and other members of the health care team in evaluating the patient's speech or language needs and formulating the plan of care;

b. provide services within the scope of practice as defined by the state law governing the practice of speech pathology, in accordance with the plan of care and in coordination with other members of the health care team;

c. observe and report the patient's response to treatment and any changes in the patient's condition to the physician and supervising registered nurse;

d. instruct and inform participating members of the health care team, the patient, and the family/caregivers regarding the plan of care, functional limitations and progress towards goals;

e. prepare clinical and or progress notes for each visit and incorporate them into the clinical record at least weekly; and

f. submit a written summary of the services provided when speech therapy services are discontinued, including an assessment of the patient's current status which shall be retained in the patient's clinical record.

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§9105. State Licensure

A. Initial Licensure

1. The Department of Health and Hospitals is the only licensing authority for home health agencies in the State of Louisiana. To initiate the review process for licensure as a home health agency, the applicant must submit the following:

a. a completed home health application form;

b. the required fee for licensure by corporate check, certified check or money order. This fee is non-refundable;

c. documentation of a line of credit from a licensed lending agency for at least $75,000 as proof of adequate finances to sustain an agency for at least six months;

d. proof of general and professional liability insurance as well as worker's compensation insurance. The general and professional liability coverage shall be for at least $300,000. The agency must maintain these insurance requirements at all times, and be able to provide proof of insurance upon request;

e. résumés and documentation of qualifications for administrator and director of nursing. Additional information may not be submitted after the original resumé is submitted for review, except for changes in the designated positions or with approval of the Health Standards Section;

f. proof of criminal background investigations on the owners and administrative personnel. If the agency is a

corporation, proof of criminal background investigations on all directors and officers shall also be submitted;

g. written documentation of any financial or familial relationship with any other entity providing home health care services in the state;

h. proof of citizenship or a valid green card for all administrative personnel, officers, directors and owners; and

i. any other forms for initial licensure as required by the Health Standards Section.

2. An application will not be reviewed until payment of application fee has been received. All requirements of the application process must be completed by the applicant within 90 days of the date of the initial submission of the home health license application. Upon approval of the application by DHH, the applicant must agree to become fully operational and prepared for initial survey within 90 days. Any application not completed within 90 days after the initial submission will be closed.

3. The applicant will be notified in writing when the application process is completed and the application is approved. The applicant will receive instructions regarding requesting an initial licensing survey.

4. Approved applicants must be fully operational, in compliance with all licensing standards and providing care to only two patients at the time of the initial survey.

5. If an applicant requests to be certified for Medicare and/or enrolled in Medicaid prior to the initial survey, the applicant must also be in compliance with the Medicare Conditions of Participation for home health agencies (42 CFR Part 484) at the time of the licensing survey.

B. Types of Licenses. The Department of Health and Hospitals shall have the authority to issue the three types of licenses described below:

1. Full License—issued to those agencies which have achieved substantial compliance with the Minimum Standards.

2. Administrative Provisional License—may be issued to an existing agency that has paid the annual renewal fee, but the survey process was not completed before the expiration of its license.

3. Provisional License—may be issued to those existing agencies that do not meet criteria for full licensure. Such licenses may be issued to any agency by the department when the agency:

a. receives more than five violations of the minimum standards in a one-year period;

b. receives more than three valid complaints in a one-year period;

c. has placed a patient at risk according to a documented incident;

d. fails to correct deficiencies within 60 days of being cited;

e. fails to submit assessed fees after notification by the department;

f. has an owner, administrator, or director of nurses who has pled guilty or nolo contendere to a felony, or been convicted of a felony as documented by a certified copy of the record of the court of conviction. If the applicant is a firm or corporation, a provisional license may also be issued when any of the members, officers, or the person designated to manage or supervise the agency has been convicted of a felony; or

g. fails to notify the department in writing within 30 days of the occurrence of a change in any of the following:

i. controlling ownership;

ii. administrator;

iii. director of nursing or alternate;

iv. address/telephone number; either parent or branch;

v. hours of operation;

vi. after-hours contact procedures.

