Chapter 93. Hospitals

Subchapter A. General Provisions

§9301. Purpose

A. The purpose of the hospital laws, rules and regulations is to provide for the development, establishment and enforcement of standards for the care of individuals in hospitals and for the construction, maintenance and operation of hospitals which shall promote safe and adequate treatment of individuals in hospitals.

B. A hospital shall be licensed in accordance with state law, rules and regulations adopted and established by the state agency responsible for the licensing of hospitals.

C. Primarily Engaged

1. Except as provided in §9301.C.2, hospitals shall be *primarily engaged*, as defined by this Rule and determined by the Department of Health, in providing inpatient hospital services to inpatients, by or under the supervision of licensed physicians. Inpatient hospital services are services defined in this licensing rule and are provided to inpatients of the hospital as one of the following:

a. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

2. Exemptions. The following licensed hospitals are not subject to the primarily engaged provisions/requirements of this Chapter:

a. a licensed hospital designated as a psychiatric hospital or a critical access hospital as defined by the Code of Federal Regulations;

b. a licensed hospital designated as a rural hospital as defined by R.S. 40:1189.3;

c. a licensed hospital currently certified and enrolled as a Medicare/Medicaid certified hospital which has not been determined out of compliance with the federal definition of primarily engaged; if a hospital is currently Medicare/Medicaid certified, and has been determined to be currently meeting the federal definition of primarily engaged, it shall be exempt from compliance with the

following provisions in this section regarding primarily engaged; and

d. a licensed hospital designated as a rural emergency hospital, as established in Section 125 of the Consolidated Appropriations Act of 2021 and defined by the Code of Federal Regulations at 42 CFR 485.500 et seq., or its successor provisions, provided that such facility is in compliance with the provisions of Section 9310 of this Chapter.

3. In reaching a determination as to whether or not an entity is primarily engaged in providing inpatient hospital services to inpatients of a hospital, the Department of Health will evaluate the total facility operations and consider multiple factors, subject to paragraph C.4 below.

a. Total Facility Operations. In evaluating the total facility operations, the department will review the actual provision of care and services to two or more inpatients, and the effects of that care, to assess whether the care provided meets the needs of individual patients by way of patient outcomes.

b. Multiple Factors. The factors that the department will consider include, but are not limited to:

i. the average daily census (ADC) of the main hospital and/or any off-site campus(es);

ii. the average length of stay (ALOS) of patients at the main hospital and/or any off-site campus(es);

iii. the number of off-site campus outpatient locations operated by the entity;

iv. the number of provider-based emergency departments for the entity;

v. the number of inpatient beds related to the size of the entity and the scope of the services offered;

vi. the volume of outpatient surgical procedures compared to the inpatient surgical procedures (if surgical services are provided);

vii. staffing patterns; and

viii. patterns of ADC by day of the week.

4. Notwithstanding any other provision of this rule, an entity shall not be considered to be primarily engaged in providing inpatient hospital services to inpatients of a hospital if a main hospital or a main hospital's off-site campus(es) has an ADC of less than two, or an average length of stay of less than two. For purposes of determining whether a main hospital and its off-site campus(es) are primarily engaged, the ADC and the average length of stay shall be made independently for each entity.

5. Hospitals are not required to have a specific inpatient bed to outpatient bed ratio in order to meet the definition of primarily engaged.

a. If the hospital has an emergency department (ED), the number of hospital inpatient beds shall be greater than the number of ED beds, with a ratio of not less than 2:1.

D. Except as otherwise provided herein, hospitals shall provide directly or under arrangements the following professional departments, services, facilities and functions which are essential to establish whether a facility is primarily engaged in providing inpatient hospital services:

1. organization and general services:
2. nursing services;
3. pharmaceutical services;
4. radiological services;
5. laboratory services;
6. nutritional and therapeutic dietetic services;
7. medical record services;
8. quality assessment and improvement;
9. physical environment;
10. infection control;
11. respiratory care services.

E. Except as otherwise provided herein, hospitals may provide the following optional services directly or under arrangements:

1. surgical services;
2. anesthesia services;
3. nuclear medicine services;
4. outpatient services;
5. rehabilitation services;
6. psychiatric services;
7. obstetrical and newborn services;
8. pediatric services;
9. emergency services.

F. Free-standing emergency departments (or an entity that holds itself out to the public mainly as a free-standing emergency department) shall not be licensed as a hospital.

G. All registered nurses, licensed practical nurses, and/or certified nurse aides supplied by staffing agencies, shall be provided through licensed nurse staffing agencies.

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§9303. Definitions

A. The following definitions of selected terminology are used in connection with Chapter 93 through Chapter 96.

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—a national accreditation program meeting the requirements of and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR §488.

Administrator—the person responsible for the operation of the hospital commensurate with the authority conferred by the governing body.

Anesthesiologist—a physician, licensed by the Louisiana State Board of Medical Examiners to practice medicine in this state who has completed postgraduate residency training in anesthesiology, and is engaged in the practice of such specialty.

Approved—acceptable to the authority having jurisdiction.

Authority Having Jurisdiction (AHJ)—an organization, office, or individual designated by a state or government agency to enforce building codes and other regulations related to construction projects.

Average Daily Census (ADC)—calculated by adding the midnight daily census of the main hospital or its off-site campus(es), independent of one another, for each day of the 12-month period and dividing the total number by the number of days in the year. In calculating the ADC for purposes of determining whether an entity meets the requirements of primarily engaged, LDH may utilize a period of between three months and 12 months.

Average Length of Stay (ALOS)—the average of the number of inpatient days a person is in the main hospital or its off-site campus(es). ALOS is calculated by dividing the total inpatient days by the total discharges during a specified period of time, which results in an average number of days in the main hospital or its off-site campus(es) for each person admitted. In calculating ALOS, LDH may utilize a period of between three months and 12 months. For purposes of calculating the ALOS of the main hospital or its off-site campus(es), each facility shall be considered an independent entity.

Certified Nurse Midwife (CNM) —an advanced practice registered nurse as defined by R.S. 37:913, or current law.

Certified Registered Nurse Anesthetist—an advanced practice registered nurse as defined by R.S. 37:913, or current law.

Cessation of Business—when a hospital is non-operational and stops providing services to the community, other than during a time of declared or non-declared emergency.

Chief Executive Officer (CEO)/Administrator—Repealed.

Clinical Nurse Specialist—an advanced practice registered nurse as defined by R.S. 37:913, or current law.

Crisis Receiving Center—a specialty unit of a hospital that shall receive, examine, triage, refer or treat an individual who is experiencing a behavioral health crisis.

Deemed Status—a status applied by CMS to a hospital that is accredited by a national accreditation program meeting the requirements of and approved by CMS in accordance with 42 CFR §488.5 or 42 CFR §488.6.

Department—Louisiana Department of Health.

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 which involves face-to-face direct contact with the person.

Emergency Services—services that are usually and customarily available at the respective hospital and that shall be provided immediately to stabilize a medical condition which, if not stabilized, could reasonably be expected to result in the loss of the person's life, serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or that is necessary to provide for the care of a woman in active labor if the hospital is so equipped and, if the hospital is not so equipped, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.

Fetal Final Disposition—the burial, cremation, or other disposition of the remains of a human fetus following fetal death in accordance with R.S. 8:651 et seq., or current law.

Food Delivery Services—the transportation of the nutritional and therapeutic dietetic services by a food management company that is delivered to the hospital and served to the patients of the hospital.

Food Management Company—an off-site vendor who provides nutritional and therapeutic dietetic services to the hospital through a contractual agreement and that is required to meet the same standards for food and dietetic services as provided by the hospital directly.

Governing Body—the board of trustees, owner or person(s) designated by the owner with ultimate authority and responsibility (both moral and legal) for the management, control, conduct and functioning of the hospital.

Health Standards Section (HSS) —the section of the Department of Health that has responsibility for licensing all healthcare facilities in Louisiana that are subject to licensing statutes. The HSS also conducts certification surveys and complaint surveys in programs that are Medicare and/or Medicaid certified.

Hospital—any institution, place, building, or agency, public or private, whether for profit or not, maintaining and operating facilities, 24 hours a day, seven days a week, having a minimum of 10 licensed beds, having staff and

equipment sufficient to meet patient needs, and providing hospital services, care and treatment for injured, disabled or sick persons who are admitted with the expectation that he or she will require hospital care that is expected to span at least two midnights. Except as otherwise noted in these licensing regulations, a hospital shall be primarily engaged in providing inpatient services to inpatients, by or under the supervision of licensed physicians. Having the capacity or potential to provide inpatient hospital services is not the equivalent of actually providing such care. The term hospital does not include the following:

a. physicians' offices, clinics, or programs that are not offsite campus(es) of licensed hospitals, where patients are not kept as bed patients for 24 hours or more;

b. nursing homes providing intermediate and/or skilled care as defined by and regulated under the provisions of R.S. 40:2009-2009.23;

c. persons, schools, institutions, or organizations engaged in the care and treatment of children with intellectual disabilities and which are required to be licensed by the provisions of the Developmental Disability Law, R.S. 28:451.1 et seq.;

d. hospitalization or care facilities maintained by the state at any of its penal or correctional institutions provided that nothing herein contained shall prevent a penal or correctional institution from applying for licensure of its hospitalization or care facilities;

e. hospitalization or care facilities maintained by the federal government or agencies thereof;

f. infirmaries or clinics maintained solely by any college or university exclusively for treatment of faculty, students, and employees;

g. an urgent care clinic; or

h. any other entity licensed for the diagnosis, treatment, or care of persons admitted for overnight stay.

Hospital Record—a compilation of the reports of the various clinical *departments* within a hospital, as well as reports from health care providers, as are customarily catalogued and maintained by the hospital medical records department. *Hospital records* include reports of procedures such as X-rays and electrocardiograms, but they do not include the image or graphic matter produced by such procedures, according to state law.

Immediate and Serious Threat—a crisis situation in which the health and safety of patients are at risk. It is a deficient practice which indicates the operator's inability to furnish safe care and services, although it may not have resulted in actual harm. The threat of probable harm is real and important and could be perceived as something which will result in potentially severe temporary or permanent injury, disability or death of patients.

Immediately Available—a person that is onsite and not assigned to any uninterruptible tasks.

Inpatient—a person who admitted to a hospital with the status of inpatient for purposes of receiving hospital services with the expectation that he/she will require hospital care expected to span at least two nights and occupy a bed even though it is later determined that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. Persons in hospital observation status are not inpatients.

Inpatient Hospital Services or Inpatient Service—includes, but is not limited to, the following services provided to inpatients of the hospital as either: diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

a. bed and board;

b. 24-hour nursing services and other related services;

c. use of hospital facilities;

d. medical social services;

e. drugs, biologicals, supplies, appliances, and equipment;

f. certain other diagnostic or therapeutic services;

g. medical or surgical services provided by certain interns or residents-in-training; and

h. transportation services, including transport by ambulance.

License Under Suspensive Appeal—a license against which the department has taken a licensing action and the hospital has filed an administrative appeal.

Licensed Bed—an adult and/or pediatric bed set up or capable of being set up within 24 hours in a hospital for the use of patients, based upon bedroom criteria expressed in these standards. Emergency, labor, delivery, newborn bassinets, surgical/procedure, and recovery room beds are excluded.

Licensed Healthcare Practitioner—a person who is acting within the scope of practice of his/her respective licensing board and/or certifications.

Licensed Independent Practitioner—a person who is *approved* by his board for independent practice and who is *approved* by the medical staff and credentialed and *approved* by the Governing Board.

Licensed Nuclear Medicine Technologist—any person licensed to practice nuclear medicine technology by the Louisiana State Radiologic Technology Board of Examiners.

Licensed Nurse-a registered nurse as defined in R.S. 37:913, or current law, or a licensed practical nurse as defined in R.S. 37:961, or current law.

Licensed Practical Nurse (LPN)—a person who practices practical nursing and who is licensed to practice practical nursing in accordance with R.S. 37:961, or current law.

Licensed Radiation Therapy Technologist—any person licensed to practice radiation therapy technology by the Louisiana State Radiologic Technology Board of Examiners.

Licensed Radiographer—any person licensed to practice general radiography by the Louisiana State Radiologic Technology Board of Examiners.

Miscarried Child—fetal remains resulting from a spontaneous fetal death that does not require compulsory registration pursuant to the provisions of R.S. 40:47, or current law.

Mobile Unit-any trailer or self-propelled unit equipped with a chassis on wheels and intended to provide health services at an LDH approved location. These units shall be maintained in good repair and equipped to be moved.

Monolithic Ceiling Construction—a ceiling constructed with a surface free of fissures, cracks, and crevices. Any penetrations such as lights, diffusers, and access panels shall be sealed or gasketed. Lay-in ceilings are not considered monolithic.

Naloxone Nasal Spray—an over-the-counter (OTC) Food and Drug Administration (FDA) approved medication that rapidly reverses the effects of opioid overdose.

Neglect—failure to provide the proper or necessary medical care, nutrition, or other care necessary for a patient's well-being, or any other act or omission classified as neglect by Louisiana law.

Neonatal—newborn immediately succeeding birth and continuing through the first 28 days of life.

Non-Operational—when the hospital ceases accepting patients and/or the doors are locked to the public and there is no available patient care staff onsite.

Nurse Practitioner—an advanced practice registered nurse as defined by R.S. 37:913, or current law.

Nurse Staffing Agency (NSA)—any person, partnership, corporation, unincorporated association, or other legal entity, including a digital website/platform or digital smart phone application that employs, assigns, or refers nurses or certified nurse aides to render healthcare services in a healthcare facility for a fee. For purposes of these regulations, NSA does not include the following:

a. A NSA that solely provides services in Louisiana under a contract or other agreement with the state of Louisiana, or any executive branch department or agency thereof, as a result of a declared disaster, emergency, or public health emergency.

b. The federal or state government department or agency that provides nursing staff or certified nurse aides to any healthcare provider setting, evacuation site, or shelter location as a result of a declared disaster, emergency, or public health emergency.

c. An entity that solely provides administrative or consulting services.

Nurses' Call System—a system that audibly and/or visibly transmits calls electronically from its place of origin (e.g., the patient's bed) to the place of receipt (e.g., the nurses' station).

Nutritional and Therapeutic Dietetic Services—the provision of a nourishing, palatable, well-balanced diet that meets the patient's daily nutritional and special dietary needs in accordance with the licensed practitioner's prescribed plan of care, and taking into consideration the preferences of each patient.

Office of the Secretary—office of the person serving as the Secretary of the Department of Health.

Off-Site Campus—all premises on which hospital services (inpatient and/or outpatient) are provided and that are not adjoining to the main hospital buildings or grounds. Each off-site campus of a hospital shall be licensed as a part of the main hospital. An off-site campus must be held out to the public as part of the hospital, appear on the hospital's cost report, and bill using the hospital's national provider identifier number. An off-site campus shall be located within 50 miles of the main hospital campus. Any building separated by a public road, not adjoined by a sky bridge or covered and enclosed walkway, or building not licensed or owned by the hospital is considered offsite.

a. Exception. If a state-owned or operated hospital ceases to do business and surrenders its license, the offsite campus(es) of that hospital which provided outpatient services may be licensed as an off-site campus(es) of another state-owned and/or operated hospital, provided that the off-site campus(es) is located within 100 miles of the main hospital campus of the state-owned and/or operated hospital.

Organ—a structural part of the body that performs a particular function, such as the liver, spleen, digestive organs, reproductive organs, or organs of special sense. For paired organs, each one can function independently of the other.

Outpatient Observation Status—the level of care assigned to a patient when a physician or licensed healthcare practitioner, authorized to do so, prescribes an order for the patient to remain in the hospital for on-going short term treatment, assessment, and reassessment before a decision can be made regarding whether the patient will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. This status is not considered inpatient level of care.

Physician Assistant—a licensed physician assistant in accordance with R.S. 37:1360.22, or current law.

Physician Assistant-Certified (PA-C)—a licensed physician assistant certified as defined in R.S. 37:1360.22, or current law. For PA-Cs providing care in the NICU, the PA-C shall have 12 months of post graduate NICU experience under the supervision of a neonatologist, and shall be deemed competent as an NICU PA-C by the supervising neonatologist.

Primarily Engaged—a hospital is directly providing inpatient hospital services to inpatients, by or under the supervision of licensed physicians. Inpatient hospital services are services defined in this licensing rule and are provided to inpatients of the hospital as one of the following:

a. diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Radiologist—a doctor of medicine or osteopathy who is qualified by education and experience in radiology.

Registered Dietitian—a dietitian who is qualified based on registration by the Commission on Dietetic Registration of the American Dietetic Association and licensing by the Louisiana Board of Examiners in Dietetics and Nutrition.

Registered Nurse (RN)—any individual licensed in accordance with R.S. 37:911 et seq., or current law, to engage in the practice of nursing as defined in R.S. 37:913, or current law.

Surgical Smoke Plume—the byproduct of using heat-producing equipment on tissue during surgery.

Therapeutic Recreational Services—services that identify leisure activities and assistance in modifying and adapting identified leisure activities to allow safe participation by the patient as a means to improve quality of life and aid in integration into the community.

Trauma Center—a hospital that is capable of treating one or more types of potentially seriously injured persons and that has been certified as a trauma center by the Department of Health.

Unit Definition—a licensed patient room.

Unlicensed Assistive Personnel (UAP)—any unlicensed, trained personnel who cannot practice independently or without supervision by a RN, including but not limited to, operating and/or procedure room technicians, instrument cleaning and/or sterilization technicians, nursing assistants or orderlies, and mental health technicians.

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§9305. Licensing Process

A. Procedures for Initial Licensing. The LDH is the only licensing authority for hospitals in the state of Louisiana.

1. Any person, organization or corporation desiring to operate a hospital shall make application to the LDH on forms prescribed by the department. Such forms may be obtained electronically via the LDH, HSS website, or from, the LDH, HSS program desk.

2. An initial applicant shall as a condition of licensing:

a. submit a completed initial hospital application packet and other required documents;

b. submit the required nonrefundable licensing fees via the department approved manner. No application packet will be reviewed until payment of the nonrefundable application packet fee. Except for good cause shown, the applicant shall complete all requirements of the application packet process within 90 days of initial submission of the application packet material. Upon 10 working days prior notice, any incomplete or inactive application packets shall be closed. A new application packet will be accepted only when accompanied by a nonrefundable application packet fee.

3. When the required documentation for licensing is approved and the building is approved for full permanent occupancy by the Office of State Fire Marshal (OSFM), a survey of the facility by representatives of HSS shall be conducted at the department's discretion to determine if the facility meets the standards set forth in Chapters 93-96.

4. The HSS shall notify the hospital of the findings of the survey in a statement of deficiencies. If non-compliance is cited, the notice of the requirements for the facility’s plan of correction will be included.

5. The hospital shall notify the HSS in writing when the deficiencies have been corrected. Following review of the hospital's Plan of Correction (POC), HSS may schedule an on-site survey of the facility.

6. No new hospital facility shall accept patients until the hospital has written approval and/or a license issued by HSS.

7. No patient shall be placed in a room that does not meet all patient room licensing criteria and that has not been previously approved by HSS.

8. The hospital shall accept only that number of inpatients for which it is licensed unless prior written approval has been secured from the department.

B. Issuance of a License

1. The agency shall have authority to issue two licenses as described below:

a. full license-issued only to those hospitals that are in substantial compliance with the rules, the standards governing hospitals and the hospital law. The license shall be issued by the department for a period of not more than 12 months for the premises named in the application packet, as determined by the department;

b. if a hospital is not in substantial compliance with the rules, the standards governing hospitals and the hospital law, the department may issue a provisional license up to a period of six months if there is no immediate and serious threat to the health and safety of patients.

i. At the discretion of the department, the provisional license may be extended for an additional period

not to exceed 90 days in order for the hospital to correct the noncompliance or deficiencies.

ii. The hospital 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.

iii. A follow-up survey shall be conducted 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 may 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 licensing process again by submitting a new license application packet and fee if no timely informal reconsideration or administrative appeal of the deficiencies is filed pursuant to this Chapter.