C. Licensure Renewal

1. Full License

a. A full license shall be for a term of one year and shall expire on the date shown on the license unless it is renewed.

b. It is the responsibility of the agency to ensure that a renewal application and appropriate fees are submitted to the Department at least 30 days prior to the expiration of the existing license.

2. Provisional License

a. A provisional license shall be valid for six months or until its expiration date.

b. Any agency issued a provisional license shall pay an additional amount equal to the annual fee for each follow-up survey. Fees shall be paid to the department prior to the survey being performed and shall be non-refundable.

D. Display of License. The agency's current license shall be displayed in a conspicuous place in the agency at all times.

E. Survey Process

1. Initial. An on-site survey will be conducted to assure compliance with the Minimum Standards. The request for initial licensing survey will be accepted after the applicant has been notified in writing by the department that the application process is completed and the applicant is approved for an initial survey. This survey will be unannounced and the agency will have only one opportunity to be in compliance with the Minimum Standards. If the initial survey finds that the agency is not in substantial compliance with the Minimum Standards, then the agency shall transfer all patients and close.

2. Renewal. An unannounced, on-site visit will be conducted to assure compliance with the Minimum Standards. This annual survey may be conducted in conjunction with a survey for Medicare recertification or other reasons.

3. Follow-up. An unannounced survey may be conducted following an annual, complaint, or previous follow-up survey when the agency is not in substantial compliance with the Minimum Standards.

4. Complaint Investigation. The Department of Health and Hospitals has the authority to conduct investigations regarding home health agencies. A complaint investigation may be conducted during an unannounced on-site visit or by telephone, as appropriate.

5. Violations of Minimum Standards. If the agency is found to be in violation of the minimum standards during any survey, a statement of deficiencies listing those violations will be issued to the agency. The agency must respond to these violations with an acceptable plan of correction, which must be submitted to the department. The plan of correction must be received by the department within 10 days of receipt of the statement of deficiencies by the agency. A follow-up survey may be conducted to assure that the agency has achieved substantial compliance with the minimum standards. If the follow-up survey reveals that the agency is still not in substantial compliance with the minimum standards, then a provisional license may be issued or a revocation action may be initiated in accordance with R.S.40:2116.32 and R.S. 40:2116.36. The agency has one opportunity to question allegations of deficient practice through an informal dispute resolution process. The agency receives a notice of its right to request the informal dispute resolution process with the statement of deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2245 (December 2001).

§9107. Fees

A. Licensing Fee. A licensing fee, in the amount determined by DHH, is required to be submitted with the initial application. The department will not consider an application as complete without the required licensing fee.

B. Renewal Fee. A license renewal fee is required to be submitted annually to the department prior to the expiration of the license.

C. Change Fee. A fee is required to be submitted for any change involving the agency business name or address, including branch offices.

D. Change of Ownership Fee. A fee equal to the amount of licensing fee is to be paid to the department by the new owner when a change of ownership occurs.

E. Branch Fee. A fee shall be paid when a new branch office is established. The branch fee shall be submitted annually with the license renewal fee.

F. Provisional License Fee. Any agency issued a provisional license shall pay an additional amount equal to the annual fee for each follow-up survey. Fees shall be paid to the department prior to the survey being performed and shall be non-refundable.

NOTE: All fees submitted to the department must be in the form of a certified check, company check, or money order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2246 (December 2001).

§9109. Changes

A. Notice of Changes. The department shall be notified in writing or by facsimile within 24 hours of the occurrence of any of the following changes:

1. geographic address of the parent or branch office (change fee required);

2. name of the agency (change fee required);

3. mailing address (if different from geographic address);

4. telephone number or FAX number of the parent or branch office

5. hours of operation;

6. 24-hour contact procedures;

7. administrator or DoN;

8. controlling ownership;

9. closure of the agency or a branch;

B. Change of Ownership. The department shall be notified in writing of a change of ownership or change of controlling interest.

1. A change of ownership (CHOW) packet is required to be submitted with required fees.

2. When a change in controlling interest occurs, written documentation and disclosure of the change must be submitted.

3. The purchaser of the agency must meet all criteria for an initial application for licensure. (See §9105, State Licensure.)

C. Voluntary Termination of License. If at any time the agency ceases to operate, the agency shall notify the department in writing and surrender its license to the department within five working days of the cessation of business.

D. Relocation of an Agency. The department shall be notified in writing of any relocation of an agency. An agency may only relocate within its geographic service area in effect on August 15, 1995, or for an agency licensed after that date, a 50-mile radius of the location where the agency was originally licensed.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2246 (December 2001).

§9111. Denial, Revocation or Nonrenewal of License

A. Denial of Licensure Applications. If an agency's license is revoked or denied renewal, no other home health agency license application will be accepted from that agency for approval by the department for two years from the date of the revocation or denial of renewal of the license.

B. Grounds for Denial or Revocation of License. The Department of Health and Hospitals may deny an application for a license, refuse to renew a license or revoke a license in accordance with R.S. 40:2116.36 and 40:2116.37.

C. Grounds for Immediate Denial or Revocation. A license shall be immediately denied or revoked if the department determines that the agency either knowingly and willfully or through gross negligence allowed or directed actions which resulted in:

1. cruelty to patients;

2. failure to uphold patient rights resulting in actual or potential harm or injury;

3. failure to protect patients or persons in the community from the harmful actions of the agency employees including, but not limited to: coercion, threat, intimidation, solicitation and harassment;

4. failure to notify an appropriate governmental agency of any suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause harm to the patient;

5. acceptance of a patient when the agency has insufficient capacity to provide care for that patient;

6. misrepresentation or other fraudulent conduct in any aspect of the conduct of home care business;

7. bribery, harassment, or intimidation of any person designed to cause that person to use the services of any particular home health agency;

8. pleading guilty or nolo contendere to a felony, or being convicted of a felony by an owner, administrator, or director of nursing as documented by a certified copy of the record of the court of conviction. If the applicant is a firm or corporation, a license may also be immediately denied or revoked when any of its members, officers, or the person designated to manage or supervise the home care has been convicted of a felony. For 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, Medicaid, or Title XX services program since the inception of those programs;

b. conviction of a felony relating to violence, abuse, and/or negligent of a person; or

c. conviction of a felony related to the misappropriation of property belonging to another person.

D. Additional Grounds for Denial or Revocation. A license may be denied, revoked or not renewed for failure to correct any violation of law and regulation for which a provisional license may have been issued under R.S. 40:2116.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 22:1135 (November 1996), LR 27:2247 (December 2001).

§9113. Informal Dispute Resolution Process, Notice and Appeal Procedure

A. Informal Dispute Resolution Process. An agency has one opportunity to question citations of deficient practice through an informal dispute resolution process. To request an informal dispute resolution discussion, the agency must submit a written request specifying the deficient practice(s) that are being disputed and why the agency is questioning the deficient practice(s). The request must be made within 10 days of the date of the agency's receipt of the notice of the deficient practice(s). Reconsideration shall be made solely on the survey report, statement of violations and all documentation the agency submits to the department at the time of its request for reconsideration. Correction of a violation shall not be a basis for reconsideration. Since this is an informal dispute resolution discussion, it is not necessary for the agency's attorney to be present. However, if the agency wishes to include their attorney in the informal dispute resolution discussion, the agency must indicate this in their written request. The informal dispute resolution process is not in lieu of the appeals process and does not extend the time limits for filing an administrative appeal.

B. Notice. Notice of reasons for nonrenewal or revocation of a license shall be given in accordance with the current Louisiana Revised Statutes.

C. Administrative Appeal Process. When an administrative appeal is requested in a timely and proper manner, the Department of Health and Hospitals shall provide an administrative hearing in accordance with the provisions of the Louisiana Administrative Procedure Act and the current Louisiana Revised Statutes.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2247 (December 2001).