2. The department also has discretion in denying, suspending or revoking a license where there has been substantial noncompliance with these requirements in accordance with the hospital law. If a license is denied, suspended or revoked, an appeal may be made as outlined in the hospital law (R.S. 40:2110).

a. Suspensive Appeal. A hospital that appeals the action of the department in denying, suspending or revoking the license may file a suspensive appeal from the action of the department.

b. A renewal license shall not be issued, nor will any changes be processed to a hospital's existing license, during the pendency of an administrative suspensive appeal of the department's decision to deny, suspend, or revoke a hospital's license for non-compliance.

c. The license for a hospital that is suspensively operating during the pendency of the appeal process shall be considered a license under suspensive appeal.

3. The hospital license is not assignable or transferable and shall be immediately void if a hospital ceases to operate or if its ownership changes.

4. Licenses issued to hospitals with off-site locations shall be inclusive of the licensed off-site beds. In no case may the total number of inpatient beds at the off-site location exceed the number of inpatient beds at the main campus.

C. Licensing Renewal. Licenses shall be renewed at least annually. The renewal application packet shall be sent by the department to the hospital 75 days prior to the expiration of its license. The application packet shall contain all forms required for renewal of the license. A hospital seeking renewal of its license shall:

1. complete all forms and return them to the department at least 30 days prior to the expiration date of its current license; and

2. submit the required annual/delinquent renewal fees. All fees shall be submitted in the manner required by the department and are nonrefundable. All state-owned facilities are exempt from licensing fees.

a. If a hospital fails to timely renew its license, the license expires on its face and is considered voluntarily surrendered.

b. 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 hospital.

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

E. Bed Changes

1. The hospital shall complete and submit the required bed change application packet.

2. For the application packet to be considered complete, the appropriate nonrefundable fee as required by state law shall be submitted to the department in the manner required by the department.

3. At the discretion of the department, signed and dated attestations to compliance with these standards, together with appropriate nonrefundable fees, may be accepted in lieu of an on-site survey.

4. Written approval of the bed increase shall be obtained before patients can be admitted to these beds.

5. No patient shall be placed in a room that does not meet all patient room licensing criteria and that has not been previously approved by HSS.

EXCEPTION: During a declaration of emergency, a hospital may exceed its licensed bed capacity with written notice to the department within five days of the increase.

F. Eviction of Hospital. If a hospital is subject to potential eviction proceedings, it shall notify the department within 23 hours of receiving a notice to vacate.

G. Change in Services

1. Prior to the addition or deletion of a service or services, the hospital shall notify the department in writing 45 days prior to implementation, if plan review is required, and 15 days prior to implementation if no plan review is necessary. The hospital shall complete and submit the appropriate service change packet for the service being added, deleted, or changed.

2. At the discretion of the department, signed and dated attestations of compliance with the standards in these Chapters may be accepted in lieu of an on-site survey.

3. Written approval for the service change shall be obtained prior to the area being used for patient care.

H. Off-Site Campuses

1. An applicant adding an off-site campus, as a condition of licensing, shall submit:

a. a completed off-site campus application packet;

b. the required nonrefundable licensing fees in the manner required by the department.

2. Except for good cause shown, all incomplete and inactive application packets shall be closed 90 days after receipt of the initial off-site campus application packet. A new application packet will be accepted only when accompanied by the required nonrefundable application packet fee.

3. At the discretion of the department, signed and dated attestations to the compliance with these standards may be accepted in lieu of an on-site survey.

4. The off-site campus will be issued a license that is a subset of the hospital's main campus license.

I. Closing Off-Site Campuses. The hospital shall notify the HSS in writing at least 30 days prior to the closure of an off-site campus to include the effective date of closure. The original license of the off-site campus is to be returned to HSS.

J. Duplicate Licenses. The required fee shall be submitted by the hospital for issuing a duplicate facility license.

K. Changes to the License. When changes to the license, such as a name change, address change, or bed reduction are requested in writing by the hospital, the required non-refundable fee and applicable application packet shall be submitted to the HSS.

L. 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 provider shall be clearly separated from each other by a clearly delineated and recognizable boundary.

a. Treatment facilities shall include, but not be limited to consumer beds, wings and operating rooms.

b. Administrative offices shall include, but not be limited to medical record rooms and administrative offices.

c. There shall be clearly identifiable and distinguishable signs for each facility.

2. If more than one licensed healthcare provider occupies the same building, premises or physical location, each healthcare provider shall have its own entrance and single identifiable geographic address (e.g., suite number). The separate entrance shall have appropriate signs and shall be clearly identifiable as belonging to a particular healthcare provider. Nothing in these licensing regulations prohibits a healthcare provider occupying the same building, premises, or physical location as another healthcare provider from utilizing the entrance, hallway, stairs, elevators, or escalators of another healthcare provider to provide access to its separate entrance.

3. Staff of the hospital within a hospital shall not be co-mingled with the staff of the host hospital for the delivery of services within any given shift.

4. The provisions and requirements of §9305.L are in addition to and not excluding any other statutes, laws and/or rules that regulate hospitals, as set forth in R.S. 40:2007.

M. Change of Ownership

1. Definition. *Change of Ownership (CHOW*)—the sale or transfer whether by purchase, lease, gift or otherwise of a hospital 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 hospital or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the hospital. Examples of actions which constitute a change of ownership (R.S. 40:2115.11 et seq.).

a. Unincorporated Sole Proprietorship. Transfer of title and property to another party constitutes a 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 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. No later than 15 working days after the effective date of the CHOW, the prospective owner(s) or provider representative shall submit to the department a completed CHOW application packet for hospital licensing, included but not limited to, the letter of intent, diagram showing ownership prior to and after the sale, executed legal transaction document, and a licensing fee consistent with state law. The hospital license is not transferable from one entity or owner(s) to another.

3. A hospital that holds provisional licensure or is under license suspension, revocation, denial, or termination may not undergo a CHOW.

4. A CHOW of the hospital shall not be submitted at time of the annual renewal of the hospital’s license.

N. Plan Review. A letter to the Department of Health, Division of Engineering and Architectural Services, shall accompany the floor plans with a request for a review of the hospital plans. The letter shall include the types of services offered, number of licensed beds and licensed patient rooms, geographical location, and whether it is a relocation, renovation, and/or new construction. A copy of this letter is to be sent to the Hospital Program Manager.

1. Submission of Plans

a. New Construction. All new construction shall be done in accordance with the specific requirements of the OSFM and the Office of Public Health (OPH). The requirements cover new construction in hospitals, including submission of preliminary plans and the final work drawings

and specifications to each of these agencies. Plan review shall be performed in accordance with the rules and regulations established by the OSFM. Plans and specifications 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.

b. Hospitals. No hospital shall hereafter be licensed without the prior written approval of, and unless in accordance with plans and specifications approved in advance by the OSFM. This includes new construction, additions, renovations, or any change in service or hospital type (e.g., acute care hospital to psychiatric hospital, outpatient surgical services to inpatient, adult care to pediatric), or the establishment of a hospital in any healthcare facility or former healthcare facility.

2. Approval of Plans

a. Notice of satisfactory review from the OSFM 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 the 2014 Edition of the Facility Guidelines Institute (FGI), Guidelines for Design and Construction of Hospitals and Outpatient Facilities, as adopted by the OSFM for building design and construction, the OSFM shall notify the party submitting the plans in writing, 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/her sole discretion, grant waivers to building and construction guidelines or requirements and to provisions of the licensing rules involving the clinical operation of the hospital. The facility shall submit a waiver request in writing to the licensing section of the department on forms prescribed by the department.

b. In the waiver request, the facility shall demonstrate the following:

i. how patient health, safety, and welfare will not be compromised if such waiver is granted;

ii. how the quality of care offered will not be compromised if such waiver is granted; and

iii. the ability of the facility to completely fulfill all other requirements of the service, condition, or regulation.

c. The licensing section of the department shall have each waiver request reviewed by an internal waiver review committee. In conducting such internal waiver review, the following shall apply:

i. the waiver review committee may consult subject matter experts as necessary, including the Office of State Fire Marshal; and

ii. the waiver review committee may require the facility to submit risk assessments or other documentation to the department.

d. The director of the licensing section of the department shall submit the waiver review committee's recommendation on each waiver to the secretary, or the secretary's designee, for final determination.

e. The department shall issue a written decision of the waiver request to the facility. The granting of any waiver may be for a specific length of time.

f. The written decision of the waiver request is final. There is no right to an appeal of the decision of the waiver request.

g. If any waiver is granted, it is not transferrable in an ownership change or change of location.

h. Waivers are subject to review and revocation upon any change of circumstance related to the waiver or upon a finding that the health, safety, or welfare of a patient may be compromised.

i. Any waivers granted by the department prior to January 15, 2023, shall remain in place, subject to any time limitations on such waivers; further, such waivers shall be subject to the following:

i. such waivers are subject to review or revocation upon any change in circumstance related to the waiver or upon a finding that the health, safety, or welfare of a patient may be compromised; and

ii. such waivers are not transferrable in an ownership change or change of location.

O. Fire Protection. All hospitals 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.

P. Sanitation and Patient Safety. All hospitals required to be licensed by the law 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 Office of Public Health to determine if applicants are complying with those requirements. No initial license shall be issued without the applicant furnishing a certificate from the Office of Public Health stating that the applicant is complying with their provisions. A provisional license may be issued to the applicant if the Office of Public Health issues the applicant a conditional certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 16:971 (November 1990), LR 21:177 (February 1995), LR 29:2401 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1413 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1074 (June 2023), amended by the Department of Health, Health Standards Section, LR 50:1475 (October 2024).

§9306. Statement of Deficiencies

A. Notice to hospital of statement of deficiencies. When the department has reasonable cause to believe through an on-site survey, a complaint investigation, or other means that there exists or has existed a threat to the health, safety, or welfare of a hospital patient, the department shall give written notice of the deficiencies.

B. The department shall send written notice to the hospital administrator.

C. The department's written notice of deficiencies shall be consistent with the findings delineated at the exit conference and shall:

1. specify the deficiencies;

2. cite the legal authority that established such deficiencies; and

3. inform the administrator that the hospital has 10 calendar days from receipt of written notice within which to request a reconsideration of the cited deficiencies.

D. Unless otherwise provided in statute or in this licensing rule, a facility shall have the right to an informal reconsideration of any deficiencies cited as a result of any survey or investigation. The right to an informal reconsideration of any deficiencies cited as a result of any survey or investigation shall not be afforded to Emergency Medical Treatment and Labor Act or deemed hospital providers with condition level deficiencies.

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

2. The facility's written request for informal reconsideration shall be considered timely if received within 10 calendar days of facility's receipt of the statement of deficiencies.

3. The request for informal reconsideration of the deficiencies shall be made to the department's Health Standards Section.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., or current law, and as provided 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. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1477 (October 2024).

§9307. Cessation of Business

A. Except as provided in §9308.A-C.9 of these licensing regulations, a license shall be immediately null and void if a hospital ceases to operate.

B. A cessation of business is deemed to be effective with the date on which the hospital stopped providing services to the community.

C. Upon the cessation of business, the hospital 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 hospital. The hospital does not have the right to appeal a cessation of business.

E. The hospital shall notify the department in writing 30 days prior to the effective date of the closure or cessation. In addition to the notice, the hospital 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 patient 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 a hospital fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a hospital for a period of two years.

G. Once the hospital has ceased doing business, the hospital shall not provide services until the hospital has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2404 (November 2003), amended

by the Department of Health, Health Standards Section, LR 50:1477 (October 2024).

§9308. Inactivation of Facility License

A. Inactivation of license due to declared disaster or emergency.

1. A hospital licensed in a parish that 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 hospital shall submit written notification to the HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

i. the hospital 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 facility intends to resume operation as a hospital facility in the same service area;

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

iv. includes an attestation that all patients have been properly discharged or transferred to another provider; and

v. provides a list of each patient's name and the location where that patient has been discharged or transferred;

b. the facility resumes operating as a hospital in the same service area within one year of the issuance of such an executive order or proclamation of emergency or disaster;

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

c. the hospital 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 hospital 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 hospital license, the department shall issue a notice of inactivation of license to the hospital.

3. Upon completion of repairs, renovations, rebuilding, or replacement of the facility, a hospital that 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 hospital shall submit a written license reinstatement request to the licensing agency of the department as soon as possible prior to the anticipated date of reopening to allow for the scheduling of a licensing survey;

b. the license reinstatement request shall include a completed licensing application packet with appropriate non-refundable licensing fees, approval from the OPH and the OSFM, and plan review, if applicable; and

c. the facility resumes operating as a hospital in the same service area within one year.

4. Upon receiving a completed written request to reinstate a hospital license, the department shall schedule a licensing survey. If the hospital meets the requirements for licensure and the requirements under this Subsection, the department shall issue a notice of reinstatement of the hospital license.

5. No change of ownership (CHOW) of the hospital shall occur until such hospital has completed repairs, renovations, rebuilding, or replacement construction and has resumed operations as a hospital.

6. The provisions of this Subsection shall not apply to a hospital 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 hospital license.

B. Partial inactivation of license due to declared disaster or emergency.

1. A hospital licensed in a parish that 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 be allowed to continue to provide hospital services in areas of the hospital that did not sustain damage.

2. The hospital shall notify the LDH, HSS of its intent to continue providing services and request an inspection of the areas, by the OSFM, OPH, and HSS.

3. The hospital shall provide in writing its plan to provide services and staff.

C. Inactivation of licensure due to a non-declared disaster or emergency.

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

a. the hospital shall have submitted written notification to the HSS within 30 days of the date of the non-declared emergency or disaster stating that:

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

ii. the facility intends to resume operation as a hospital in the same service area;

iii. the hospital attests that the non-declared emergency or disaster is the sole causal factor in the interruption of the provision of services.

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

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

c. the hospital 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

d. the hospital 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 temporarily inactivate a hospital license, the department shall issue a notice of inactivation of license to the hospital.

3. Upon receipt of the department's approval of request to inactivate the hospital's license, the hospital shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to OSFM and OPH as required.

4. The facility shall resume operating as a hospital 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 hospital requires an extension of this timeframe due to circumstances beyond the hospital's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the hospital's active efforts to complete construction or repairs and the reasons for request for extension of the hospital's inactive license. Any approval for extension is at the sole discretion of the department.

5. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a hospital that 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 hospital shall submit a written license reinstatement request to the licensing agency of the department;

b. 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

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

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

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

8. The provisions of this Subsection shall not apply to a hospital that has voluntarily surrendered its license and ceased operation.

9. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the hospital license.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1478 (October 2024).

§9309. Exceptions

A. Exceptions to these Rules and standards governing hospitals are as follows.

1. If a hospital does not provide an optional service or department, those relating requirements shall not be applicable.

2. If a hospital is accredited by a CMS recognized accrediting organization, the department shall accept such accreditation in lieu of its annual on-site re-survey. This accreditation will be accepted as evidence of satisfactory compliance with all provisions except those expressed in §9305.O and P.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2404 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1479 (October 2024).

§9310. Rural Emergency Hospitals

A. A rural emergency hospital (REH) is a hospital facility that converts from either a critical access hospital (CAH) or a rural hospital with less than 50 beds, as established in Section 125 of the Consolidated Appropriations Act of 2021. Only a CAH or rural hospital with less than 50 beds that was licensed by the department as of December 27, 2020 may convert to a REH.

B. A REH shall be in compliance with the federal regulations for REHs, namely 42 CFR 485.500 et seq., or successor regulations.

C. Pursuant to the federal requirements, the REH shall provide emergency department services and observation care, but shall not provide acute inpatient services except for the optional service of post-hospital extended care services furnished in a unit of the facility that is a distinct part skilled nursing unit.

1. The CAH or rural hospital that is converting to a REH shall contact the licensing section of the department to temporarily

inactivate its licensed acute care hospital beds while it is designated and certified as a REH by the Medicare program.

2. If the facility loses its designation or certification as a REH or begins operating again as a CAH or rural hospital, the facility shall contact the licensing section of the department to immediately re-activate its licensed acute care hospital beds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:1221 (July 2023).

§9311. Enforcement

A. The department shall have the authority to interpret and enforce Chapter 93 through Chapter 96 as authorized by and in accordance with the Health Care Facilities and Services Enforcement Act, R.S. 40:2199.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2404 (November 2003), LR 49:1221 (July 2023).

Subchapter B. Hospital Organization and Services

§9317. Governing Body

A. The hospital shall have either an effective governing body or individual(s) who are legally responsible for the conduct of the hospital operations, including the conduct of all hospital staff, contracted, direct, or otherwise. In the absence of an organized governing body, there shall be written documentation that identifies the individual(s) who are legally responsible to carry out the functions specified in this part that pertain to the governing body. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

B. The governing body shall:

1. establish hospital-wide policy;

2. adopt bylaws;

3. appoint a chief executive officer or administrator;

4. maintain quality of care;

5. determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff; and

6. provide an overall institutional plan and budget.

C. The governing body and/or their designee(s) shall develop and approve policies and procedures which define and describe the scope of services offered. They shall be revised as necessary and reviewed at least every two years.

D. There shall be an organizational chart that delineates lines of authority and responsibility for all hospital personnel.

E. In addition to requirements stated herein, all licensed hospitals shall comply with applicable local, state, and federal laws and regulations, including but not limited to:

1. the Safe Haven Act;

2. criminal background history checks;

3. direct service worker registry checks of non-licensed personnel; and

4. preventing, responding to, reporting, and mitigating instances of healthcare workplace violence.

F. All off-site campuses operating under the license of a single provider institution (i.e., a hospital with a main facility and off-site campuses) are subject to the control and direction of one common governing body that is responsible for the operational decisions of the entire hospital enterprise.

1. The off-site campus is subject to the bylaws and operating decisions of the provider's governing body.

2. The provider has final responsibility for administrative decisions, final approval for personnel actions and final approval for medical staff appointments at the off-site campus.

3. The off-site campus functions as a department of the hospital.

4. The hospital shall submit documentation from the accrediting body that it recognizes the off-site campus as part of the hospital.

5. The off-site campus director is under the day-to-day supervision of the provider, as evidenced by:

a. patients treated at the off-site campus are considered patients of the provider and shall have full access to all appropriate provider services;

b. the off-site campus is held out to the public as part of the hospital, i.e., patients know they are entering the provider and will be billed accordingly;

c. the off-site campus director or the individual responsible for the day-to-day operations at the site is accountable to the provider's chief executive officer and reports through that individual to the provider's governing body; and

d. the administrative functions of the off-site campus, (i.e., QI, infection control, dietary, medical records, billing, laundry, housekeeping and purchasing) are integrated with those of the provider, as appropriate to that off-site campus.

6. All components of a single provider institution shall comply with applicable state licensing laws.

G. If emergency services are not provided at the hospital, the governing body shall assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and transfer as appropriate. The governing body shall ensure exterior signage is present and viewable by the public stating that the hospital does not provide emergency services.

1. These policies and procedures shall address at a minimum the following:

a. needed emergency equipment and drugs to include but not be limited to, suction, oxygen, and artificial manual breathing unit (AMBU) bag;

b. training and competence of staff appropriate to the approved use of emergency equipment and drugs;

c. determining when an emergency exists;

d. rendering lifesaving first aid;

e. making appropriate referrals to hospitals that are capable of providing needed services, inclusive of a parent surrendering an infant in accordance with the provisions of the Safe Haven Act.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2405 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1479 (October 2024).