§9115. Agency Operations

A. Hours of Operation. An agency shall be required to have regular posted business hours and be fully operational at least eight hours a day, five days a week between 7 a.m.

and 6 p.m. Patient care services shall be made available as needed 24 hours a day, seven days a week.

B. Operational Requirements

1. A home health agency shall:

a. be open for the business of providing home health care services;

b. post its hours of operation and emergency contact procedures in a prominent and easily accessible manner;

c. have a registered nurse immediately available by telecommunications at all times;

d. respond to patient care needs and physician orders in a timely manner;

e. be able to accept referrals at all times;

f. have at least two patients at all times;

g. have adequate staff to provide for patient care needs according to accepted standards of practice;

h. have policies and procedures specific to the agency which address staff responsibilities and qualifications; agency operations; patient care standards; problem and complaint resolution; purpose and goals of operation; and regulatory and compliance subjects;

i. have policies and procedures that are written, current, and annually reviewed by appropriate personnel;

j. accept medical orders only from a physician or authorized physician representative (e.g., hospital discharge planner);

k. use only factual information in advertising;

l. have an emergency preparedness plan (which conforms to the Louisiana Model Home Health Emergency Preparedness Plan) designed to manage the consequences of natural disasters or other emergencies that disrupt the home health agency's ability to provide home health services;

m. limit the geographic service area of the agency to a 50-mile radius of the parent agency;

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

o. protect the patient from unsafe clinical practices;

p. ensure that staff is competent in the treatments and procedures provided to patients prior to the treatments or procedures being provided;

q. operate within the laws and regulations of all local, federal and state agencies which have authority over the operations of such businesses;

r. notify the department of any change of address, services added or ceased, and change of all key employees in accordance with ɔ9109;

s. maintain general and professional liability insurance with minimum limits of $300,000 and workers' compensation insurance in the minimum statutory amount.

2. A home health agency may:

a. participate as educators in public health fairs and may provide free non-invasive services, such as blood pressure screenings; and

b. advertise its services and provide truthful and accurate informational material to the public in so doing.

3. A home health agency shall not:

a. harass, bribe, coerce, or intimidate any patient to change agencies or to select an agency;

b. allow, permit, or encourage any employee or volunteer representing the agency to harass, bribe, coerce, or mistreat any patient in any manner or form; and

c. advertise untruthfully regarding the services provided, professional credentials of any employee, accreditation awards, or other such information that misleads and misinforms the public.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001).

§9117. Operation of Branch Offices

A. Branch Office Approval. No branch office may be opened without written approval from the department. In order for a branch office to be approved, the parent agency must have full licensure for at least one year. Branch office approval will be renewed at the time of renewal of the parent agency's license if the parent agency meets the requirements for licensure.

B. Identification. The branch shall be held out to the public as a branch or division of the parent agency, so that the public will be aware of the identity of the agency operating the branch. Reference to the name of the parent agency shall be contained in any written documents, signs, or other promotional materials relating to the branch.

C. Personnel Records. Original personnel files shall not be maintained at the branch office.

D. Survey. A branch office is subject to survey by the Department at any time to determine compliance with the minimum standards which apply to branches.

E. Operational Requirements. A branch office shall:

1. serve a part of the geographic service area approved for the parent agency;

2. offer all home health services provided by the parent agency;

3. retain all original 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; and

4. maintain a statement of personnel policies on site for staff usage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001).

§9119. Personnel Policies and Records

A. Personnel Policies. Each home health agency will formulate and adhere to personnel policies. The policies will be reviewed on an annual basis and must specify agency requirements with regard to the following:

1. hours of work;

2. an organizational chart down to the patient care level;

3. job description and realistic performance expectations for each category of personnel;

4. an annual employee health screening in accordance with current local, federal, and state laws;

5. an outline of the planned orientation to be provided to each employee, including the length of the orientation;

6. annual personnel evaluations as well as annual verification of current Louisiana licensure and certification of applicable health professionals;

7. continuing education related to health care activities:

a. health professionals must attend inservice training as required by respective licensing boards.

b. home health aides must attend inservice training 12 hours per calendar year;

8. disciplinary actions;

9. grievance proceedings;

10. specifications for employee health/safety;

11. payroll; and

12. criminal background investigations ("history check"), if applicable.