§9319. Patient Rights and Privacy

A. Every patient shall have the following rights, none of which shall be abridged by the hospital or any of its staff. The hospital administrator shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patient rights. These rights shall include at least the following:

1. every patient, or his/her designated representative, shall whenever possible, be informed of the patient's rights and responsibilities in advance of furnishing or discontinuing patient care;

2. the right to have a family member, chosen representative and/or his or her own physician notified promptly of admission to the hospital;

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 be informed of the names and functions of all physicians and other health care professionals who are providing direct care to the patient. These people shall identify themselves by introduction and/or by wearing a name tag;

6. the right to receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and the hospital's health care personnel;

7. the right to participate in the development and implementation of his/her plan of care;

8. every patient or his or her representative (as allowed by state law) has the right to make informed decisions regarding his or her care;

9. the patient's rights include being informed of his/her health status, including whether being admitted as an inpatient or being kept on observation status, being involved in care planning and treatment, and being able to request or refuse treatment. This right shall not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate;

10. the right to be included in experimental research only when he or she gives informed, written consent to such participation, or when a guardian provides such consent for an incompetent patient in accordance with appropriate laws and regulations. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices;

11. the right to be informed if the hospital has authorized other health care and/or educational institutions to participate in the patient's treatment. The patient shall also have a right to know the identity and function of these institutions, and may refuse to allow their participation in his/her treatment;

12. the right to formulate advance directives and have hospital staff and practitioners who provide care in the hospital comply with these directives;

13. the right to be informed by the attending physician and other providers of health care services about any continuing health care requirements after his/her discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

14. the right to have his/her medical records, including all computerized medical information, kept confidential;

15. the right to access information contained in his/her medical records within a reasonable time frame in accordance with the requirements in §9387;

16. the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff;

17. the right to be free from all forms of abuse and harassment;

18. the right to receive care in a safe setting;

19. the right to examine and receive an explanation of the patient's hospital bill regardless of source of payment, and may receive upon request, information relating to financial assistance available through the hospital. Such explanation shall include information in relation to balance billing disclosure in accordance with R.S. 22:1880 et seq., or current law;

20. the right to be informed in writing about the hospital's policies and procedures for initiation, review and resolution of patient complaints/grievances, including the

address and telephone number of where complaints/grievances may be filed with the department;

21. the right to be informed of his/her responsibility to comply with hospital rules, cooperate in the patient's own treatment, provide a complete and accurate medical history, be respectful of other patients, staff and property, and provide required information regarding payment of charges;

22. except in emergencies, the patient may be transferred to another facility only with a full explanation of the reason for transfer, provisions for continuing care and acceptance by the receiving institution;

23. the right for each inpatient or, if applicable, the patient's legal guardian, to have one opportunity to designate an uncompensated caregiver following the patient's inpatient admission into a hospital and prior to the patient's discharge, for provision of the patient's post hospital aftercare at the patient's residence; and

24. the right to be informed of the visitation policies of the hospital including any clinical restriction or limitation on such rights; and to receive visitors whom the patient designates, including, but not limited to, a spouse, a domestic partner, another family member, or a friend; and the patient's right to withdraw or deny such consent at any time.

B. The policies on patient rights and responsibilities shall also provide that patients who receive treatment for mental illness or developmental disability, in addition to the rights listed herein, have the rights provided in the Louisiana Mental Health Law.

C. The policies on patient rights and responsibilities shall also provide that patients who receive treatment for a miscarried child have the option of fetal final disposition in accordance with R.S. 8:651 et seq or current law.

D. Hospital staff assigned to provide direct patient care shall be informed of and demonstrate their understanding of the policies on patient rights and responsibilities through orientation and appropriate in service training activities.

E. The hospital shall report allegations of patient abuse, neglect, and/or exploitation in writing to HSS on the HSS approved form within 24 hours of discovery. The hospital's final internal investigation shall be completed and submitted to HSS within five business days of the initial report.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2405 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 43:74 (January 2017), amended by the Department of Health, Health Standards Section, LR 50:1480 (October 2024).

§9321. Medical Staff

A. The medical staff develops and adopts bylaws and rules for self-governance of professional activity and accountability to the governing body. In addition to physicians and dentists, the medical staff membership shall include licensed healthcare practitioners as appropriate to adequately meet the needs of the patients served by the hospital. The bylaws and rules shall contain provisions for at least the following.

1. The medical executive committee shall:

a. develop the structure of the medical staff and categories of membership;

b. develop and implement a mechanism to review credentials, at least every three years, and delineate individual privileges;

c. develop and implement a mechanism for determining that all medical staff hold current Louisiana licenses;

d. make recommendations for membership to medical staff, for approval by the governing body, with initial appointments and reappointments not to exceed two years;

e. develop and implement a mechanism for suspension and/or termination of membership to the medical staff;

f. develop and implement a mechanism for fair hearings and appellate reviews for both potential (new) applicants and current members of the medical staff;

g. define the required functions of the medical staff to include:

i. basic medical record review, drug usage review, pharmacy and therapeutics review, infection control and utilization review;

ii. if applicable, surgical and other invasive procedures and blood usage.

2. The medical staff shall provide a mechanism to monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated clinical privileges.

3. Each person admitted to the hospital shall be under the care of a member of the medical staff and shall not be admitted except on the recommendation of a medical staff member.

4. There shall be a member of the medical staff on call at all times for emergency medical care of hospital patients.

5. The medical staff bylaws shall include specifications for orders for the care or treatment of patients that are given to the hospital verbally or transmitted to the hospital electronically, whether by telephone, facsimile transmission, or otherwise. Such bylaws may grant the medical staff up to 10 calendar days following the date an order is transmitted verbally or electronically to provide the signature or countersignature for such orders. Orders entered via use of computerized provider order entry (CPOE) do not require a signature if the CPOE used has an immediate download into the provider's electronic health record (EHR) as the order would be dated, timed, authenticated, and promptly placed in the medical record.

6. There shall be a single chief of medical staff who reports directly to the governing body and who is responsible for all medical staff activities for the entire hospital, including any offsite facilities operating under the license of the hospital.

7. There shall be total integration of the organized medical staff as evidenced by these factors:

a. all medical staff members have privileges at all off-site campuses;

b. all medical staff committees are responsible for their respective areas of responsibility at all off-site campuses of the hospital; and

c. the medical director of the off-site campus (if the off-site campus has a medical director) maintains a day-to-day reporting relationship to the chief medical officer or other similar official of the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2406 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1481 (October 2024).

§9323. Administration

A. In accordance with the hospital policy, there shall be a full-time, administrator who is responsible for the operation of the hospital commensurate with the authority conferred by the governing body. Beginning June 1, 2025, no administrator shall be administrator of more than one licensed hospital.

B. The chief executive officer or administrator of the hospital shall have at least one of the following qualifications:

1. a master's degree and at least three years of full-time experience in progressively responsible management positions in healthcare;

2. a baccalaureate degree and at least five years of full-time experience in progressively responsible management positions in healthcare; or

3. at least 10 years of full-time experience in hospital administration;

a. hospital administrators employed in Louisiana licensed hospitals at the time the final regulations are adopted and become effective shall be deemed to meet the qualifications as long as the individual holds their current position. If the individual leaves their current position as hospital administrator, they shall meet one of the qualifications above to be re-employed into such a position.

C. There shall be sufficient qualified personnel to properly operate each department of the hospital and provide quality patient care and related services.

D. All new employees, including volunteer workers, prior to or at the time of employment and annually thereafter shall be verified to be free of tuberculosis in a communicable state.

E. The hospital shall have policies and procedures that define how the facility will comply with current regulations regarding healthcare screenings of hospital personnel.

F. The hospital shall have policies and procedures and require all personnel to immediately report any signs or symptoms of a communicable disease or personal illness to their supervisor or administrator as appropriate for possible reassignment or other appropriate action to prevent the disease or illness from spreading to other patients or personnel.

G. The hospital shall have policies and procedures that define how the facility shall:

1. comply with the provisions of the Safe Haven Act inclusive of training and designating responsible employees;

2. comply with the regulations for checking the DSW registry for new employees, rehired employees, or when an employee has a break in service;

3. comply with obtaining criminal history checks on unlicensed assistive personnel or other direct care staff upon hiring or reemploying or when employee has a break in service. Such policy shall address the disposition of any charges;

4. prevent, respond to, report, and mitigate instances of healthcare workplace violence; and

5. comply 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.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2407 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1481 (October 2024).

§9325. Staff Orientation, Training, Education and Evaluation

A. New employees, including contract employees, shall have an orientation program of sufficient scope and duration to inform the individual about his/her responsibilities and how to fulfill them.

B. The orientation program shall include, at least, a review of policies and procedures, job descriptions, competency evaluation and performance expectations prior to the employee performing his/her responsibilities.

C. A staff development program shall be conducted by educationally competent staff and/or consultants and planned based upon annual employee performance appraisals, patient population served by the hospital, information from quality

assessment and improvement activities, and/or as determined by facility staff.

D. The hospital shall document appropriate training and orientation prior to reassignment of currently employed staff.

E. Records shall be maintained that indicate the training content, time, names of employees in attendance and the name of the presenter.

F. At least annually the performance of all hospital and contract employees shall be evaluated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2407 (November 2003).

§9327. Emergency Services

A. If emergency services are provided, the emergency services shall be on a 24-hour/seven-day basis in an emergency care area. The hospital shall have at least 1 physician available to the emergency care area within 30 minutes through a medical call roster.

B. Organization

1. Emergency services shall have written policies and procedures which:

a. define and describe the scope of services offered;

b. assures the integration of emergency services with other hospital services, delineating when the hospital shall divert emergency patients, the criteria for the diversion, and the notification of local emergency medical services and hospitals of the diversion; and

c. governs referrals if a clinical specialty service is not provided.

2. The emergency services shall be organized under the direction of a qualified member of the medical staff and a roster of on-call medical staff with service specialties shall be maintained. The services shall be integrated with other departments of the hospital. Ancillary services routinely available at the hospital for inpatients shall be available to patients presenting with emergency medical conditions.

3. The emergency service area shall be supplied with:

a. basic trauma equipment and drugs;

b. suction and oxygen equipment; and

c. cardiopulmonary resuscitation equipment.

C. All licensed hospitals shall comply with current provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA).

D. In accordance with R.S. 40:2113.6, no officer or member of the medical staff of a hospital licensed by the department shall deny emergency services available at the hospital to a person diagnosed by a licensed physician as requiring emergency services because the person is unable to establish his ability to pay for the services or his race, religion or national ancestry. In addition, the person needing the services shall not be subjected to arbitrary, capricious or unreasonable discrimination based on age, sex, physical condition or economic status. Emergency services are services that are usually and customarily available at the hospital and that shall be provided immediately to stabilize a medical condition which if not stabilized could reasonably be expected to result in the loss of life, serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or for the care of a woman in active labor if the hospital is so equipped. If not so equipped, the hospital shall provide treatment to allow the patient to travel to a more appropriate facility without undue risk of serious harm.

E. Personnel

1. The emergency services shall make provisions for physician coverage at all hours and a qualified member of the medical staff shall be designated to supervise emergency services. There shall be a registered nurse and other nursing service personnel qualified in emergency care to meet written emergency procedures and needs anticipated by the hospital. All registered nurses working in emergency services shall be trained in advanced cardiac life support, pediatric trauma and pediatric advanced life support.

2. There are specific assigned duties for emergency care personnel with a clear chain of command.

F. The hospital shall maintain an emergency service register on every individual seeking care. At a minimum, the register shall contain the following data:

1. name, age and sex of patient;

2. date, time and means of arrival;

3. nature of complaint;

4. disposition;

5. time of departure;

6. name of the on-call or treating physician.

G. Trauma Center. In addition to the requirements above, all hospitals that request official certification by the department as a trauma center shall meet the requirements provided under state law (R.S. 40:2171).

1. All healthcare facilities offering trauma care services may request to be certified on a voluntary basis.

2. Application packet for certification shall be made by a hospital to the HSS upon forms furnished by the department. Upon determination that the hospital is in compliance with acceptable, nationally recognized standards of practice and/or guidelines for designation of trauma centers specified by the American College of Surgeons in Hospital and Pre-Hospital Resources for Optimal Care of the Injured Patient and any published appendices thereto, the department shall issue a certificate for such period as may be determined by the department.

3. There shall be a certification fee for any certificate issued in accordance with the provisions of this section, renewable every three years.

4. Trauma care services is distinct and different from the trauma center certification by the department. To be certified as a trauma center, a hospital shall satisfy the requirements of R.S. 40:2172 and 2173.

5. The department shall certify a hospital as a trauma center when the requirements of this section have been fulfilled and upon verification from the American College of Surgeons that the facility has met its criteria for Level I, II, or III. The trauma center label shall be reserved exclusively for hospitals with state-issued trauma center certification.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2407 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1481 (October 2024).

§9329. After Life Care

A. The hospital shall establish and implement written policies and procedures governing after life care that are reviewed at least every two years and revised as needed. These policies shall delineate the responsibilities of the medical staff, nursing and morgue staff, and shall include procedures for at least the following:

1. identifying the body;

2. safe and proper handling to prevent damage to the body;

3. safeguarding the personal effects of the deceased and release of personal effects to the appropriate individual;

4. handling of toxic chemicals by morgue and housekeeping staff;

5. infection control, including disinfecting of equipment;

6. identifying and handling high-risk and/or infectious bodies in accordance with Centers for Disease Control guidelines and in compliance with Louisiana law;

7. release of the body to the funeral director;

8. release of the body to the coroner upon his request for autopsy;

9. policy for autopsy requests by the physician or family and physician communication to family members regarding the autopsy requests/results;

10. availability of autopsy reports, including reports of microscopic autopsy findings, to physicians and in the medical records within specified time frames in accordance with R.S. 13:5713, or current law; and

11. completion of the autopsy, including microscopic and other procedures, within specified time frames in accordance with R.S. 13:5713, or current law, and when conducted by staff of the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2408 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1482 (October 2024).

§9331. Organ, Tissue, and Eye Procurement

A. The hospital shall have policies and procedures approved by the governing body, or its designee, for:

1. organ, tissue, and eye procurement; and

2. ensuring that appropriate hospital staff are trained on donation issues. The training shall be developed in cooperation with the OPO.

B. Beginning June 1, 2025, the hospital shall have an agreement with the designated organ procurement organization (OPO) for the state and at least one tissue bank and one eye bank, if the OPO does not include these services. At a minimum the agreement shall address the following:

1. the criteria for referral, including the referral of all individuals whose death is imminent or who have died in the hospital;

2. a definition of imminent death;

3. a definition of timely notification;

4. the OPO's responsibility to determine medical suitability for organ donation;

5. how the tissue and/or eye bank will be notified about potential donors using notification protocols developed by the OPO in consultation with the hospital-designated tissue and eye bank(s);

6. notification of each individual death in a timely manner to the OPO in accordance with the terms of the agreement;

7. the designated requestor training program offered by the OPO has been developed in cooperation with the tissue bank and eye bank designated by the hospital;

8. the organ procurement organization, tissue bank, and eye bank access to the hospital's death record information according to a designated schedule, (e.g., monthly or quarterly);

9. that the hospital is not required to perform credentialing reviews for, or grant privileges to, members of organ recovery teams as long as the OPO sends only qualified, trained individuals to perform organ recovery; and

10. the interventions the hospital will utilize to maintain potential organ donor patients so that the patient organs remain viable.

C. The hospital, shall ensure in collaboration with the OPO that the family of each potential donor is informed of its options to donate organs, tissues or eyes, or to decline to donate.

D. The individual designated by the hospital to initiate the request to the family shall be an OPO representative or a designated requestor. A designated requestor is 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 or tissue donation.

E. Upon approval of the donation, the OPO or retrieval organization shall be notified and shall cooperate in the procurement of the anatomical gift. When a request is made, the person making the request shall complete a certificate of request for an anatomical gift on a form approved by the LDH.

F. The certificate shall include the following:

1. a statement indicating that a request for an anatomical gift was made;

2. the name and affiliation of the person making the request;

3. an indication of whether consent was granted and, if so, what organs and tissues were donated;

4. the name of the person granting or refusing the request, and his relationship to the decedent.

G. A copy of the certificate of request shall be included in the decedent's medical records.

H. The following persons shall be requested to consent to a gift, in the order of priority stated:

1. the spouse if one survives; if not:

a. an adult son or daughter;

b. either parent;

c. an adult brother or sister;

d. the curator or tutor of the decedent at the time of death;

e. any other person authorized or under obligation to dispose of the body.

I. Upon the arrival of a person who is dead or near death, a reasonable search for a document of gift or other information which may indicate that a person is a donor or has refused to make such a donation shall be made by the hospital.

J. If a person at or near death has been admitted or is in transit to a hospital and has been identified as a donor of his body, organs, tissue or any part thereof, the hospital shall immediately notify the named recipient if one is named and known, and if not, the OPO federally approved organ procurement agency.

K. The hospital shall cooperate in the implementation of the anatomical gift, including the removal and release of organs and tissue, or any parts thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2408 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1482 (October 2024).

§9333. Specialty Units

A. Specialty units are designated areas in a hospital organized and dedicated to providing a specific, concentrated service to a targeted group of patients.

B. Each unit shall be organized and function as a physically identifiable section with beds that are not commingled with other hospital beds.

C. Each unit shall be staffed with professional and support personnel, appropriate to the scope of services provided. Central support services such as dietary, housekeeping, maintenance, administration and therapeutic services may be shared with the rest of the hospital.

D. There shall be written policies and procedures that define and describe the scope of services offered, including admission criteria. The policies and procedures shall be developed and approved by the governing body. They shall be reviewed at least every two years, and revised as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2409 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1482 (October 2024).

§9335. Emergency Preparedness

A. The hospital shall have an emergency preparedness plan designed to manage the consequences of natural disasters or other emergencies that disrupt the hospital's ability to provide care and treatment or threatens the lives or safety of the hospital patients 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, LDH and the OSFM and shall include the four core elements of emergency preparedness:

1. comprehensive risk assessment and emergency planning of:

a. all hazards likely in geographic area;

b. care-related emergencies;

c. equipment and power failures;

d. interruption in communications, including cyber-attacks;

e. loss of all/portion of facility;

f. loss of all/portion of supplies; and

g. reviewed and updated at least every 2 years;

2. communication plan that:

a. complies with federal and state laws;

b. has a system to contact staff, including patients' physicians, other necessary persons; and

c. is well-coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management agencies;

3. policies and procedures that comply with federal and state laws; and

4. training and testing that:

a. complies with federal and state laws; and

b. are maintained, reviewed, and updated at least every two years.

B. As a minimum, the plan shall include the following:

1. an all hazards risk assessment and identification of potential hazards that could necessitate an evacuation, including internal and external disasters such as a natural disaster, acts of bio-terrorism, weapons of mass destruction, labor work stoppage, or industrial or nuclear accidents;

2. emergency procedures for evacuation of the hospital;

3. comprehensive measures for receiving and managing care for a large influx of emergency patients. At a minimum, these measures shall include the following roles:

a. the emergency department/services;

b. surgical suite; and

c. patient care units;

4. comprehensive plans for receiving patients who are being relocated from another facility due to a disaster. This plan shall include at least an estimate of the number and type of patients the facility would accommodate and current contact information for receiving hospitals and other facilities;

5. procedures in the case of interruption of utility services that address the provision of alternate sources of energy to maintain:

a. temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;

b. emergency lighting; and

c. fire detection, extinguishing;

6. identification of the facility and an alternate facility to which evacuated patients would be relocated;

7. the estimated number of patients and staff that would require relocation in the event of an evacuation;

8. the system or procedure to ensure that medical charts accompany patients in the event of a patient evacuation and that supplies, equipment, records, and medications would be transported as part of an evacuation;

9. the roles and responsibilities of staff members in implementing the disaster plan; and

10. a system to track on-duty staff and sheltered patients during the emergency.

C. The hospital shall assure that patients receive nursing care throughout the period of evacuation and while being returned to the original hospital.

D. The hospital shall ensure that evacuated patients, who are not discharged, are returned to the hospital after the emergency is over, unless the patient prefers to remain at the receiving facility or be discharged instead of being returned to the original hospital.

E. Any staff member who is designated as the acting administrator shall be knowledgeable about, and authorized to implement the hospital's plans in the event of an emergency.

F. The hospital administrator shall appoint an individual who shall be responsible for disaster planning for the hospital.

G. While developing the hospital's plan for evacuating patients, the disaster planner shall communicate with the facility or facilities designated to receive relocated patients for development of a method for sharing information and medical documentation of evacuated patients.

H. The hospital shall conduct exercises to test the emergency plan twice per year. The hospital shall do all of the following:

1. Participate in a full-scale exercise that is community-based every two years or when a community-based exercise is not available, conduct an individual, facility based functional exercise every two years; or if the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event.

2. Conduct an additional exercise at least every two years opposite the year the full-scale or functional exercise under number one above is conducted, that may include, but is not limited to the following:

a. a second full-scale exercise that is community-based or individual, facility-based functional exercise;

b. a mock disaster drill; or

c. a tabletop exercise or workshop that is led by a facilitator and includes a group discussion;

3. Analyze the hospital's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital's emergency plan as needed.

I. The hospital shall also conduct at least one drill each year, in which a large influx of emergency patients is simulated. An actual emergency of this type shall be considered a drill, if it is documented.

J. In case of an emergency, the hospital shall have a policy for supply of food and water.

K. The hospital shall have a policy for the provision of emergency sources (e.g., generators) of critical utilities such as electricity, natural gas, water and fuel during any period in which the normal supply is temporarily disrupted.

L. The hospital's plan shall be developed in coordination with the local/parish office of emergency preparedness, utilizing community wide resources.

M. A hospital may temporarily exceed its licensed capacity in emergency situations, such as during a declared emergency. Such hospitals shall notify LDH in writing of the situation within 24 hours or as soon as practical thereafter.

N. Effective immediately, upon declaration of the secretary and notification to the Louisiana Hospital Association, all hospitals licensed in Louisiana shall file an electronic report with the Mstat, or a successor emergency support function (ESF)-8 portal operating system during a declared emergency, disaster, or public health emergency.

1. The electronic report shall be filed once a day or in accordance with federal, state, and local statutes, regulations, and guidance throughout the duration of the disaster or emergency event or as directed by the department.

2. The electronic report shall include, but not be limited to the following:

a. status of operation (open, limited or closed);

b. availability of beds by category (medical/surgery, intensive care unit, pediatric, psychiatric, etc.);

c. other resources that may be needed by a hospital in an emergency (blood products, fuel, pharmaceuticals, personnel, etc.);

d. generator status;

e. evacuation status; and

f. shelter in place status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), amended LR 29:2409 (November 2003), LR 35:245 (February 2009), amended by the Department of Health, Health Standards Section, LR 50:1483 (October 2024).

§9336. Visitation by Members of the Clergy during a Declared Public Health Emergency

A. For purposes of this Section, a public health emergency (PHE) is a declaration made pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760 et seq., or current law.

B. A licensed hospital shall comply with any federal law, regulation, requirement, order, or guideline that is more restrictive than this Section regarding visitation in hospitals during a declared PHE issued by any federal government agency.

C. For purposes of this Section, clergy shall be defined as follows:

1. a minister, priest, preacher, rabbi, imam, Christian Science practitioner; or

2. other similar functionary of a religious organization; or

3. an individual reasonably believed so to be by the person consulting him.

D. The provisions of this Section regarding visitation by members of the clergy shall apply to all hospitals licensed by the Department of Health, except for a licensed hospital that is designated as a forensic facility.

E. Subject to compliance with the requirements of this Section, each hospital shall allow members of the clergy to visit patients of the hospital during a declared PHE when a patient, or his legal or designated representative, requests a visit with a member of the clergy, subject to the following conditions and requirements:

1. each hospital shall have a written policy and procedure addressing visitation by members of the clergy. A copy of the written policy and procedure shall be available, without cost, to the patient and his legal or designated representative, upon request. The hospital shall provide a link to an electronic copy of the policy and procedure to a member of the clergy, upon request;

2. a hospital’s policy and procedure regarding clergy visitation may adopt reasonable time, place, and manner restrictions, provided that such restrictions are implemented by the hospital, in consultation with appropriate medical personnel, for the purpose of mitigating the possibility of transmission of any infectious agent or infectious disease or for the purpose of addressing the medical condition or clinical considerations of an individual patient;

3. a hospital’s policy and procedure on clergy visitation, at a minimum, requires the following:

a. that the hospital shall give special consideration and priority for clergy visitation to patients receiving end-of-life care;

b. that a clergy member may be screened for infectious agents or infectious diseases, utilizing at least the current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention, as applicable;

c. that a clergy member may not be allowed to visit a hospital patient if such clergy member has obvious signs or symptoms of an infectious agent or infectious disease, or if such clergy member tests positive for an infectious agent or infectious disease;

d. that a clergy member may not be allowed to visit a hospital patient if the clergy member refuses to comply with the provisions of the hospital’s policy and procedure or refuses to comply with the hospital’s reasonable time, place, and manner restrictions;

e. that a clergy member may be required to wear personal protective equipment as determined appropriate by the hospital, considering the patient’s medical condition or clinical considerations. At the hospital’s discretion, personal

protective equipment may be made available by the hospital to clergy members;

f. that a hospital's policy and procedure include provisions for compliance with a state health officer (SHO) order limiting visitation during a declared PHE;

g. that a patient shall have the right to consensual, nonsexual physical contact such as hand holding or hugging with members of the clergy; and

h. that a hospital's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines regarding visitation in hospitals during a declared PHE issued by any federal government agency that are more restrictive than this Section.

4. A hospital shall submit a written copy of its visitation policies and procedures to the Health Standards Section of LDH at the initial licensure survey.

5. After licensure, the hospital shall make its visitation policies and procedures available for review by LDH at any time, upon request.

6. A hospital shall within 24 hours after establishing its visitation policies and procedures, make its policies and procedures easily accessible from the homepage of its website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 29:760.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:1580 (June 2022), amended LR 49:1934 (November 2023).

§9337. Smoking Prohibition

A. Smoking shall be prohibited in all enclosed areas of the hospital. For purposes of this section, enclosed areas shall be determined by the governing board of the hospital but shall include, at a minimum, all areas of the building that are air conditioned or heated. At the discretion of the hospital's governing body, smoking may be permitted in patient rooms, but only:

1. upon the order of the patient's primary treating physician;

2. with the consent of all patients in the room; and

3. in accordance with all other applicable state and federal laws.

B. Notwithstanding the provisions of the above, the hospital's governing body may designate a well-ventilated area for smokers. Additionally, the governing body of a psychiatric hospital shall establish policies to reasonably accommodate inpatients that smoke.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40: 2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2410 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1484 (October 2024).

Subchapter C. Nursing Services

§9343. Organization and Staffing

A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction and supervision of an RN director of nursing licensed to practice in Louisiana with a minimum of two years of full-time experience as an RN in a hospital setting, employed full time, as defined by hospital policy, or at a minimum of 36 hours per week. There shall be a similarly qualified RN to act in the absence of the director of nursing services.

B. 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 hospital have a valid and current Louisiana license to practice, prior to providing any care.

C. Nursing services are either furnished or supervised and evaluated by a registered nurse.

D. Each inpatient nursing unit shall have at least one RN on duty at all times when there are patients admitted to the unit.

E. A registered nurse shall assign the nursing service staff for each patient in the hospital. Staffing shall be planned in accordance with the nursing needs of the patients, as demonstrated by a specific assessment process, specialized qualifications and competence of the nursing staff available.

F. The nursing staff shall be assigned clinical and/or management responsibilities according to education, experience and assessment of current competency and applicable laws.

G. There shall be at least two hospital employees, one of whom shall be a registered nurse, physically present in the hospital when there is one or more hospitalized patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2410 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1484 (October 2024).

§9345. Delivery of Services

A. A registered nurse shall perform an initial assessment of the patient upon admission and identify problems for each patient. The registered nurse may delegate part(s) of the data collection to other nursing personnel, however the registered nurse shall by signature validate the assessment.

B. A nursing plan of care shall be developed based on identified nursing diagnoses and/or patient care needs and patient care standards, implemented in accordance with the

Louisiana Nurse Practice Act, and shall be consistent with the plan of all other health care disciplines.

C. Isolation precautions shall be instituted when appropriate to prevent the spread of communicable diseases within the hospital.

D. All drugs and biologicals shall be administered in accordance with the orders of the practitioner(s) responsible for the patient's care and accepted standards of practice.

E. Blood transfusions and intravenous medications shall be handled, labeled and administered according to state law and approved medical staff and nursing service policies and procedures.

F. Blood and blood products shall be refrigerated separately from food, beverages and laboratory specimens.

G. An appropriate patient consent form shall be signed prior to blood transfusion administration.

H. There shall be policies and procedures for reporting transfusion reactions, adverse drug reactions and errors in the administration of drugs. It shall include immediate oral reporting to the treating physician, a written report to the director of pharmacy and the appropriate hospital committee, and an appropriate entry in the patient's record.

I. Safety policies and procedures shall be established for the care of patients, who because of their condition, are not responsible for their acts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2410 (November 2003).

Subchapter D. Pharmaceutical Services

§9349. General Provisions

A. The hospital shall provide pharmaceutical services that meet the needs of the patients. The hospital shall have a pharmacy directed by a registered pharmacist or a drug storage area supervised by a registered pharmacist. The hospital pharmacy shall have a permit, issued by the Louisiana Board of Pharmacy, allowing the ordering, storage, dispensing and delivering of legend prescription orders. The hospital shall have a current controlled dangerous substance (CDS) license to dispense controlled substances to patients in the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2411 (November 2003).

§9351. Organization and Staffing

A. Pharmaceutical services shall be directed by a registered pharmacist, licensed to practice in Louisiana on either a full-time, part-time or consulting basis. The director of pharmacy shall be responsible for the procurement, storage, dispensing, supervision and management of all legend and non-legend drugs for the hospital, and shall maintain complete and accurate records of all drug transactions by the pharmacy. There shall be an adequate number of personnel to ensure quality services, including emergency services, 24 hours per day, seven days per week. A pharmacist shall be on call after hours, whenever the pharmacy does not provide 24-hour service.

B. Hospital pharmacies that are not staffed on a 24-hour basis shall have an adequate security detection device.

C. Hospital pharmacies that are not open after regular working hours shall make drugs available for the staff by use of a night drug cabinet, after-hours medication carts, or an automated storage and distribution device. The hospital pharmacy shall maintain an inventory and a list of these drugs, which are approved by the pharmacy director and the appropriate hospital committee.

D. Each off-site campus shall have a site specific controlled dangerous substance (CDS) license if they will be dispensing controlled dangerous substances.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2411 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1484 (October 2024).

§9353. Delivery of Services

A. All compounding, packaging, and dispensing of drugs, biologicals, legend and controlled substances shall be accomplished in accordance with Louisiana law and Board of Pharmacy regulations and be performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

B. Dispensing of prescription legend or controlled substance drugs direct to the public or patient by vending machines is prohibited.

C. Current and accurate records shall be maintained on the receipt, distribution and dispensing of all scheduled drugs in such a manner as to facilitate complete accounting for the handling of these controlled substances. An annual inventory, at the same time each year, shall be conducted for all schedule I, II, III, IV and V drugs.

D. A hospital outpatient pharmacy shall maintain all records and inventory separate and apart from that of the inpatient pharmacy, and shall require a separate pharmacy permit to operate.

E. Medications are to be dispensed only upon written or electronic orders, facsimile, or oral orders from a physician or other legally authorized prescriber, and be taken by a qualified professional.

F. All inpatient drug containers shall be labeled to show at least the patient's full name, room number, 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. Floor stock containers shall contain the name and strength of the drug, lot and control number or equivalent, and the expiration date. In unit dose systems, each single unit dose package shall contain the name and strength of the drug, lot and control number or equivalent, and expiration date. Outpatient drug containers shall be labeled to show at least the patient's full name, the prescriber's name, the chemical or generic drug's name, directions, name of the pharmacy and pharmacist, prescription number, and appropriate accessory and cautionary statements. Outdated, mislabeled or otherwise unusable drugs and biologicals shall be separated from useable stock, shall not be available for patient or other use and shall be returned to an authorized agency for credit or destroyed according to current state or federal laws as applicable.

G. In accordance with the acceptable, nationally recognized standards of practice and/or guidelines, the medical staff, in coordination and consultation with the pharmacy service, shall determine and establish the reasonable time to automatically stop orders for drugs and biologicals not specifically prescribed as to time or number of doses. The hospital shall implement, monitor, and enforce the automatic stop system.

H. The director of pharmacy shall develop and implement a procedure that in the event of a drug recall, all employees involved with the procurement, storage, prescribing, dispensing and administering of recalled drugs in the facility will be notified to return these drugs to the pharmacy for proper disposition.

I. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician, pharmacist and, if appropriate, to the hospital-wide quality assessment and improvement program. An entry shall be made in the patient's record.

J. Abuses and losses of controlled substances shall be reported to the individual responsible for pharmaceutical services, the chief executive officer, the Louisiana Board of Pharmacy, and to the Regional Drug Enforcement Administration (DEA) office, as appropriate.

K. Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use and routes of administration shall be available to the staff.

L. A formulary system shall be established by the appropriate hospital committee to assure quality pharmaceuticals at reasonable costs, in accordance with applicable federal and state laws.

M. Naloxone nasal spray, as an over-the-counter (OTC) non-prescription drug, may be distributed by the hospital to patients and/or non-patients who present in the hospital. Other non OTC formulations and dosages of naloxone will remain available by prescription only.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2411 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1279 (September 2024), LR 50:1484 (October 2024).

§9355. Environment

A. All drugs and biologicals shall be kept in a locked, well illuminated clean medicine cupboard, closet, cabinet, or room under proper temperature controls and accessible only to individuals authorized to administer or dispense drugs. A list of authorized individuals shall be developed in cooperation with the medical, nursing, administrative and pharmaceutical staff. Compartments appropriately marked shall be provided for the storage of poisons and external use drugs and biologicals, separate from internal and injectable medications.

B. All controlled substances shall be kept separately from other non-controlled substances in a locked cabinet or compartment. Exceptions may be made, if listed in the pharmacy policy and procedures manual and deemed necessary by the director of pharmacy, to allow some abusable nonscheduled drugs to be maintained in the same locked compartment.

C. Drugs and biologicals that require refrigeration shall be stored separately from food, beverages, blood and laboratory specimens.

D. The area within the pharmacy used for the compounding of sterile parenteral preparations shall be separate and apart, shall meet the requirements of the Board of Pharmacy regulation §2541 and be designed and equipped to facilitate controlled aseptic conditions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2412 (November 2003).

Subchapter E. Radiologic Services

§9361. General Provisions

A. The hospital shall maintain, or have available through written contract, radiologic services according to the needs of the patients. If therapeutic services are also provided, they, as well as the diagnostic services, shall meet professionally approved standards for safety and personnel qualifications. The hospital shall comply with periodic inspections by the Department of Environmental Quality, Radiation Protection Division and shall promptly correct any identified hazards.

B. A full-time, part-time, or consulting qualified radiologist shall direct and supervise radiologic services.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing LR 21:177 (February 1995), amended LR 29:2412 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1484 (October 2024).

§9363. Safety

A. The radiologic services, particularly ionizing radiology, shall adopt written policies and procedures to provide for the safety and health of patients and hospital personnel. The policies and procedures shall be available to all staff in the radiology department. At a minimum, the policies and procedures shall cover the following:

1. shielding for patients, personnel and facilities;

2. storage, use and disposal of radioactive materials;

3. periodic inspection of equipment and handling of identified hazards;

4. periodic checks by exposure meters or test badges on radiation workers;

5. radiologic services provided on the orders of practitioners with clinical privileges or other practitioners authorized by the medical staff and the governing body to order the service; and

6. managing medical emergencies in the radiologic department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2412 (November 2003).

§9365. Personnel

A. A qualified full-time, part-time, or consulting radiologist shall supervise the ionizing radiology services and shall interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. The radiologist shall have clinical privileges delineated by the medical staff.

B. Only personnel who are registered and/or licensed in the appropriate radiologic technology modality or category by the Louisiana 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.

C. All practitioners who read and interpret radiologic reports shall be credentialed by the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1485 (October 2024).

§9367. Records

A. Radiologic reports shall be signed by the practitioner who reads and interprets them.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 13:246 (April 1987), amended LR 21:177 (February 1995), LR 29:2413 (November 2003).

Subchapter F. Laboratory Services

§9371. Organization and Staffing

A. The hospital shall maintain, or have available, adequate laboratory services to meet the needs of its patients as determined by the medical staff on a 24-hour basis. Emergency laboratory services shall be available 24 hours a day.

1. Laboratory services shall be directed by an individual who meets appropriate qualifications of a director and is credentialed by the medical staff.

2. There shall be sufficient licensed qualified clinical laboratory scientists and supportive technical staff to perform the tests required of the clinical laboratory services.

3. A written description of services provided shall be available to the medical staff.

B. The hospital shall ensure that all laboratory services provided to its patients are performed in a laboratory certified in accordance with the clinical laboratory improvement amendments (CLIA) of 1988.

1. If a hospital regularly uses the services of an outside blood collecting establishment, it shall have a written agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components.

C. The hospital shall have policies and procedures that address the administration of potentially HIV infectious blood or blood products, and the notification of patient, legal representative or relative within a specified time frame.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003), amended by the Department of Health, Health Standards Section LR 50:1485 (October 2024).

Subchapter G. Nutritional and Therapeutic Dietetic Services

§9377. General Provisions

A. There shall be an organized dietary service that provides nutritional and therapeutic dietetic services to patients. All hospital contracts or arrangements for off-site food preparation shall be with a provider who is licensed by the department's healthcare division or operating under the authority of the federal government.

B. A hospital may meet the requirements of §9377.A through a contractual agreement with a provider who is licensed by the department’s Health Standards Section or through a contract with an outside food management company. If the hospital has a contract with an outside food

management company, the following requirements shall be met.

1. The hospital shall provide written notices to the department's Health Standards Section and to the department's Office of Public Health within 10 calendar days of the effective date of the contract.

2. The outside food management company shall possess a valid LDH, Office of Public Health retail food permit and meet all of the requirements for operating a retail food establishment that serves a highly susceptible population, in accordance with the most current version of the provisions found in Title 51, *Public Health—Sanitary Code*.

3. Either the hospital or the food management company shall employ or contract with a registered dietician who serves the hospital on a full-time, part-time, or consultant basis to ensure that the nutritional needs of the patients are met in accordance with the licensed healthcare practitioners' orders and acceptable, nationally recognized standards of practice and/or guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1413 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1476 (October 2019), amended by the Department of Health, Health Standards Section, LR 50:1485 (October 2024).

§9379. Organization and Staffing

A. Nutritional and therapeutic dietetic 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.

B. The dietary manager shall:

1. be a qualified dietitian; or

2. be a graduate of a dietetic technician program, correspondence program or otherwise approved by the American Dietetics Association; or

3. have successfully completed a course of study, by correspondence or classroom, which meets the eligibility requirements for certification by the Dietary Manager's Association; or

4. have successfully completed a training course at a state approved school, vocational or university, which includes course work in foods and food service, supervision, and diet therapy. Documentation of an eight-hour course of formalized instruction in diet therapy conducted by the employing facility's qualified dietitian is permissible if the course meets only the foods, food service, and supervision requirements; and

a. Exception. Hospitals with 25 or fewer beds that do not have on site food preparation for patient meals and contract for food services, another full-time employee, i.e., RN or LPN, will be allowed to carry out the responsibilities of the dietary manager. The RN or LPN shall be qualified by training and experience and employed full time.

5. not be the director of nursing.

C. The registered dietitian shall be responsible for assuring that quality nutritional and therapeutic dietetic services are provided to patients. This shall be accomplished by providing and supervising the nutritional aspects of patient care including nutritional screening, nutritional assessments of patients at nutritional risk, patient education related to nutritional intake and diet therapy, and recording information in the medical record regarding the nutritional status and care of the patient and the patient's response to the therapeutic diet.

D. The hospital shall employ sufficient support personnel, competent in their respective duties, to carry out the function of the dietary service adequate to meet the nutritional and therapeutic dietetic needs of the patients in accordance with the prescribed plan of care.

E. For hospitals that provide dietary services in accordance with §9377 above, a registered dietician shall be employed or under contract to assure proper dietary services are being provided in accordance with §9379.B.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2413 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1476 (October 2019), amended by the Department of Health, Health Standards Section, LR 50:1485 (October 2024).

§9381. Menus and Therapeutic Diets

A. Menus shall be prepared in advance, meet the nutritional needs of the patients in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, or as modified in accordance with the orders of the practitioner(s) responsible for the care of the patient, and followed as planned.

B. Therapeutic diets shall be prescribed by the licensed practitioner(s) responsible for the care of the patient. Therapeutic diets, and laboratory tests to monitor the effectiveness of the dietary plan, may be prescribed by a licensed dietitian/nutritionist subject to the approval of, and authorization by, the facility's medical staff or bylaws and in accordance with state law. Each patient's nutritional intake shall be documented in the patient's medical record. Nutritional intake includes both enteral and parenteral nutrition.

C. There shall be a procedure for the accurate transmittal of dietary orders to the dietary service and for informing the dietary service when the patient does not receive the ordered diet, or is unable to consume the prescribed diet.

D. There shall be a current therapeutic diet manual, which shall be the guide used for ordering and serving diets

and other nutritional intake. The manual shall be approved by the dietitian and medical staff and be readily available to all medical, nursing and food service personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2414 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 43:74 (January 2017).

§9383. Dietary Services

A. Dietary services, whether provided by the hospital directly, through a contractual agreement or by an off-site vendor, shall comply with Title 51, *Public Health Sanitary Code*.