B. Personnel Records. Original personnel files must be maintained either at the parent agency or integrated with the human resources department of a hospital, agency home office or the parent corporation of the agency. Personnel records must be made available to surveyors on request. There shall be a personnel record on file for each employee and contract staff member including, but not limited to, the following information:

1. name, address and telephone number;

2. job application/résumé;

3. the results of an annual employee health screening in accordance with current local, federal, and state laws;

4. current license or certification verification, if applicable;

5. current job description, including duties to be performed;

6. documentation of orientation;

7. current contract, if applicable;

8. annual personnel evaluations;

9. documentation of continuing education; and

10. criminal background investigation ("history check"), if applicable.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2248 (December 2001).

§9121. Emergency Preparedness

A. The home health agency shall have an emergency preparedness plan which conforms to the current Office of Emergency Preparedness model plan and is designed to manage the consequences of natural disasters or other emergencies that disrupt the home health agency's ability to provide care and treatment or threaten the lives or safety of its clients. The home health agency is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from the Louisiana Office of Emergency Preparedness.

B. At a minimum, the agency shall have a written plan that describes:

1. the evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to another location;

2. the delivery of essential care and services to agency clients, whether they are in a shelter or other locations;

3. the provisions for the management of staff, including distribution and assignment of responsibilities and functions;

4. a plan for coordinating transportation services required for evacuating agency clients to another location; and

5. assurance that the agency will notify the client's family or caregiver, if client is evacuated to another location.

C. The home health agency's plan shall be activated at least annually, either in response to an emergency or in a planned drill. The home health agency's performance during the activation of the plan shall be evaluated and documented. The plan shall be revised if the agency's performance during an actual emergency or a planned drill indicates that it is necessary.

D. Any updates or revisions to the plan shall be submitted to the parish Office of Emergency Preparedness for review. The parish Office of Emergency Preparedness shall review the home health agency's plan by utilizing community wide resources.

E. As a result of an evacuation order issued by the parish Office of Emergency Preparedness (OEP), it may be necessary for a home health agency to temporarily relocate outside of its licensed geographic service area. In such a case, the agency may request a waiver to operate outside of

its licensed location for a time period not to exceed 90 days in order to provide needed services to its clients and/or other evacuees of the affected areas. The agency must provide documentation as required by the department.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2249 (December 2001), LR 32:846 (May 2006).

§9123. Patient Care Standards

A. Admission Criteria. The home health agency shall follow written policies in making decisions regarding the acceptance of patients for care. Decisions must be based upon medical and social information provided by the patient's attending physician, and the patient and/or the family as well as the agency resources available to meet the needs of potential patients. The home health agency shall accept patients for care without regard to age, color, creed, sex, national origin or handicap. Patients shall be admitted to an agency based on the following written criteria:

1. the ability of the agency and its resources to provide services on a timely basis (within 24 hours unless specified otherwise by physician's order);

2. the willingness of the patient and caregiver to participate in the plan of care;

3. the patient's medical, nursing or social needs can be adequately met in his/her residence; and

4. all other criteria required by any applicable payor source(s).

B. Admission Procedure. Patients are to be admitted only upon the order of the patient's physician. The patient shall have the right to choose a physician and a home health agency without interference. Admission procedures are as follows:

1. an initial visit shall be made by a registered nurse or an appropriate therapist who will perform the assessment and instruct the patient regarding home care services. This visit shall be made within 24 hours of referral unless otherwise ordered by physician;

2. an initial Plan of Care (PoC) must be completed by a R.N. or an appropriate therapist and incorporated into the patient's clinical record within seven days from the start of care; and

3. documentation shall be obtained at admission and retained in the clinical record including:

a. the referral for home care and/or physician's order to assess patient;

b. a history;

c. a physical assessment;

d. a functional assessment, including a listing of all ADL's;

e. current problems, needs, and strengths;

f. prescribed and over-the-counter medications currently used by the patient;

g. services needed, including frequency and duration expected;

h. defined expected outcomes, including estimated date of resolution;

i. ability, availability, and willingness of potential care-givers;

j. barriers to the provision of care;

k. orientation, which includes:

i. advanced directives;

ii. agency services;

iii. patient's rights and responsibilities, including the telephone number for the home health hotline;

iv. agency contact procedures; and

v. conflict resolution;

l. freedom of choice statement signed by patient or patient representative; and

m. other pertinent information.

C. Plan of Care. The plan of care (PoC) for each patient must be individualized to address the patient's problems, goals, and required services.

1. The PoC, telephone and/or verbal orders must 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 must be cosigned by a RN or appropriate therapist.

2. Agency staff shall administer services and treatments only as ordered by the physician.

3. A PoC for continuation of services must be completed by a RN or an appropriate therapist and incorporated into the patient's clinical record within seven days from the date of the development of the PoC.

D. Review of the Plan of Care. The total plan of care must be reviewed by the patient's attending physician in consultation with the agency's professional personnel at such intervals as required by the severity of the patient's illness, but at least once every two months.

E. Drugs and Biologicals. The agency shall institute procedures that protect the patient from medication errors. Agency policy and procedures shall be established to insure that agency staff has adequate information regarding the drugs and treatments ordered for the patient.

1. Agency staff will only administer drugs and treatments as ordered by the physician.

2. Only medications dispensed, compounded or mixed by a licensed pharmacist and properly labeled with the drug name, dosage, frequency of administration and the name of the prescribing physician shall be administered.

3. The agency will provide verbal and written instruction to patient and family as indicated.

F. Coordination of Services. Patient care goals and interventions must be coordinated in conjunction with providers, patients and/or caregivers to ensure appropriate continuity of care from admission through discharge.

1. All agencies shall provide for nursing services at least eight hours a day, five days a week and be available on emergency basis 24 hours a day, seven days a week. Agencies must maintain an on-call schedule for RN's.

2. The agency must maintain a system of communication and integration of services, whether provided directly or under arrangement, that ensures identification of patient needs and barriers to care, the ongoing coordination of all disciplines providing care, and contact with the physician regarding for relevant medical issues.

G. Discharge Policy and Procedures

1. The patient may be discharged from an agency when any of the following occur:

a. the patient care goals of home care have been attained or are no longer attainable;

b. a caregiver has been prepared and is capable of assuming responsibility for care;

c. the patient moves from the geographic service area served by the agency;

d. the patient and/or caregiver refuses or discontinues care;

e. the patient and/or caregiver refuses to cooperate in attaining the objectives of home care;

f. conditions in the home are no longer safe for the patient or agency personnel. The agency shall make every effort to satisfactorily resolve problems before discharging the patient;

g. the patient's physician fails to renew orders for the patient;

h. the patient, family, or third-party payor refuses to meet financial obligations to agency;

i. the patient no longer meets the criteria for services established by the payor source;

j. the agency is closing out a particular service or any of its services;

k. death of the patient.

2. The agency must have discharge procedures that include, but are not limited to:

a. notification of the patient's physician;

b. documentation of discharge planning in the patient's record;

c. documentation of a discharge summary in the patient's record; and

d. forwarding of the discharge summary to the physician, if requested.

3. The following procedures shall be followed in the event of the death of a patient in the home:

a. the proper authorities shall be notified immediately in accordance with state and local ordinances;

b. the home health agency parent office shall be notified;

c. the home health agency personnel in attendance shall offer whatever assistance they can to the family and others present at scene; and

d. progress notes shall be completed in detail and must include observations of the patient, any treatment provided, individuals notified, and time of death, if established by the physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2249 (December 2001)

§9125. Patient Rights

A. The patient must be informed of his or her rights in receiving home care services. The patient has the right to exercise his/her rights as a patient of the home health agency. If the patient has been judged incompetent, the family or guardian may exercise the patient's rights. The agency must protect and promote the exercise of these rights.