B. Food shall be in good condition, free from spoilage, filth, or other contamination and shall be safe for human consumption. All food shall be procured from sources that comply with laws and regulations related to food and food labeling.

C. All food shall be transported, 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 41 degrees Fahrenheit, except when being prepared and served.

1. For those hospitals that contract with a food delivery service for nutritional and therapeutic dietary services, food shall be transported only via vehicles designed, equipped, and maintained solely for the purpose of the transportation and delivery of food by the food management company.

D. The physical environment in which all food preparation takes place shall be kept clean and in safe operating condition.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2414 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1476 (October 2019), amended by the Department of Health, Health Standards Section, LR 50:1486 (October 2024).

Subchapter H. Medical Record Services

§9387. Organization and Staffing

A. There shall be a medical records department that has administrative responsibility for maintaining medical records for every person evaluated or treated as an inpatient, outpatient or emergency patient. Medical records for patients at off-site campuses shall be integrated into the unified records system of the provider.

B. Medical records shall be under the supervision of a medical records practitioner (i.e., registered record administrator or accredited record technician) on either a full-time, part-time or consulting basis.

C. Medical records shall be legibly and accurately written in ink, dated, timed, and signed by the recording person or, if an electronic medical records system is used, authenticated, complete, properly filed and retained, and accessible.

D. If a facsimile communications system (fax) is used, the hospital shall take precautions when thermal paper is used to ensure that a legible copy is retained as long as the medical record is retained.

E. Written orders signed by a member of the medical staff shall be required for all medications and treatments administered to patients. There shall be a reliable method for personal identification of each patient. The medical staff bylaws shall include specifications for orders for the care or treatment of patients which are given to the hospital verbally or transmitted to the hospital electronically, whether by telephone, facsimile transmission or otherwise. The bylaws may grant the medical staff up to 10 calendar days following the date an order is transmitted verbally or electronically to provide the signature or countersignature for such order. Orders entered via use of computerized provider order entry (CPOE) do not require a signature if the CPOE used has an immediate download into the provider's electronic health record (EHR) as the order would be dated, timed, authenticated, and promptly placed in the medical record.

F. If rubber stamp signatures are authorized for physician use, the administrative office shall have on file a signed statement from the medical staff member whose stamp is involved that ensures that he/she is the only one who has the stamp and uses it. The delegation of their use by others is prohibited.

G. If electronic signatures are used, the hospital shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.

H. There shall be adequate medical record personnel to ensure prompt completion, filing and retrieval of records.

I. The hospital shall have a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support quality assessment and improvement evaluations.

J. The hospital shall ensure that all medical records are completed within 30 days following discharge.

K. A patient or his/her personal representative shall be given reasonable access to the information contained in his/her hospital record. The hospital shall, upon request in writing signed and dated by either the patient or personal representative initiating the request, furnish a copy of the hospital record as soon as practicable, not to exceed 15 calendar days following the receipt of the request and written authorization and upon payment of the reasonable cost of reproduction in accordance with Louisiana R.S. 40:1165.1. However, the hospital may deny the patient access if a licensed healthcare professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person.

L. Upon request of a competent adult victim of a sexually oriented criminal offense as defined in R.S. 15:622, or current law, the hospital that performed the forensic medical exam shall provide a reproduction of any written documentation which is in the possession of the hospital resulting from the forensic medical exam of the victim.

1. The documentation shall be provided to the victim no later than 14 days after the hospital receives the request or the hospital completes the documentation, whichever is later.

2. The reproduction of written documentation provided for in this Subsection shall be made available at no cost to the victim and may only be released at the direction of the victim who is a competent adult. This release does not invalidate the victim's reasonable expectation of privacy nor does the record become a public record after the release to the victim.

M. A hospital record may be kept in any written, photographic, microfilm, or other similar method or may be kept by any magnetic, electronic, optical or similar form of data compilation which is approved for such use by the department. No magnetic, electronic, optical or similar method shall be approved unless it provides reasonable safeguards against erasure or alteration.

N. A hospital may at its discretion, cause any hospital record or part to be microfilmed, or similarly reproduced, in order to accomplish efficient storage and preservation of hospital records.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2415 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1934 (November 2023), amended by the Department of Health, Health Standards Section, LR 50:1486 (October 2024).

§9389. Content

A. The medical record shall contain the following minimum data:

1. unique patient identification data;

2. admission and discharge dates;

3. complete history and physical examination, in accordance with medical staff policies and procedures;

4. provisional admitting diagnosis and final diagnosis;

5. medical staff orders;

6. progress notes;

7. nursing documentation and care plans;

8. record of all medical care or treatments; and

9. discharge summary.

B. The medical record shall contain the following when applicable:

1. clinical laboratory, pathological, nuclear medicine, radiological and/or diagnostic reports;

2. consultation reports;

3. pre-anesthesia note, anesthesia record, and post-anesthesia notes;

4. operative reports;

5. obstetrical records, including:

a. record of mother's labor, delivery, and postpartum period;

b. separate infant record containing date and time of birth, condition at birth, sex, weight at birth if condition permits weighing, and condition of infant at time of discharge;

c. autopsy reports; and/or

d. any other reports pertinent to the patient's care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2415 (November 2003).

§9391. Registers and Reports

A. The hospital shall have the following registers and reports, where applicable, which may be computer generated:

1. patients' register;

2. emergency room register;

3. birth register;

4. delivery room register;

5. operating room register;

6. death register;

7. analysis of hospital service via the quality assessment and improvement program, based on patient statistics; and

8. daily census report of admissions, births, discharges and deaths.

B. All hospitals licensed by the Department of Health that provide emergency treatment, due to complications following an abortion as defined in R.S. 40:1061.9 shall:

1. ensure proper electronic coding and tracking of post-abortion complications;

2. submit to the department, on a form provided by the department, a report on patients who present for post-abortion complication emergency treatment. The report shall:

a. be confidential;

b. be exempt from disclosure pursuant to the Public Records Law, R.S. 44:1 et seq.;

c. not contain the name or address of the patient;

d. include the following:

i. the date of the abortion;

ii. the name and address of the facility where the abortion was performed or induced;

iii. the nature of the abortion complication diagnosed or treated;

iv. the name and address of the facility where the post-abortion care was performed; and

3. ensure that a staff member of the hospital attempts to obtain the information required in this section from any patient prior to the patient's discharge from the hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:1061.9.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 48:1581 (June 2022).

§9393. Confidentiality

A. The hospital shall ensure the confidentiality of patient records, including information in an electronic medical record system, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (Title 45, Part 164, Subpart E of the Code of Federal Regulations) and any Louisiana state laws and regulations which provide a more stringent standard of confidentiality than the HIPAA Privacy Regulations. Information from or copies of records may be released only to authorized individuals, and the hospital shall ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records shall not be released outside the hospital unless under court order or subpoena or in order to safeguard the record in the event of a physical plant emergency or natural disaster. Psychiatric medical records shall be segregated to ensure confidentiality.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1486 (October 2024).

§9395. Retention

A. Hospital records shall be retained by the hospital in their original, microfilmed, or similarly reproduced form for a minimum period of 10 years from the date a patient is discharged, or as required by current law.

B. Graphic matter, images, x-ray films, nuclear medicine reports and like matter that were necessary to produce a diagnostic or therapeutic report shall be retained, preserved and properly stored by the hospital in their original, microfilmed or similarly reproduced form for a minimum period of three years from the date a patient is discharged. (Note: Medicare and/or Medicaid participating hospitals shall maintain copies of reports and printouts, films, scans, and other image records for at least six years). Such graphic matter, images, x-ray film, and like matter shall be retained for longer periods when requested in writing by any one of the following:

1. an attending or consulting physician of the patient;

2. the patient or someone acting legally in his/her behalf; or

3. legal counsel for a party having an interest affected by the patient's medical records.

C. A hospital that is closing shall act in accordance with the requirements of §9307.

D. Medical records shall be properly stored in secure locations where they are protected from fire, water damage, and other threats.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1486 (October 2024).

Subchapter I. Quality Assessment and Improvement

§9399. General Provisions

A. The governing body shall ensure that the hospital has an effective, written, ongoing, hospital-wide, data driven quality assessment and performance improvement program designed to assess and improve the quality of patient care.

B. The governing body shall ensure that the hospital's quality assessment and performance improvement program reflects the complexity of the hospital's organization and services, includes all hospital departments and services including those under contract or arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1487 (October 2024).

§9401. Quality Assessment and Performance Improvement

A. There is a written plan for assessing and improving quality that describes the objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation, and improvement activities. All organized services related to patient care, including services furnished by a contractor, shall be evaluated. Nosocomial infections and medication therapy shall be evaluated. All medical and surgical services and other invasive procedures performed in the hospital shall be evaluated as they relate to appropriateness of diagnosis and treatment. The services provided by each practitioner with hospital privileges shall be periodically evaluated to determine whether they are of an acceptable level of quality and appropriateness.

B. Each department or service of the hospital shall address:

1. patient care problems;

2. cause of problems;

3. documented corrective actions; and

4. monitoring or follow-up to determine effectiveness of corrective actions taken.

C. Each department or service of the hospital, through its governing body, shall take and document appropriate remedial action to address deficiencies found through the quality assessment and improvement program. The hospital shall document the outcome of all remedial actions.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2416 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1487 (October 2024).

§9405. Patient Care Services

A. The hospital shall have an on-going plan, consistent with available community and hospital resources, to provide or make available social work, psychological and educational services to meet the medically related needs of its patients.

B. The hospital shall also have an effective, on-going discharge planning program that facilitates the provision of follow-up care. Each patient's record shall be annotated with a note regarding the nature of post hospital care arrangements. Discharge planning shall be initiated in a timely manner. Patients, along with necessary medical information (e.g., the patient's functional capacity, nursing and other care requirements, discharge summary, referral forms) shall be transferred or referred to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.

1. If a patient has designated an uncompensated caregiver for aftercare, a hospital shall make a good faith attempt to notify the patient's designated caregiver of the patient's discharge to the patient's residence as soon as possible prior to the patient's discharge. If the hospital is unable to contact the designated caregiver, the lack of contact may not interfere with, delay or otherwise affect the medical care provided to the patient, or an appropriate discharge of the patient.

a. For purposes of §9405.B.1-3, a residence does not include any rehabilitation facility, hospital, nursing home, assisted living facility or group home.

2. As soon as practicable prior to the patient's discharge, the hospital shall make a reasonable effort to consult with the designated caregiver along with the patient, taking into account the capabilities and limitations of the caregiver, to accomplish the aftercare tasks that may be included in a discharge care plan that describes the patient's aftercare needs at his residence.

3. The hospital shall educate and instruct the caregiver concerning the aftercare needs of the patient in a manner that is consistent with the discharge plan and is based on the learning needs of the caregiver. In addition, the hospital shall also provide an opportunity for the caregiver and patient to ask questions and receive explanations about the aftercare tasks.

C. Services to persons who are elderly and persons with disabilities. Any licensed hospital, which is owned or operated, or both, by a hospital service district, or which benefits from being financed by the sale of bonds from the state or guaranteed by the state that are exempt from taxation as provided by Louisiana law, or which receives any other type of financial assistance from the state, is directed to give, when possible, priority to the treatment of persons who are elderly and persons with physical or mental disabilities in the delivery of nonemergency healthcare services.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 43:74 (January 2017), amended by the Department of Health, Health Standards Section, LR 50:1487 (October 2024).

Subchapter J. Physical Environment

§9409. General Provisions

A. The hospital shall be constructed, arranged and maintained to ensure the health, safety, and welfare of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

B. Hospitals with specialty units such as psychiatric or rehabilitative units must also comply with the physical environment requirements as expressed within those particular chapters.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1487 (October 2024).

§9411. Buildings

A. The buildings shall reflect good housekeeping and shall by means of an effective pest control program, be free of insects and rodents.

B. The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the health, safety, or welfare of patients are assured.

1. There shall be emergency power and lighting in at least the operating, recovery, intensive care, emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights shall be available.

2. There shall be facilities for emergency medical gas and water supply.

C. The hospital shall have procedures for the proper routine storage and prompt disposal of garbage and waste in in accordance with Title 51, *Public Health Sanitary Code.*

D. The hospital shall have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel, and guests; evacuation; and cooperation with fire-fighting authorities.

E. The hospital shall maintain written evidence of regular inspection and approval by State or local fire control agencies.

F. A hospital may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access;

G. When a sprinkler system is shut down for more than 10 hours, the hospital shall:

1. Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

2. Establish a fire watch until the system is back in service.

H. Facilities, supplies, and equipment shall be maintained to ensure an acceptable level of safety and quality.

I. There shall be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

J. For all new construction or renovations, hospitals shall follow the 2014 Edition of the Facility Guidelines Institute (FGI), Guidelines for Design and Construction of Hospitals and Outpatient Facilities, as adopted by the OSFM, for building design and construction.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2417 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1487 (October 2024).

§9417. Patient Room Furnishings

A. A hospital type bed with suitable mattress, pillow and necessary coverings shall be provided for each patient. There shall be a bedside stand, chair, and wardrobe, locker, or closet suitable for hanging full-length garments and storing personal effects for each patient.

B. A nurses' call system, within easy reach of each bed, shall be provided. The call system shall also be provided in each patient toilet and bathing area. Call systems shall be readily accessible to a patient and shall be in proper working order.

C. Each bed in multi-bed rooms shall have approved ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. A properly designed lamp or over-bed light, which can be operated by the patient, shall be provided at each bed.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2418 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1488 (October 2024).

§9419. Equipment

A. Facilities, supplies, and equipment shall be maintained to ensure an acceptable level of health, safety, and welfare of patients, staff, and visitors.

B. Therapeutic, diagnostic and other patient care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. All patients, when appropriate due to diagnosis, shall be provided with patient care items such as a bedpan, washbasin, emesis basin, drinking glass, and soap dish. These supplies and equipment shall be properly cleaned and in appropriate cases shall be sterilized in between use for different patients. Disposable one time use items shall not be re-used.

D. 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.

E. After discharge of a patient, the room, bed, mattress, cover, bedside furniture, and equipment shall be properly cleaned and disinfected.

F. Items, including equipment, furniture, supplies, etc. that are no longer able to be cleaned and/or disinfected due to wear and tear shall not be used.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2418 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1488 (October 2024).

Subchapter K. Infection Prevention and Control

§9423. Organization and Policies

A. The hospital shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases.

B. There shall be an effective infection control program for the prevention, control, investigation and reporting of communicable disease and infections. The infection control program shall meet or exceed the latest criteria established by the following:

1. Centers for Disease Control;

2. Occupational Safety and Health Administration; and

3. Title 51, Public Health Sanitary Code.

C. A person or persons qualified by education and experience and competent in infection control practices shall be designated as infection control officer(s). This individual(s) shall be responsible for the development and implementation of a hospital-wide infection control program.

D. The infection control officer(s) shall develop, with approval of the medical director and governing body, policies and procedures for identifying, reporting, investigating, preventing and controlling infections and communicable diseases of patients and hospital personnel. The infection control officer(s) shall maintain a log of incidents related to infections and communicable diseases.

E. Employees with symptoms of illness that have the potential of being communicable (i.e. diarrhea, skin lesions, respiratory symptoms) shall be either evaluated by hospital staff or restricted from patient care activities during the infectious stage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2418 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1488 (October 2024).

§9425. Responsibilities

A. The chief executive officer or administrator, the medical staff and the director of nursing services shall ensure that the hospital-wide quality assessment and improvement program and training programs address problems identified by the infection control officer(s). They shall be responsible for the implementation of successful corrective action plans in affected problem areas. Infection control activities or programs conducted or instituted in different departments of the hospital shall have the approval of the infection control officer(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9427. Laundry Services

A. A supply of clean linen, sufficient to meet the requirements of the patients, shall be provided by a laundry service either in-house, contracted with another healthcare facility or in accordance with an outside commercial laundry service. All linens shall be handled, cleaned, sanitized, stored and transported in such a way as to prevent infection.

B. Clean linen shall be delivered in such a way as to minimize microbial contamination from surface contact or airborne deposition. Soiled linen shall be collected in such a manner as to minimize microbial dissemination into the environment. All linen shall be laundered between patient use.

C. Contaminated laundry shall be specially handled according to the hospital's written protocol, which is approved by the infection control officer(s). If laundry chutes exist, linen shall be bagged and the chutes shall empty into an enclosed collection room.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9429. Central Supply

A. Space shall be provided for the decontamination, packaging, sterilization, and storage. All central supply departments shall adhere to strict traffic control in their departments.

B. There shall be written policies and procedures for the decontamination and sterilization of supplies and equipment, and the shelf life of all stored sterile items in accordance with the latest criteria established by the Centers for Disease Control and Prevention.

C. All steam, ethylene oxide (ETO), and other low-temperature sterilizers shall be tested with biological and chemical indicators upon installation, when the sterilizer is relocated, redesigned, after major repair, and after a sterilization failure has occurred, to ensure they are functioning prior to placing them into routine use. This shall be done in accordance with latest criteria established by the Centers for Disease Control and Prevention. If tests are positive, a system shall be in place to recall supplies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1488 (October 2024).

§9431. Isolation

A. The hospital shall have appropriate facilities and procedures for infection control and the isolation of patients as necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

§9433. Waste and Hazardous Materials Management

A. The hospital shall have a written and implemented waste management program that identifies and controls wastes and hazardous materials. The program shall comply with all applicable laws and regulations governing wastes and hazardous materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003).

Subchapter L. Surgical Services (Optional)

§9437. General Provisions

A. Surgical services, if provided, shall be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered, the services shall be consistent in quality with inpatient care in accordance with the complexity of services offered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1488 (October 2024).

§9439. Organization and Staffing

A. Surgical services shall be under the medical direction of a qualified physician who is a member of the medical staff and appointed by the governing body.

B. Surgical privileges shall be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical services shall maintain a roster of practitioners specifying the surgical privileges of each practitioner.

C. The surgical suite shall be supervised by a registered nurse experienced and competent in the management of surgical services.

D. A qualified registered nurse shall perform circulating duties for surgical procedures performed. In accordance with the needs of patients and the complexity of services performed, licensed practical nurses and operating room technicians may assist in circulatory duties under the supervision of a registered nurse who is immediately available to respond to emergencies. Licensed practical nurses and operating room technicians may perform scrub functions under the supervision of a registered nurse.

E. The operating room register or log, including those created by electronic means, shall be complete and up-to-date. It shall include at least the following:

1. patient's name;
2. patient's hospital identification number;
3. date of the operation;
4. inclusive or total time of the operation;
5. name of the surgeon and any assistant(s);
6. name of nursing personnel (scrub and circulating);
7. type of anesthesia used;
8. name of the person administering the anesthesia;
9. surgical procedure performed;
10. pre and post-operative diagnosis;
11. age of patient;
12. operating room number; and
13. complications, if any.

F. An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated immediately following surgery and signed by the surgeon. It shall include at least:

1. the name and hospital identification number of the patient;
2. date of surgery;
3. name of the surgeon and assistant(s);
4. pre-operative and post-operative diagnoses;
5. name of the specific surgical procedure(s) performed;
6. type of anesthesia administered;
7. complications, if any;
8. name of the person administering the anesthesia;
9. surgical procedure performed;
10. pre and post-operative diagnosis;
11. age of patient;
12. operating room number; and
13. complications, if any.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2419 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1489 (October 2024).

§9441. Delivery of Service

A. There shall be a complete history and physical work-up in the chart of every patient prior to surgery, except in emergency surgery. If the history and physical has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.

B. A properly executed informed consent form for the procedure shall be in the patient's chart before surgery, except in emergencies. The consent form shall contain at least the following:

1. name of the patient;
2. hospital and patient identification number;
3. name of the procedure(s) or operation;
4. the reasonably foreseeable risks and benefits involved;
5. name of the practitioner(s);
6. signature of the patient or legal guardian;
7. date and time the consent is obtained; and
8. date, time, and signature of the person witnessing the patient or the patient’s legal representative sign the consent form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2420 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1489 (October 2024).

§9443. Surgery Suite and Equipment

A. The surgical suite shall be appropriately equipped and consist of a clear floor area to accommodate the equipment and personnel required, allowing for aseptic technique.

B. The surgical suite(s) shall be located in a segregated area out of the line of traffic of visitors and personnel from other departments and arranged so as to prevent traffic through them.

C. There shall be scrub-up facilities in the surgical suite providing hot and cold running water and equipped with knee, foot or elbow faucet controls.