1. Notice of Rights. The agency must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. The agency must maintain documentation that it has complied with the requirements of this ∋9125.

2. Right to be Informed and to Participate in Planning Care and Treatment. The patient has the right to be informed, in advance, about the care to be furnished and of any proposed changes in the care being furnished. The patient also has the right to participate in the planning of care and to be informed regarding advance directives.

a. The agency must advise the patient, in advance, of the disciplines that will furnish care and the proposed frequency of visits to be furnished.

b. The agency must advise the patient of any proposed change in the plan of care before the change is made.

c. The agency must advise the patient, in advance, of his/her right to participate in the planning of care or

treatment as well as in the planning of changes in care or treatment.

d. The agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The advance directives information may be given to a patient at the time of the first home visit, as long as the information is furnished before care is provided. The agency must maintain written policies and procedures regarding advance directives.

3. Right to Respect for Person and Property. The patient has the right to be treated with respect and to have his/her property treated with respect. The patient also has the right to file a grievance regarding the treatment or care that is or is not being furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency. The patient shall not be subjected to discrimination or reprisal for filing a grievance.

a. The agency must investigate complaints made by a patient or the patient's family or guardian regarding the treatment or care that is or is not being furnished or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the agency. The agency must document both the receipt and subsequent resolution of the complaint.

4. Right to Confidentiality of Medical Records. The patient has the right to expect the agency to maintain the confidentiality of his/her clinical records. The agency must advise the patient of its policies and procedures regarding disclosure of clinical records.

5. Right to be Informed about Patient Liability for Payment.

a. The patient has the right to be advised, before care is initiated, of his/her liability for payment for services furnished by the agency. Before care is initiated, the agency must inform the patient, orally and in writing, of:

i. the charges for services furnished by the agency;

ii. those charges for services that will not be covered by the patient's payor source; and

iii. the charges that the patient may be responsible for paying.

b. The patient has the right to be advised, orally and in writing, of any changes to the preceding requirements when they occur.

i. The agency must advise the patient of these changes orally and in writing as soon as possible, but no later than 30 calendar days from the date that the agency becomes aware of a change.

6. Home Health Hotline. The patient has the right to be advised of the availability of the state's toll-free home health hotline. When the agency accepts a patient for treatment or care, the agency must advise the patient, in writing, of the telephone number of the state's home health hotline, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local home health agencies. The patient also has the right to use this hotline to lodge complaints concerning the implementation of advance directives requirements.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21: 177 (February 1995), LR 27:2251 (December 2001).

§9127. Contract Services

A. An agency may contract with other companies or individuals to provide services to a patient. However, the agency is responsible for the management of the patient's care and for all services provided by the contractor or its personnel.

1. Contract Requirements. Whenever services are provided by an outside agency or individual, there must be a written contract. The contract shall include all of the following items:

a. designation of the services which are being arranged for by contract;

b. specification of the period of time that the contract is to be in effect, if it is for a specified time period;

c. a statement that services provided to the patient are in accordance with a plan of care established by the patient's physician in conjunction with the home health agency staff and, when appropriate, others involved in the patient's care;

d. a statement that services are being provided within the scope and limitations set forth in the plan of care, and may not be altered in type, scope, or duration by the contractor;

e. assurance that the contractor meets the same requirements as those specified for home health agency personnel such as staff qualifications, functions, evaluations, orientation and in-service training. The agency shall be responsible for assuring the contractor's compliance with the personnel policies required for a home health agency during the contractual period;

f. assurance that the contractor completes the clinical record in the same timely manner as required by the staff personnel of the agency;

g. payment of fees and terms; and

h. assurance that reporting requirements are met.