D. There shall be a provision for washing instruments and equipment, which are to be cleaned within the surgical suite. If an autoclave is present, the same operating requirements referenced in Subchapter K, Infection Control shall be implemented.

E. There shall be policies and procedures, approved by the Infection Control Officer(s) that addresses terminal cleaning of the operating room as well as cleaning of the room between surgical cases.

F. There shall be policies and procedures for a surgical smoke plume evacuation plan to mitigate and remove surgical smoke plume during a surgical procedure that uses heat-producing equipment, including but not limited to electrosurgery and lasers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2420 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1935 (November 2023), amended by the Department of Health, Health Standards Section, LR 50:1489 (October 2024).

§9445. Post-Anesthesia Care Unit (PACU)

A. There shall be a PACU (recovery room) that is a separate area of the hospital, unless provisions are made for close observation of the patient until they have regained consciousness (e.g., direct observation by an RN in the patient's room). Access shall be limited to authorized personnel. There shall be policies and procedures which specify transfer requirements to and from the PACU.

B. Effective as of the promulgation of these requirements, any new or existing hospitals undergoing renovations shall have a centralized nursing station with a direct line of sight to the recovering patient(s) that have received sedation or anesthesia.

C. There shall be at least two healthcare personnel, one of which is a RN, present whenever there is a patient in the post-anesthesia care area. There shall be emergency equipment and monitoring equipment in the immediate area of the post-anesthesia care area. The equipment shall be commensurate with the surgical procedure and the medical requirements of the patient. That equipment shall include, but not be limited to, the following:

1. electrocardiogram (EKG/ECG) monitor;
2. pulse oximetry monitor;
3. temperature monitoring equipment;
4. equipment to administer oxygen;
5. equipment necessary to monitor vital signs; and
6. suction equipment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2420 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1489 (October 2024).

Subchapter M. Anesthesia Services (Optional)

§9449. General Provisions

A. If anesthesia services are provided, which is mandatory when surgical or obstetric services are provided, they shall be provided in a well-organized manner in accordance with acceptable, nationally recognized standards of practice and/or guidelines, under the direction of a qualified doctor of medicine or osteopathy.

B. The standards in this Chapter apply to services for all patients who:

1. receive general, spinal, or other major regional anesthesia; or

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 hospital, may result in the loss of the patient's protective reflexes.

C. Invasive procedures include, but are not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterization, and endoscopies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2421 (November 2003)., amended by the Department of Health, Health Standards Section, LR 50:1489 (October 2024).

§9451. Organization and Staffing

A. Anesthesia services shall be administered by practitioners with appropriate clinical privileges obtained through a mechanism that assures that each practitioner provide only those services for which they have been licensed, trained and deemed to be competent to administer

anesthesia within the scope of their practice. Those practitioners include:

1. a qualified anesthesiologist;

2. a doctor of medicine or osteopathy;

3. a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law;

4. a certified registered nurse anesthetist (CRNA) licensed by the Louisiana State Board of Nursing who is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed as defined in the medical staff bylaws; or

5. a bona fide student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia educational programs whose graduates are acceptable for certification by a nationally recognized certifying body may administer anesthesia as related to such course of study under the direct supervision of a certified registered nurse anesthetist or an anesthesiologist.

B. The individual administering the anesthesia shall be present throughout its administration and attending the patient until the patient is under the care of post-anesthesia staff.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2421 (November 2003).

§9453. Delivery of Service

A. Policies on anesthesia procedures shall include the delineation of pre-anesthesia and post-anesthesia responsibilities. As a minimum, they shall address:

1. the qualifications, responsibilities and supervision required of all personnel who administer anesthesia;

2. patient consent for anesthesia;

3. infection control measures;

4. safety practices in all anesthetizing areas;

5. protocol for supportive life functions, e.g., cardiac and respiratory emergencies;

6. reporting requirements;

7. documentation requirements;

8. inspection and maintenance reports on all supplies and equipment used in anesthesia; and

9. trace gas reports.

B. The policies shall also ensure that the following are provided for each patient:

1. a pre-anesthesia evaluation performed and recorded within 48 hours prior to surgery by an individual qualified to administer anesthesia;

2. a reevaluation of each patient immediately prior to induction of anesthesia;

3. an intra-operative anesthesia record that records monitoring of the patient during anesthesia and documentation of at least the following:

a. prior to induction of the 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 and total dosages of all drugs and agents used;

c. type and amount of all fluid administered, including blood and blood products;

d. technique(s) used;

e. unusual events during the anesthesia period;

f. the status of the patient at the conclusion of anesthesia;

g. a post-anesthesia follow-up report written within 48 hours after surgery on inpatients and prior to discharge for patients undergoing one-day/same-day surgery by the individual who administers the anesthesia or another fully qualified practitioner within the anesthesia section; and

h. a post-anesthesia evaluation on outpatients for proper anesthesia recovery performed in accordance with policies and procedures approved by the medical staff.

C. The anesthesia policy and procedure manual shall ensure that the following are provided for each patient undergoing:

1. general anesthesia:

a. the use of an anesthesia machine that provides the availability and use of safety devices including, but not limited to, an oxygen analyzer, pressure and disconnect alarm, pin-index safety system, gas-scavenging system, and oxygen pressure interlock system;

b. continuous monitoring of the patient's temperature and vital signs, as well as the continuous use of an EKG/ECG, pulse oximetry monitor, end tidal carbon dioxide volume monitor, and peripheral nerve stimulator monitor;

2. regional anesthesia (major nerve blocks):

a. all equipment listed in the above list for general anesthesia shall be immediately available and in the operating room where the procedure is being performed; and

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; and

c. monitored by the practitioner who administered the regional anesthetic or individuals identified as a practitioner listed in §9451.A.1-5;

3. local anesthesia (infiltration or topical). There shall be:

a. continuous monitoring of the patient's vital signs and temperature as well as the continuous use of an EKG/ECG, and pulse oximeter monitor; and

b. monitoring by the practitioner who administered the local anesthetic or a practitioner listed within §9451.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2421 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1489 (October 2024).

Subchapter N. Nuclear Medicine Services (Optional)

§9457. General Provisions

A. If the hospital provides nuclear medicine services or contracts for the services, those services shall meet the needs of the patients in accordance with acceptable, nationally recognized standards of practice and/or guidelines, and be provided in a safe and effective manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1490 (October 2024).

§9459. Organization and Staffing

A. The organization of the nuclear medicine services shall be appropriate to the scope and complexity of the services offered. There shall be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine and named in the Department of Environmental Quality, Radiation Protection Division radioactive material license as authorized to use radioactive materials in humans.

B. Nuclear medicine services shall be ordered only by a practitioner whose scope of federal or state licensing and defined staff privileges allow such referrals.

C. The performance of nuclear medicine diagnostic procedures and the administration of radioactive material to humans may be accomplished only by the licensed physician practitioner or by the licensed nuclear medicine technologist.

AUTHORITY NOTE: promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9461. Delivery of Service

A. Radioactive materials shall be prepared, labeled, used, transported, stored and disposed of in accordance with acceptable standards of practice.

B. In-house preparation of radiopharmaceuticals shall be by, or under the supervision of an appropriately trained registered pharmacist or a doctor of medicine or osteopathy whose use of radioactive materials is authorized in the facility's Department of Environmental Quality, Radiation Protection Division radioactive material license.

C. There shall be proper storage and disposal of radioactive materials. If clinical laboratory tests are performed in the nuclear medicine service, the service shall meet the requirements for clinical laboratories with respect to management, adequacy of facilities, proficiency testing and quality control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9463. Facilities

A. Equipment and supplies shall be appropriate for the types of nuclear medicine services offered and shall be maintained for safe and efficient performance.

B. The equipment shall be maintained in safe operating condition, and inspected, tested, and calibrated at least annually by qualified personnel. The nuclear medicine service shall have and follow a preventive maintenance schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

§9465. Records

A. The hospital shall maintain signed and dated reports of nuclear medicine interpretations, consultations and procedures. The hospital shall maintain copies of nuclear medicine reports in accordance with the retention requirement specified in Subchapter H, Medical Record Services.

B. The practitioner approved by the medical staff and authorized by the facility's Department of Environmental Quality, Radiation Protection Division radioactive material license to interpret diagnostic procedures shall sign and date the interpretations of these tests.

C. The hospital shall maintain records of the receipt and disposition of radiopharmaceuticals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2422 (November 2003).

Subchapter O. Outpatient Services (Optional)

§9469. General Provisions and Organization

A. If the hospital provides outpatient services, the services shall meet the needs of the patients in accordance with acceptable standards of practice.

B. Outpatient services shall be appropriately organized, integrated with and provided in accordance with the

standards applicable to the same service provided by the hospital on an inpatient basis.

1. Outpatient services shall be provided only under conditions stated in Subparagraphs a, b, or Clauses b.i.-ii below.

a. Outpatient services may be provided by a hospital if that hospital provides inpatient services for the same area of service. For example, a hospital may provide psychiatric outpatient services if that hospital provides psychiatric services on an inpatient basis.

b. Outpatient services may be provided by a hospital that does not provide inpatient services for the same area of service only if that hospital has a written policy and procedure to ensure a patient's placement and admission into an inpatient program to receive inpatient services for that area of service. The policy and procedure shall ensure that the hospital is responsible for coordination of admission into an inpatient facility and shall include, but not be limited to, the following:

i. the hospital personnel and/or staff responsible for coordination of placement and admission into an inpatient facility; and

ii. the procedure for securing inpatient services for that patient.

2. For all outpatient services, there shall be established methods of communication as well as established procedures to assure integration with inpatient services that provide continuity of care.

3. When patients are admitted, pertinent information from the outpatient record shall be provided to the inpatient facility so that it may be included in the inpatient record.

C. There shall be policies and procedures established by the medical staff to ensure quality of care and safety of patients for any room designated for procedures or treatment involving conscious sedation. Such guidelines shall include at a minimum:

1. pre-procedure preparation;

2. patient monitoring;

3. discharge criteria; and

4. staff competency requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003), LR 33:284 (February 2007), amended by the Department of Health, Health Standards Section, LR 50:1490 (October 2024).

§9471. Personnel

A. The hospital shall assign one or more individuals to be responsible for the outpatient services. There shall be appropriate professional and non-professional personnel available based on the outpatient services provided.

B. There shall be an RN on the outpatient unit as long as there are patients admitted to the unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1490 (October 2024).

Subchapter P. Rehabilitation Services (Optional)

§9477. General Provisions

A. If the hospital provides a range of rehabilitation services, including but not limited to physical therapy, occupational therapy, audiology or speech pathology services, the services shall be organized, operated and staffed in accordance with the provisions of this Subchapter P to ensure the health and safety of patients.

B. A rehabilitation unit or facility is defined as a designated unit or hospital that primarily provides physiological rehabilitation services to inpatients and/or outpatients.

C. For rehabilitation services that have multiple geographic locations, each geographical site shall meet the requirements in §9483.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003).

§9479. Organization and Staffing

A. The organization of services shall be appropriate to the scope of the services offered. The rehabilitation service shall employ and define the leadership structure in accordance with the facility administration.

B. Medical Director. The medical director of rehabilitation services shall:

1. be a doctor of medicine or osteopathy;

2. be licensed to practice medicine or surgery in accordance with state law;

3. have completed a one-year hospital internship;

4. have had at least two years of training or experience, within the last five years, in the medical management of patients requiring rehabilitation services;

5. provide services to the rehabilitation hospital or rehabilitation unit on a full-time basis;

a. This provision does not apply to rehabilitation units.

b. The hospital shall define the term full-time as it applies to all of its employees.

6. have experience and training of rehabilitation services to perform all of the functions within the service; and

7. be responsible to ensure that the objectives of each of the therapeutic disciplines of the rehabilitation program are efficiently conducted within the stated mission of the program and in accordance with acceptable, nationally recognized standards of practice and/or guidelines for rehabilitation medicine.

C. Physical therapy, occupational therapy, psychology/neuropsychology, speech therapy and audiology services shall be provided by staff that meet the qualifications in accordance with Louisiana law. All rehabilitation staff shall be duly licensed to practice in the areas in which they provide service.

D. A rehabilitation unit in a general hospital shall have an RN as manager of the rehabilitation unit. The RN shall have at least one year of clinical nursing experience providing rehabilitative nursing care. The unit shall provide 24-hour RN coverage with an adequate number of licensed nurses and rehabilitative workers to provide the nursing care necessary under each patient's active treatment program.

E. In a rehabilitation hospital, the director of nursing services shall be a full-time registered nurse who has three years clinical nursing experience, one of which shall be in providing rehabilitative nursing care. In addition to the director of nursing services, the hospital shall provide 24-hour registered nurse coverage with an adequate number of licensed nurses and rehabilitative workers to provide the nursing care necessary under each patient's active treatment program.

F. If provided, psychological services shall be provided by or supervised by a psychologist licensed by the Louisiana State Board of Examiners of Psychologists.

G. Social services shall be provided by a licensed clinical social worker and shall meet the needs of the patients.

H. If the hospital provides a range of rehabilitation services, the services shall define criteria for admission to the inpatient rehabilitation program and discharge from the inpatient program.

I. There shall be an interdisciplinary team that shall include, but not be limited to:

1. a registered nurse with rehabilitation experience on each shift;

2. restorative nursing assistants and/or certified nursing aides;

3. a physical therapist;

4. an occupational therapist;

5. a physician experienced in rehabilitation medicine;

6. a social worker; and

7. a speech-language pathologist.

J. The program should provide or make arrangements for:

1. audiology services;

2. driver assessment;

3. driver education;

4. medical nutrition therapy;

5. orthotic services;

6. prosthetic services;

7. rehabilitation resources (independent centers);

8. vocational rehabilitation;

9. durable medical equipment;

10. specialty consultants;

11. a psychologist/neuropsychologist; and

12. other services consistent with the criteria for admission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2423 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1490 (October 2024).

§9481. Delivery of Services

A. Rehabilitation services shall be furnished in accordance with a written plan of treatment based upon an assessment performed by the qualified professional. The written plan of treatment shall be established prior to the beginning of treatment. The plan of treatment shall consist of at least the treatment goals, type, amount, frequency and duration of services.

B. Rehabilitation services shall be given in accordance with the orders of practitioners who are authorized by the medical staff to order the services. The orders shall be incorporated in the patient's medical record.

C. The patient's progress shall be documented on a timely and regular basis in accordance with written policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

§9483. Rehabilitation Hospital or Unit Physical Space

A. Space and equipment shall be appropriate for the types of rehabilitation services offered and shall be maintained for safe and efficient performance and in accordance with the 2014 Edition of the Hospital Units and Rehabilitation Units of the Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals and Outpatient Facilities, as adopted by the OSFM, for building design and construction.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), amended LR 29:2424 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1491 (October 2024).

Subchapter Q. Respiratory Care Services (Mandatory)

§9487. General Provisions

A. The hospital shall provide respiratory care services. The services shall meet the needs of the patients in accordance with acceptable standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

§9489. Organization and Staffing

A. The organization of the respiratory care services shall be appropriate to the scope and complexity of the services offered. There shall be a director of the service who shall have the administrative authority and responsibility for implementing the hospital's policies. The director shall be a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the services properly. The director may serve on either a full-time or part-time basis.

B. There shall be adequate numbers of respiratory therapists, respiratory therapy technicians and other personnel who meet the qualifications specified by the medical staff and approved by the governing body, consistent with Louisiana law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2424 (November 2003).

§9491. Delivery of Services

A. Respiratory care services shall be delivered in accordance with medical staff directives and incorporated in the patient's medical record. The order shall specify the type, frequency and duration of treatment, and as appropriate, the type and dose of medication, type of diluent, and the oxygen concentration. All respiratory care services provided shall be documented in the patient's medical record, including the type of therapy, date and time of administration, effects of therapy, and any adverse reactions.

B. Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures shall be designated in writing.

C. If blood gases or other clinical laboratory tests are performed in the respiratory care unit, the unit shall meet the requirement for clinical laboratories with respect to management, adequacy of facilities, proficiency testing and quality control as set forth in Subchapter F of these requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2425 (November 2003).

Subchapter R. Psychiatric Services (Optional)

§9495. General Provisions

A. These requirements are applicable to those hospitals which are primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons or have organized a physically and functionally distinct part unit within the hospital to provide these services. Pediatric and adolescent psychiatric units shall be physically separated from adult psychiatric units. Facilities without separate pediatric and adolescent units shall have policies and procedures that prevent adult patients from co-mingling with pediatric and/or adolescent psychiatric patients.

B. For psychiatric services/facilities that have multiple geographic locations, each geographic site shall meet the requirements in §9497, §9499, and §9501.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2425 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1491 (October 2024).

§9497. Psychiatric Hospital or Psychiatric Unit Physical Space

A. The layout and design of a psychiatric hospital or psychiatric unit shall be in accordance with the 2014 Edition of the Facility Guidelines Institute (FGI), Guidelines for Design and Construction of Hospitals and Outpatient Facilities, as adopted by the OSFM, for building design and construction. In addition to the FGI Guidelines, details, equipment, and furnishings shall be such that patients shall be under close observation and shall not be afforded opportunities for hiding, escape, or injury to themselves or others. The environment of the unit shall be characterized by a feeling of openness with emphasis on natural light and exterior views. Interior finishes, lighting, and furnishings shall suggest a residential rather than an institutional setting while conforming to applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

B. The psychiatric hospital or unit shall develop and implement strategy to identify environmental safety risks within its specific environment and specific to its patient population. The operation of windows shall be restricted to inhibit possible escape or suicide. Where windows or vents require the use of tools or keys for operation, the tools or keys shall be either located on the same floor in a prominent location accessible to staff or carried by every staff member. There shall be no curtain or venetian blind cords.

C. Plastic bags and/or trash can lines shall not be used in patient care areas.

D. Patient Rooms

1. An electric nurses' call system is not required however, the hospital shall have policies and procedures for how patients call for assistance.

2. Bedpan-flushing devices may be omitted from patient room toilets in psychiatric nursing units.

3. Visual privacy (e.g., cubicle curtains) in multi-bed rooms is not required.

4. Free standing closets shall be secured to the wall.

5. Electric patient beds are not to be used. The secretary of the department may, within his/her sole discretion, grant a waiver of this provision in accordance with section 9305.

E. Service Areas

1. A secured storage area controlled by staff shall be provided for patients' belongings that are determined to be potentially harmful (e.g., razors, nail files, cigarette lighters).

2. Drugs and biologicals shall be stored in locked compartments under proper temperature controls, and only authorized personnel shall have access to the keys.

3. Food service may be one or a combination of the following:

a. a nourishment station;

b. a kitchenette designed for patient use with staff control of heating and cooking devices; and

c. a kitchen service including a hand washing fixture, storage space, refrigerator, and facilities for meal preparation.

4. Storage space for stretchers and wheelchairs may be outside the psychiatric unit, provided that provisions are made for convenient access as needed for handicapped patients.

F. Seclusion Treatment Room

1. There shall be at least one seclusion room for up to 24 beds or a major fraction thereof. It is intended for short-term occupancy by violent or suicidal patients and provides for patients requiring security and protection. The room(s) shall be either located for direct nursing staff supervision or observed through the use of electronic monitoring equipment.

2. If electronic monitoring equipment is used, it shall be connected to the hospital's emergency electrical source. It shall be constructed to prevent patient hiding, escape, injury, or suicide.

3. If a facility has more than one psychiatric unit, located at the same geographic address, the number of seclusion rooms shall be determined by the total number of psychiatric beds at that location. However, if there are psychiatric units located at multiple and different geographic addresses, there shall be a seclusion room that meets these requirements at each off-site campus that offers inpatient psychiatric services.

4. Special fixtures and hardware for electrical circuits shall be used.

5. Seclusion rooms shall be accessed by an anteroom or vestibule that also provides direct access to a toilet room.

G. Ceiling construction in psychiatric patient rooms and seclusion room(s) shall be monolithic or tamper proof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 21:177 (February 1995), amended LR 29:2425 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1491 (October 2024).

§9499. Supplies and Equipment

A. Restraint equipment shall be immediately available and accessible to staff, if restraint use is part of the functional plan of the hospital or unit.

B. Recreational supplies and therapy equipment shall be available.

C. Locked storage areas shall be available for safekeeping of patient belongings and any items that may be considered contraband.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2426 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1492 (October 2024).

§9501. Staffing

A. The hospital or unit shall provide qualified professional, technical and consultative personnel to evaluate patients, formulate written individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning.

B. The hospital or unit shall employ a clinical director, who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry. The clinical director shall monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

C. In a psychiatric hospital, the director of nursing (DON) services, shall be provided by a full-time RN.

1. A DON hired or promoted prior to May 31, 2026, shall meet the following criteria for education and experience:

a. a master's degree in psychiatric or mental health nursing or its equivalent, from a school of nursing accredited by the National League for Nursing;

b. a master's degree in a related field such as psychology or nursing education, and five years nursing

experience. Three years of this experience shall be in providing nursing care to the mentally ill; or

c. a bachelor's, associate degree or diploma in nursing with documented evidence of educational programs focused on treating psychiatric patients, which has occurred at intervals sufficient enough to keep the nurse current on psychiatric nursing techniques. In addition, the nurse shall have at least five years of nursing experience, three years of which were providing nursing care to the mentally ill, or receive regular, documented supervision/consultation from a master's prepared psychiatric nurse.

2. A DON hired or promoted on or after June 1, 2026, shall meet the following criteria for education and experience:

a. a master's degree in psychiatric or mental health nursing or its equivalent, from a school of nursing accredited by the National League for Nursing; or

b. at least three years clinical RN experience in providing psychiatric nursing care, and on-going training in psychiatric nursing. Documentation from a RN with a master's degree in psychiatric nursing constitutes on-going training. Such documentation shall be maintained in the personnel file for the DON.

D. A psychiatric unit within a general hospital shall have an RN as a manager of the psychiatric unit. The RN shall meet the same requirements as that of the DON in a psychiatric hospital.

E. The DON of a psychiatric hospital or the psychiatric unit RN manager shall demonstrate competence to participate in interdisciplinary formulation of individual treatment plans, to give skilled nursing care and therapy if needed, and to direct, monitor, and evaluate the nursing care furnished.

F. In addition to the director of psychiatric nursing service, the hospital or unit shall provide 24-hour RN coverage with an adequate number of licensed nurses and mental health workers to provide the nursing care necessary under each patient's active treatment program.

G. Psychological services shall be provided by or supervised by a psychologist licensed by the Louisiana State Board of Examiners of Psychologists.

H. Social services shall be provided by a director who is a licensed clinical social worker and who is experienced in the social service needs of the mentally ill.

I. Therapeutic recreational services shall be provided by qualified recreational therapists, support personnel, and consultants adequate in number to provide comprehensive therapeutic recreational services consistent with each patient's care plan.

1. An individual who clinically supervises therapeutic recreational services shall meet the following qualifications:

a. have a degree in therapeutic recreational services from an accredited post-secondary institution; or

b. have a degree in another field of study and has also attained certification in accordance with the National Council for Therapeutic Recreation Certification requirements.

2. An individual who provides therapeutic recreational services shall have the following qualification:

a. a degree in therapeutic recreational services from an accredited post-secondary institution; or

b. a degree in another field of study and has also attained certification in accordance with the National Council for Therapeutic Recreation Certification requirements; or

c. a minimum of 10 years' experience providing therapeutic recreational services; or

d. be currently employed as a therapeutic recreational services specialist 2 per Louisiana Civil Service requirements.

3. Therapeutic recreational services shall be designed to:

a. restore, remediate, and rehabilitate a person's level of functioning and independence in life activities;

b. promote health and wellness; and

c. reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.

NOTE: Examples of intervention modalities include, but are not limited to, creative arts (e.g., crafts, music, dance, drama, among others), sports, adventure programming, dance/movement, and leisure education.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2426 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1489 (August 2015), amended by the Department of Health, Health Standards Section, LR 50:1492 (October 2024).

Subchapter S. Obstetrical and Newborn Services (Optional)

§9505. General Provisions for Hospitals Licensed as of January 1, 2022

A. Sections 9505-9509 shall be effective immediately upon publication of these provisions for existing hospitals licensed as of July 1, 2022, and shall remain in effect through November 30, 2023. Such hospitals must be in compliance with Sections 9511-9517 beginning December 1, 2023.

1. The level of care of the neonatal intensive care unit (NICU) is not required to match or exceed the level of obstetrical care for each level of obstetrical service.

2. For facilities that change the level of care and services of the facility's NICU unit, either decreasing or increasing the level provided, the facility shall submit an attestation of this change to the department's Health Standards Section (HSS) in writing and on the appropriate state neonatal services Medicaid attestation form. Such

notice shall be submitted to the HSS within 90 days of the facility's change in NICU level provided. For facilities that change the level of care and services of a facility's obstetrical unit, by either decreasing or increasing the level provided, the facility shall submit written notice of this change to HSS within 90 days of such change.

B. For purposes of this Subchapter, hospital privileges are such privileges that are unrestricted and approved by the medical staff committee and the governing body that allows the practitioner to perform all duties within their scope of practice and certification(s) at the hospital in which the privileges are granted and such duties are performed.

1. The requirements for privileges, such as active privileges, inpatient privileges or full privileges, shall be defined in hospital policy and approved by each hospital's governing body.

C. In accordance with R.S. 40:2109, a hospital located in a parish with a population of 250,000 people or less shall not be required to maintain personnel in-house with credentials to administer obstetric anesthesia on a 24-hour basis in order to qualify for Medicaid reimbursement for level III, neonatal or obstetric medical services, or as a prerequisite for licensure to provide such services. Personnel with such credentials may be required to be on staff and readily available on a 24-hour on-call basis and demonstrate ability to provide anesthesia services within 20 minutes.

NOTE: The provisions of §9505.C shall not apply to any hospital with level IIIS, IIIR or IV obstetrical and neonatal services.

D. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being immediately or readily available shall be defined by hospital policy and approved by each hospital's governing body.

E. Any transfer agreements shall be in writing and approved by the hospital medical staff and by each hospital's governing body. Transfer agreements shall be reviewed at least annually and revised as needed.

F. For those hospitals providing transports, the qualifications of the transport team shall be in writing, defined by hospital policy and approved by each hospital's governing body. Such qualifications shall be reviewed at least annually and revised as needed.

G. The hospital shall have data collection and retrieval capabilities in use, and shall cooperate and report the requested data to the appropriate supervisory agencies to review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:75 (January 2017), LR 46:1087 (August 2020), LR 48:2569 (October 2022).

§9507. Obstetrical Units

A. These requirements are applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care Units. There are five established obstetrical levels of care units:

1. obstetrical level I unit;

2. obstetrical level II unit;

3. obstetrical level III unit;

4. obstetrical level III regional unit; and

5. obstetrical level IV.

C. Obstetrical services shall be provided in accordance with acceptable standards of practice as delineated in the 2014 *AAP/ACOG Guidelines for Perinatal Care*. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a level IV unit must meet the requirements of a level I, II, III and III regional unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:75 (January 2017).

§9509. Obstetrical Unit Functions

A. Obstetrical Level I Unit

1. General Provisions

a. Care and supervision for low risk pregnancies greater or equal to 35 weeks gestation shall be provided.

b. There shall be a triage system present in policies and procedures for identification, stabilization and referral of high risk maternal and fetal conditions beyond the scope of care of a level I unit.

c. There shall be protocols and capabilities for massive transfusion, emergency release of blood products, and management of multiple component therapy available on-site.

d. Postpartum care facilities shall be available on-site.

e. There shall be capability to provide for resuscitation and stabilization of inborn neonates.

f. The hospital shall have a policy for infant security and an organized program to prevent infant abductions.

g. The hospital shall have a program in place to address the needs of the family, including parent-sibling-neonate visitation.

h. The hospital shall have a written transfer agreement with another hospital that has an approved appropriate higher level of care.

2. Personnel Requirements

a. Obstetrical services shall be under the medical direction of a qualified physician who is a member of the medical staff with obstetric privileges. The physician shall

be board certified or board eligible in obstetrics/gynecology or family practice medicine. The physician has the responsibility of coordinating perinatal services with the pediatric chief of service.

b. The nursing staff shall be adequately trained and staffed to provide patient care at the appropriate level of service. Registered nurse to patient ratios may vary in accordance with patient needs.

c. The unit shall provide credentialed medical staff to ensure the capability to perform emergency Cesarean delivery within 30 minutes of the decision to operate (30 minutes from decision to incision).

d. Anesthesia, radiology, ultrasound, electronic fetal monitoring (along with personnel skilled in the use of these) and laboratory services shall be available on a 24-hour basis. Anesthesia services shall be available to ensure performance of a Cesarean delivery within 30 minutes as specified in Subparagraph c above.

e. At least one credentialed physician or certified registered nurse midwife shall attend all deliveries, and at least one individual who is American Academy of Pediatrics (AAP) certified in neonatal resuscitation and capable of neonatal resuscitation shall attend all deliveries.

f. The nurse manager shall be a registered nurse (RN) with specific training and experience in obstetric care. The RN manager shall participate in the development of written policies, procedures for the obstetrical care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

g. A facility shall have at least one individual with additional education in breastfeeding who is available for support, counseling and assessment of breastfeeding mothers.

h. A facility shall have ability to initiate education and quality improvement programs to maximize patient safety, and/or collaborate with higher-level facilities to do so.

3. Physical Plant

a. Obstetrical patients shall not be placed in rooms with non-obstetrical patients.

b. Each room shall have at least one toilet and lavatory basin for the use of obstetrical patients.

c. 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(s).

d. There shall be an isolation room provided with hand washing facilities for immediate segregation and isolation of a mother and/or baby with a known or suspected communicable disease.

e. For any new construction or major alteration of the obstetrical unit/suite, the hospital shall ensure that the OB unit has a Cesarean delivery room (surgical operative room) to perform Cesarean deliveries at all times.

B. Obstetrical Level II Unit

1. General Provisions

a. The role of an obstetrical Level II unit is to provide care for most obstetric conditions in its population, but not to accept transports of obstetrical patients with gestation age of less than 32 weeks or 1,500 grams if delivery of a viable infant is likely to occur.

b. Women with conditions that would result in the delivery of an infant weighing less than 1,500 grams or less than 32 weeks gestation shall be referred to an approved level III or above unit unless the attending physician has documented that the patient is unstable to transport safely. Written transfer agreements with approved obstetrical level III and above units for transfer of these patients shall exist for all obstetrical level II units.

c. Ultrasound equipment shall be on site, in the hospital, and available to labor and delivery 24 hours a day.

2. Personnel Requirements

a. The chief of obstetric services shall be a board-certified obstetrician or a board eligible candidate for certification in obstetrics. This obstetrician has the responsibility of coordinating perinatal services with the neonatologist in charge of the neonatal intensive care unit (NICU).

b. A board-certified radiologist and a board-certified clinical pathologist shall be available 24 hours a day. Specialized medical and surgical consultation shall be readily available.

c. There shall be a continuous availability of qualified RNs with the ability to stabilize and transfer high-risk women.

d. A board-certified or board eligible OB-GYN physician shall be available 24 hours a day.

> EXCEPTION: For those hospitals whose staff OB-GYN physician(s) do not meet the provisions of §9509.B(2)d, such physician(s) may be grandfathered as satisfying the requirement of §9509.B(2)d when the hospital has documented evidence that the OB-GYN physician(s) was granted clinical staff privileges by the hospital prior to the effective date of this Rule. This exception applies only to the physician at the licensed hospital location and is not transferrable.

e. A licensed physician board-certified in maternal fetal medicine (MFM) shall be available 24 hours a day for consultation onsite, by telephone, or by telemedicine, as needed.

f. Anesthesia services shall be available 24 hours a day to provide labor analgesia and surgical anesthesia.

g. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be available 24 hours a day for consultation.

h. Medical and surgical consultants shall be available 24 hours a day to stabilize obstetric patients who have been admitted to the facility or transferred from other facilities.

C. Obstetrical Level III Unit

1. General Provisions

a. Women with conditions requiring a medical team approach not available to the perinatologist in an obstetrical level III unit shall be transported to a higher-level unit.

b. The unit shall have written cooperative transfer agreements with approved higher level units for the transport of mothers and fetuses requiring care unavailable in an obstetrical level III unit or that are better coordinated at a higher level unit.

c. The hospital shall have advanced imaging services available 24 hours a day which will include magnetic resonance imaging (MRI) and computed topography (CT).

d. The hospital shall have medical and surgical ICUs to accept pregnant women and have qualified critical care providers available as needed to actively collaborate with MFM physicians 24 hours a day.

e. Participation is required in a statewide quality collaborative and database selected by the Medicaid Quality Committee, Maternity Subcommittee, with a focus on quality of maternity care. Proof of such participation will be available from the LDH website.

f. Equipment and qualified personnel, adequate in number, shall be available onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.

g. This unit shall accept maternal transfers as deemed appropriate by the medical staff and governing body.

2. Personnel Requirements

a. The delivery of safe and effective perinatal nursing care requires appropriately qualified registered nurses in adequate numbers to meet the nursing needs of each patient. The hospital shall develop, maintain and adhere to an acuity-based classification system based on nationally recognized staffing guidelines and shall have documentation of such.

b. A board-certified or board-eligible MFM physician with inpatient privileges shall be available 24 hours a day, either onsite, by telephone, or by telemedicine.

c. The director of MFM services shall be a board-certified or board eligible MFM physician.

d. The director of obstetric service shall be a board-certified OB-GYN with active staff privileges in obstetrical care.

e. Anesthesia services shall be available 24 hours a day onsite.

f. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be in charge of obstetric anesthesia services and shall be available onsite as needed.

g. A full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, urology, hematology, cardiology, nephrology, neurology, neonatology and pulmonology shall be available for inpatient consultations.

h. A lactation consultant or counselor shall be on staff to assist breastfeeding mothers as needed.

i. The lactation consultant or counselor shall be certified by a nationally recognized board on breastfeeding.

i. A nutritionist and a social worker shall be on staff and available for the care of these patients as needed.

D. Obstetrical Level III Regional Unit

1. General Provisions

a. This unit shall provide care for the most challenging of perinatal conditions. Women with such conditions requiring a medical team approach not available to the MFM physician in an obstetrical level III Regional unit shall be transported to a level IV unit.

b. This unit shall have written cooperative transfer agreements with a level IV unit for the transport of mothers and fetuses requiring care that is unavailable in the level III regional unit or that is better coordinated at a level IV.

c. This unit shall accept maternal transfers as deemed appropriate by the medical staff and hospital governing body.

2. Personnel Requirements

a. This unit shall have a board-certified or board-eligible OB/GYN available onsite 24 hours a day.

b. The director of MFM services for this unit shall be board-certified in MFM.

c. This unit shall have an anesthesiologist qualified in the delivery of obstetric anesthesia services available to be onsite 24 hours a day.

E. Obstetrical Level IV Unit

1. General Provisions

a. This unit shall provide onsite medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.

2. Unit Requirements

a. This unit shall have perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement.

b. Participation is required in the department's designated statewide quality collaborative program.

NOTE: The hospital shall acquire and maintain documented proof of participation.

3. Personnel

a. This unit shall have a MFM care team with the expertise to assume responsibility for pregnant women and

women in the postpartum period who are in critical condition or have complex medical conditions. This includes co-management of ICU-admitted obstetric patients. The MFM team members shall have full privileges and shall be available 24 hours per day for onsite consultation and management. This team shall be led by a board-certified MFM physician.

b. The director of obstetric services for this unit shall be a board-certified MFM physician.

c. This unit shall have qualified subspecialists on staff to provide consultation in the care of critically ill pregnant women in the following areas:

i. cardiothoracic surgery;

ii. neurosurgery;

iii. endocrinology; and

iv. gastroenterology.

d. Obstetrical Medical Subspecialties

Table 1—Obstetrical Medical Subspecialties

Each higher level obstetrical unit shall meet the requirements of each lower level obstetrical unit.

Level I	Level II	Level III	Level III Regional	Level IV
Board Certified or Eligible OB/GYN or Family Practice Physician	Board Certified/Eligible OB/GYN §9509.B(2)d -See Exception	Board Certified/Eligible Anesthesiologist	Board Certified/Eligible Anesthesiologist	Board Certified/Eligible Anesthesiologist
Anesthesia services	Anesthesia services*	Board Certified OB/GYN	Board Certified OB/GYN	Board Certified OB/GYN
Radiology services	Clinical Pathologist[1]	Board Certified/Board Eligible MFM[1]**	Board Certified/Board Eligible MFM**	Board Certified MFM**
Ultrasonography	Clinical Radiologist	Clinical Pathologist[1]	Clinical Pathologist[1]	Clinical Pathologist[1]
Laboratory services	MFM[1]**	Clinical Radiologist[1]	Clinical Radiologist[1]	Clinical Radiologist[1]
Electronic fetal monitoring	Lactation Consultant/Counselor See §9509.B(h.i)	Critical Care[1]	Critical Care[1]	Critical Care[1]
		General Surgery[1]	General Surgery[1]	General Surgery[1]
		Infectious Disease[1]	Infectious Disease[1]	Infectious Disease[1]
		Urology[1]	Urology[1]	Urology[1]
		Hematology[1]	Hematology[1]	Hematology[1]
		Cardiology[1]	Cardiology[1]	Cardiology[1]
		Nephrology[1]	Nephrology[1]	Nephrology[1]
		Neurology[1]	Neurology[1]	Neurology[1]
		Neonatology[1]	Neonatology[1]	Neonatology[1]
		Pulmonology[1]	Pulmonology[1]	Pulmonology[1]
		Lactation Consultant/Counselor	Lactation Consultant/Counselor	Lactation Consultant/Counselor
		Nutritionist	Nutritionist	Nutritionist
		Social Worker	Social Worker	Social Worker
				Cardiothoracic Surgery[1]
				Gastroenterology[1]
				Endocrinology[1]
[1] physician shall be available in person on site as needed by the facility.				Neurosurgery[1]
*Anesthesia services shall be available 24 hours a day to provide labor analgesia and surgical anesthesia. A board-certified/eligible anesthesiologist with specialized training or experience in obstetric anesthesia shall be available 24 hours a day for consultation.				
**Licensed MFM shall be available for consultation onsite, by telephone, or by telemedicine, as needed.				

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended LR 33:284 (February 2007).

§9511. General Provisions for Hospitals Licensed After January 1, 2022, and for Existing Hospitals Beginning July 1, 2023

A. Sections 9511-9517 shall be effective immediately upon publication of these provisions for hospitals licensed after January 1, 2022.

1. Sections 9511-9517 shall be effective for existing hospitals (those licensed by or before January 1, 2022) beginning July 1, 2023.

B. The level of care of the neonatal ICU is not required to match or exceed the level of obstetrical care for each level of obstetrical service.

C. For facilities that change the level of care and services of the facility's NICU unit, either decreasing or increasing the level provided, the facility shall submit an attestation of this change to the department's HSS in writing and on the appropriate state neonatal services Medicaid attestation form. Such notice shall be submitted to the HSS within 90 days of the facility's change in NICU level provided. For facilities that change the level of care and services of a

facility's obstetrical unit, by either decreasing or increasing the level provided, the facility shall submit written notice of this change to HSS within 90 days of such change.

D. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being physically present at all times specifies the hospital staff and/or equipment shall be on-site in the location 24 hours a day, 7 days a week.

E. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being readily available at all times specifies the hospital staff and/or equipment shall be available, as approved by hospital policy, 24 hours a day, 7 days a week.

F. Any transfer agreements shall be in writing and approved by the hospital medical staff and by each hospital's governing body. Transfer agreements shall be reviewed at least annually and revised as needed.

G. For those hospitals providing transports, the qualifications of the transport team shall be in writing, defined by hospital policy and approved by each hospital's governing body. Such qualifications shall be reviewed at least annually and revised as needed.

H. The hospital shall have data collection and retrieval capabilities in use, and shall cooperate and report the requested data to the appropriate supervisory agencies to review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2428 (November 2003), amended LR 33:286 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:78 (January 2017), LR 48:2569 (October 2022), amended by the Department of Health, Health Standards Section, LR 50:1493 (October 2024).

§9513. Organization and Staffing

A. For purposes of this Subchapter, hospital privileges are such privileges that are unrestricted and approved by the medical staff committee and the governing body that allows the practitioner to perform all duties within their scope of practice and certification(s) at the hospital in which the privileges are granted and such duties are performed.

1. The requirements for privileges, such as active privileges, inpatient privileges or full privileges, shall be defined in hospital policy and approved by each hospital's governing body.