B. Contract Review. The home health agency and contractor shall document review of their contract on an annual basis.

C. Coordination of Contract Services. The home health agency shall coordinate services with contract personnel to assure continuity of patient care.

NOTE: Administration and one other service must be provided directly by the agency at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2251 (December 2001).

§9129. Clinical Records

A. Requirements. A clinical record containing past and current findings shall be maintained for every patient who is accepted by the agency for home health service. In addition, the agency must comply with the following requirements for clinical records.

1. The information contained in the clinical record must be accurate and immediately available to the patient's physician and appropriate home health agency staff. The record may be maintained electronically.

2. All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry with the unique identifier of a primary author who has reviewed and approved the entry.

3. The original clinical records of active patients may be kept in the branch office for the convenience of the staff providing services. The records of patients whose services are provided by parent office staff must be kept in that office.

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

5. A signed "consent for treatment" form must be obtained from the patient and/or the patient's family and retained in the record.

6. When applicable, a signed "release of information" form must be obtained from the patient and/or the patient's family and a copy must be retained in the record.

7. A written summary report for each patient must be sent to the attending physician every two months.

8. If a patient is transferred to another health facility, a copy of the records, a transfer form, or a discharge summary must be sent with the patient.

9. Records shall be made available to DHH staff upon request.

10. Records must be retained for five years from the date on which the record was established unless there is an audit or litigation that involves the record.

11. The agency must have internal policies that provide for the retention of clinical records even if the agency discontinues operation.

B. Clinical Note. A clinical note shall be legibly written by the person making the visit and incorporated into the clinical record within one week of the visit. A patient care clinical note must be completed on each visit and must contain the following:

1. the date of the visit;

2. time of arrival;

3. time of exit;

4. services rendered and/or justification for the visit;

5. signature of the person making the visit;

6. vital signs, according to physician's order or accepted standards of practice; and

7. comments when indicated.

NOTE: The patient or a responsible person must sign the permanent record of visit that is retained by the agency. However, it is not necessary for the patient or a responsible person to sign on the clinical note.

C. Clinical Record Contents. An active clinical record shall contain all of the following documentation:

1. the initial assessment;

2. the current plan of care signed and dated by the physician. If the physician does not date the PoC when it is signed, then the agency must date it when the signed PoC is received from the physician;

3. the current comprehensive assessment;

4. the current clinical notes for at least the past 60 days, including a description of measurable outcomes relative to the goals in the PoC that have been achieved;

5. identifying data, including:

a. name;

b. address;

c. date of birth;

d. gender;

e. agency case number; and

f. next of kin;

6. the date that care started;

7. attending physician data, including:

a. name;

b. address; and

c. telephone number;

8. the diagnoses, including all conditions relevant to the current plan of care;

9. the types of services rendered, including frequency, duration and the applicable clinical notes;

10. a list of current medications indicating the drug, dosage, frequency, route of administration if other than oral, dates that a drug was initiated and discontinued, drug allergies, dates that non-prescription remedies were initiated and discontinued, side effects and a tracking procedure, and any adverse reactions experienced by the patient;

11. the current medical orders;

12. diet;

13. functional status;

14. rehabilitation potential;

15. the prognosis;

16. durable medical equipment available and/or needed;

17. when applicable, a copy of the transfer form that was forwarded to the appropriate health care facility that will be assuming responsibility for the patient's care; and

18. the discharge summary which shall be available to physicians upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), amended LR 22:1135 (November 1996), LR 27:2252 (December 2001).

§9131. Continuous Quality Improvement

A. The agency shall have written policies requiring that an overall evaluation of the agency's total program be conducted at least once a year by a group of professional personnel (or a committee of this group), agency staff, and consumers or by a independent group of professionals outside the agency working in conjunction with consumers. The evaluation shall consist of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. The results of the evaluation must be reported to and acted upon by those persons who are responsible for the operation of the agency. The evaluation results shall be maintained separately as administrative records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.31-40.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 18:57 (January 1992), amended LR 21:177 (February 1995), LR 27:2253 (December 2001).