B. In accordance with R.S. 40:2109, a hospital located in a parish with a population of 250,000 people or less shall not be required to maintain personnel in-house with credentials to administer obstetric anesthesia on a 24-hour basis in order to qualify for Medicaid reimbursement for level III, neonatal or obstetric medical services, or as a prerequisite for licensure to provide such services. Personnel with such credentials may be required to be on staff and readily available on a 24-hour on-call basis and demonstrate ability to provide anesthesia services within 20 minutes.

NOTE: The provisions of §9513.B shall not apply to any hospital with level IIIS, IIIR or IV obstetrical and neonatal services.

C. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being physically present at all times specifies the hospital staff and/or equipment shall be on-site in the location 24 hours a day, 7 days a week.

D. For purposes of this Subchapter, the requirements for hospital staff and/or equipment as being readily available at all times means that the hospital staff and/or equipment shall be available, as approved by hospital policy, 24 hours a day, 7 days a week.

E. Any transfer agreements shall be in writing and approved by the hospital medical staff and by each hospital's governing body. Transfer agreements shall be reviewed at least annually and revised as needed.

F. For those hospitals providing transports, the qualifications of the transport team shall be in writing, defined by hospital policy and approved by each hospital's governing body. Such qualifications shall be reviewed at least annually and revised as needed.

G. The hospital shall have data collection and retrieval capabilities in use, and shall cooperate and report the requested data to the appropriate supervisory agencies to review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2429 (November 2003), amended LR 33:286 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:78 (January 2017), LR 43:1979 (October 2017), LR 48:2569 (October 2022), amended by the Department of Health, Health Standards Section, LR 50:1493 (October 2024).

§9515. Obstetrical Units

A. These requirements are applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care Units. These are five established obstetrical levels of care units:

1. obstetrical level I unit;
2. obstetrical level II unit;
3. obstetrical level III unit;
4. obstetrical level III regional unit; and
5. obstetrical level IV.

C. The guidance for these standards is based on *Obstetric Care Consensus: Levels of Maternal Care* published in August 2019. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a level IV unit shall meet the requirements of a level I, II, III and III regional unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2429 (November 2003), amended LR 33:288 (February 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 48:2570 (October 2022).

§9517. Obstetrical Unit Functions

A. Obstetrical Level I Unit (Basic Care)

1. General Provisions

a. Care and supervision for low risk pregnancies greater or equal to 35 weeks gestation and postpartum patients who are generally healthy and do not have medical, surgical, or obstetrical conditions that present a significant risk of maternal morbidity or mortality, shall be provided.

b. Participation in the state perinatal quality collaborative, which is under the authority of the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality, is required and defined as reporting national perinatal measures determined by the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality.

c. There shall be a triage system present in policies and procedures for identification, stabilization and referral of high risk maternal and fetal conditions beyond the scope of care of a level I unit, including situations where an infant will require a higher level of care than what may be provided by the neonatal level of care of the facility.

d. Postpartum care facilities shall be available on-site.

e. There shall be capability to provide for resuscitation and stabilization of inborn neonates.

f. The hospital shall have a policy for infant security and an organized program to prevent infant abductions.

g. The hospital shall have a program in place to address the needs of the family, including parent-sibling-neonate visitation.

h. The hospital shall have a written transfer agreement with another hospital that has an approved appropriate higher level of care.

i. The hospital shall have the capability to screen, provide brief intervention and refer to treatment through consultation with appropriate personnel for behavioral health disorders, including depression, and substance use disorder.

j. Social services, pastoral care and bereavement services shall be provided as appropriate to meet the needs of the patient population served.

2. Personnel Requirements

a. Obstetrical services shall be under the medical direction of a qualified physician who is a member of the medical staff with obstetric privileges. The physician shall be board certified or board eligible in obstetrics/gynecology or family practice medicine. The physician has the responsibility of coordinating perinatal services with the pediatric chief of service.

b. The nursing staff shall be adequately trained and staffed to provide patient care at the appropriate level of service. Registered nurse to patient ratios may vary in accordance with patient needs.

c. The unit shall provide credentialed medical staff to ensure the capability to perform emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits.

d. The maternal care providers, including midwives, family physicians or obstetricians, shall be readily available at all times.

e. Anesthesia, radiology, ultrasound, electronic fetal monitoring (along with personnel skilled in the use of these) and laboratory services shall be readily available at all times.

f. At least one credentialed physician or certified registered nurse midwife shall attend all deliveries, and at least one individual who is American Academy of Pediatrics (AAP) certified in neonatal resuscitation and capable of neonatal resuscitation shall attend all deliveries.

g. The nurse manager shall be a registered nurse (RN) with specific training and experience in obstetric care. The RN manager shall participate in the development of written policies, procedures for the obstetrical care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

h. A facility shall have at least one individual with additional education in breastfeeding who is available for support, counseling and assessment of breastfeeding mothers.

i. A facility shall have ability to initiate education and quality improvement programs to maximize patient safety, and/or collaborate with higher-level facilities to do so.

3. Physical Plant

a. Laboring and postpartum patients shall not be placed in rooms with non-obstetrical patients.

b. Each room shall have at least one toilet and lavatory basin for the use of obstetrical patients.

c. 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(s).

d. There shall be an isolation room provided with hand washing facilities for immediate segregation and isolation of a mother and/or baby with a known or suspected communicable disease.

e. For any new construction or major alteration of the obstetrical unit/suite, the hospital shall ensure that the OB unit has a cesarean delivery room (surgical operative room) to perform cesarean deliveries at all times.

4. Program Functions and Services

a. Laboratory and Blood Bank Services

i. There shall be protocols and capabilities for massive transfusion with process to obtain more blood and component therapy as needed, emergency release of blood products and management of multiple component therapy available on-site.

b. Medical Imaging Services

i. Ultrasound equipment shall be physically present at all times in the hospital and available during labor and delivery.

ii. Basic ultrasound imaging for maternal or fetal assessment including interpretation, shall be readily available at all times.

c. Obstetrical Services

i. Ensure the availability and interpretation of non-stress testing and electronic fetal monitoring.

ii. A trial of labor for patients with prior cesarean delivery may be attempted only if the necessary personnel to perform a cesarean delivery and perform maternal resuscitation are physically present. This personnel includes, all credentialed medical staff needed to perform an emergency cesarean delivery.

iii. The facility shall have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity and/or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols shall address at a minimum:

(a). massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination with the blood bank, including management of unanticipated hemorrhage and/or coagulopathy;

(b). hypertensive disorders in pregnancy;

(c). sepsis and/or systemic infection in the pregnant or postpartum patient; and

(d). venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, and early diagnosis and treatment.

B. Obstetrical Level II Unit (Specialty Care)

1. General Provisions

a. the role of an obstetrical level II unit is to provide care for pregnant and postpartum patients with medical, surgical and/or obstetrical conditions that present a moderate risk of maternal morbidity or mortality; and

b. women with high risk of morbidity or mortality or conditions that would result in the delivery of an infant weighing less than 1,500 grams or less than 32 weeks gestation that will require a higher level of care than what may be provided by the neonatal level of care of the facility, shall be referred to an approved level III or above unit unless the attending physician has documented that the patient is unstable to transport safely. Written transfer agreements with approved obstetrical level III and above units for transfer of these patients shall exist for all obstetrical level II units.

2. Personnel Requirements

a. Obstetric Service Leadership

i. The physician obstetric leader shall be a board-certified obstetrician or a board eligible candidate for certification in obstetrics. This obstetrician has the responsibility of coordinating perinatal services with the neonatal healthcare provider in charge of the neonatal intensive care unit (NICU).

b. Personnel

i. A board-certified or board eligible OB-GYN physician shall be readily available at all times.

EXCEPTION: For those hospitals whose staff OB-GYN physician(s) do not meet the provisions of §9517.B.2.b.i, such physician(s) may be grandfathered as satisfying the requirement of §9517.B.2.b.i when the hospital has documented evidence that the OB-GYN physician(s) was granted clinical staff privileges by the hospital prior to the effective date of this Rule. This exception applies only to the physician at the licensed hospital location and shall not be transferrable.

ii. A licensed physician board-certified or board eligible in maternal fetal medicine (MFM) shall be readily available at all times for consultation on-site, by telephone or by telemedicine, as needed. Timing and need to be on-site or available by telemedicine shall be directed by the urgency of the clinical situation.

iii. Anesthesia services shall be readily available at all times to provide labor analgesia and surgical anesthesia. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be readily available at all times for consultation.

iv. A board-certified radiologist and a board-certified clinical pathologist shall be readily available at all times. Internal or family medicine physician(s) and general surgeon(s) shall be readily available at all times for consultation to stabilize obstetric patients who have been admitted to the facility or transferred from other facilities.

v. There shall be a continuous availability of qualified RNs with the ability to stabilize and transfer high-risk women.

vi. A lactation consultant or counselor, on staff or contracted, holding certification by a nationally recognized board on breastfeeding shall be available to assist breastfeeding mothers as needed. Such services may be provided through the use of telehealth.

3. Program Functions and Services

a. Medical Imaging Services

i. Computed tomography (CT) scan, magnetic resonance imaging (MRI), non-obstetric ultrasound imagining and maternal echocardiography with interpretation shall be readily available at all times.

ii. Specialized obstetric ultrasound and fetal assessment with interpretation shall be readily available at all times.

C. Obstetrical Level III Unit (Subspecialty Care)

1. General Provisions

a. This unit shall provide care for moderate to high-risk perinatal conditions. Women with such conditions requiring a medical team approach not available to the perinatologist in an obstetrical level III unit shall be transported to a higher-level unit.

b. The unit shall have written cooperative transfer agreements with approved higher level units for the transport of mothers and fetuses requiring care unavailable in an obstetrical level III unit or that are better coordinated at a higher level unit.

c. The hospital shall have advanced imaging services readily available at all times which shall include MRI and CT.

d. The hospital shall have medical and surgical ICUs to accept pregnant women and women in the postpartum period and, shall have qualified critical care providers readily available at all times to actively collaborate with MFM physicians.

e. Equipment and qualified personnel, adequate in number, shall be available on-site to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.

f. This unit shall accept maternal transfers as deemed appropriate by the medical staff and governing body.

2. Personnel Requirements

a. Obstetric Leadership

i. The physician obstetric leader shall be a board-certified OB-GYN with active staff privileges in obstetrical care.

ii. A board-certified anesthesiologist with specialized training or experience in obstetric anesthesia shall be in charge of obstetric anesthesia services.

iii. The director of MFM services shall be a board-certified or board eligible MFM physician.

b. Personnel

i. This unit shall have a board-certified or board-eligible OB-GYN readily available at all times and available to be physically present within 20 minutes of request to be on-site.

ii. This unit shall have a board-certified or a board-eligible anesthesiologist qualified in the delivery of obstetric anesthesia services readily available at all times. Personnel with such credentials shall be required to be on staff and readily available on a 24-hour on-call basis, and demonstrate the ability to provide anesthesia services within 20 minutes.

iii. A board-certified or board-eligible MFM physician with inpatient privileges shall be readily available at all times, either on-site, by telephone or by telemedicine.

iv. A full complement of subspecialists, including subspecialists in critical care, general surgery, infectious disease, urology, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, neonatology and pulmonology shall be readily available at all times for inpatient consultations.

v. Anesthesia services shall be physically present at all times, unless otherwise provided by R.S. 40:2109(B)(6).

vi. The delivery of safe and effective perinatal nursing care requires appropriately qualified registered nurses in adequate numbers to meet the nursing needs of each patient. The hospital shall develop, maintain and adhere to an acuity-based classification system based on nationally recognized staffing guidelines and shall have documentation of such.

vii. A nutritionist and a social worker shall be on staff and available for the care of these patients as needed.

D. Obstetrical Level III Regional Unit (Regional Transfer Unit).

1. General Provisions

a. This unit shall provide care for the most challenging of perinatal conditions. Women with such conditions requiring a medical team approach not available to the MFM physician in an obstetrical level III regional unit shall be transported to a level IV unit.

b. This unit shall have written cooperative transfer agreements with a level IV unit for the transport of mothers and fetuses requiring care that is unavailable in the level III regional unit or that is better coordinated at a level IV.

c. This unit shall accept maternal transfers as deemed appropriate by the medical staff and hospital governing body.

2. Personnel Requirements

a. This unit shall have a board-certified or board-eligible OB-GYN physically present at all times.

b. The director of MFM services for this unit shall be a board-certified MFM physician.

c. This unit shall have an anesthesiologist qualified in the delivery of obstetric anesthesia services physically present at all times.

E. Obstetrical Level IV Unit (Regional Subspecialty Perinatal Health Care Centers)

1. General Provisions

a. This unit shall provide on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.

2. Unit Requirements

a. This unit shall have perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement.

3. Personnel

a. Obstetric Leadership

i. The physician obstetric leader for this unit shall be a board-certified MFM physician.

b. Personnel

i. This unit shall have a MFM care team with the expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. This includes co-management of ICU-admitted obstetric patients. The MFM team members shall have full privileges and shall be available 24 hours per day for on-site consultation and management. This team shall be led by a board-certified MFM physician.

ii. This unit shall have qualified subspecialists on staff, readily available at all times, to provide consultation and treatment as needed on-site in the care of critically ill pregnant women in the following areas:

(a). cardiothoracic surgery and

(b). neurosurgery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2570 (October 2022), amended by the Department of Health, Health Standards Section, LR 50:1493 (October 2024).

§9519. Neonatal Intensive Care [Formerly LAC 48:I.9511]

A. This §9519 is applicable to those hospitals which provide obstetrical and neonatal services.

B. Levels of Care. There are five established neonatal levels of care units:

1. neonatal level I unit;

2. neonatal level II unit;

3. level III NICU unit;

4. level III surgical NICU; and

5. level IV NICU unit.

C. Each advanced level of care unit shall provide all services and meet the personnel requirements of the lower designated units, as applicable, i.e., a level III surgical unit must meet the requirements of the level I, II, and III units.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2573 (October 2022).

§9521. Neonatal Unit Functions [Formerly LAC 48:I.9513]

A. Level I Neonatal Unit (Well Newborn Nursery)

1. General Provisions

a. This unit shall have the capability for resuscitation and stabilization of all inborn neonates in accordance with Neonatal Resuscitation Program (NRP) guidelines. The unit shall stabilize unexpectedly small or sick neonates before transfer to the appropriate advanced level of care.

b. The unit shall stabilize and provide care for infants born at 35 weeks or greater gestation and who remain physiologically stable. The requirements for maternal transport at lesser gestations for transfer to a higher level of care shall be determined by the medical staff and approved by the hospital governing body.

c. This unit shall have the capability to stabilize newborns born at less than 35 weeks gestational age for transfer to higher level of care.

d. This unit shall maintain consultation and written transfer agreements with an approved level II or III as appropriate.

e. This unit shall have a defined, secured nursery area with limited public access and/or secured rooming-in facilities with supervision of access.

f. Parent and/or sibling visitation/interaction with the neonate shall be provided.

2. Personnel Requirements

a. The unit's chief of service shall be a physician who is board-certified or board-eligible in pediatric or family practice medicine.

b. The nurse manager shall be a registered nurse with specific training and experience in neonatal care. The RN manager shall participate in the development of written policies and procedures for the neonatal care areas, and coordinate staff education and budget preparation with the chief of service. The RN manager shall name qualified substitutes to fulfill duties during absences.

c. Registered nurse to patient ratios may vary in accordance with patient needs. If couplet care or rooming-in is used, a registered nurse who is responsible for the mother shall coordinate and administer neonatal care. If direct assignment of the nurse is also made to the nursery to cover the newborn's care, there shall be double assignment (one nurse for the mother-neonate couplet and one for just the neonate if returned to the nursery). A registered nurse shall be available 24 hours a day, but only one may be necessary as most neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the registered nurse's direct supervision. Adequate staff is needed to respond to acute and emergency situations.

B. Neonatal Level II Unit (Special Care Nursery)

1. General Provisions

a. This unit shall provide care for infants born at more than 32 weeks gestation and weighing more than 1,500 grams.

i. infants who have medical problems that are expected to resolve rapidly and are not anticipated to need emergent subspecialty services from a higher level NICU as determined by the attending medical staff.

b. This unit shall have the capability to provide mechanical ventilation and/or CPAP for a brief duration (less than 24 hours) for infants born at more than 32 weeks and weighing more than 1,500 grams.

c. Neonates requiring greater than 24 hours of continuous ventilator support shall be transferred to a higher-level neonatal intensive care facility.

d. This unit shall have the ability to stabilize infants born before 32 weeks gestation and/or weighing less than 1,500 grams until transfer to a higher level neonatal intensive care facility.

e. Neonates requiring transfer to a higher-level neonatal intensive care facility may be returned to a level II unit for convalescence.

2. Personnel Requirements

a. A board-certified neonatologist shall be the chief of service.

NOTE: This unit shall have continuously available medical staff defined as available 24 hours per day/7 days per week/365 days per year on call for consultation as defined by medical staff bylaws.

b. Registered nurse to patient ratios may vary in accordance with patient needs.

c. This unit shall have at least one full-time social worker to be available as needed to assist with the socioeconomic and psychosocial problems of high-risk mothers, sick neonates, and their families.

d. This unit shall have at least one occupational or physical therapist to be available as needed to assist with the care of the newborn.

e. This unit shall have at least one registered dietitian/nutritionist to be available as needed who can plan diets as required to meet the special needs of mothers and high-risk neonates.

f. This unit shall have staff available 24 hours per day who have the demonstrated knowledge, skills, abilities and training to provide the care and services to infants in this unit, such as but not limited to:

i. nurses;

ii. respiratory therapists;

iii. radiology technicians; and

iv. laboratory technicians.

3. Equipment Requirements

a. This unit shall have hospital based equipment to provide care to infants available 24 hours per day, such as but not limited to:

i. portable x-ray machine;

ii. blood gas analyzer.

C. Level III NICU

1. General Provisions

a. There shall be a written neonatal transport agreement with an approved level III surgical unit or level IV unit.

b. This unit shall have either a neonatologist, a neonatal nurse practitioner, a physician assistant-certified, or a neonatology fellow in-house 24 hours per day.

c. The staffing of this unit shall be based on patient acuity and consistent with the recommended acceptable, nationally recognized standards of practice and/or guidelines of the American Academy of Pediatrics (AAP). For medical sub-specialty requirements, refer to Table 1, Neonatal Medical Subspecialties and Transport Requirements.

NOTE: All provisions of level III NICUs are required of level IIIS and IV NICUs.

2. Personnel Requirements

a. The chief of service of a level III NICU shall be a board-certified neonatologist.

EXCEPTION: In 1995, those physicians in existing units who were designated as the chief of service of the unit and who were not neonatal or perinatal board-certified, were granted a waiver by written application to the Office of the Secretary, Department of Health. This waiver shall be maintained as it applies only to the hospital where that chief of service's position is held. The physician cannot relocate to another hospital nor can the hospital replace the chief of service for whom the exception was granted and retain the exception.

b. This unit shall have at least one full-time social worker available as needed who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families. For units with greater than 30 patients, the social worker staffing ratios shall be at least one social worker to 30 patients (additional social workers may be required in accordance with hospital staffing guidelines.

c. This unit shall have at least one occupational or physical therapist available as needed with neonatal expertise and at least one individual skilled in evaluation and management of neonatal feeding and swallowing disorders (e.g., speech-language pathologist).

d. This unit shall have at least one registered dietitian/nutritionist available as needed who has training or experience in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.

e. Delivery of safe and effective perinatal nursing care requires this unit to have qualified registered nurses in adequate numbers to meet the nursing needs of each patient. To meet the nursing needs of this unit, hospitals shall develop and adhere to an acuity based classification system based on nationally recognized staffing guidelines and have documentation available on such guidelines.

f. This unit shall have the following support personnel immediately available as needed to be on-site in the hospital, including but not limited to:

i. licensed respiratory therapists or registered nurses with specialized training who can supervise the

assisted ventilation of neonates with cardiopulmonary disease.

3. Equipment Requirements

a. This unit shall have the following support equipment, in sufficient number, immediately available as needed in the hospital that includes, but is not limited to:

i. advanced imaging with interpretation on an urgent basis (computed tomography, ultrasound (including cranial ultrasound), MRI, echocardiography and electroencephalography); and

ii. respiratory support that allows provision of continuous mechanical ventilation for infants less than 32 weeks gestation and weighing less than 1,500 grams.

4. Transport

a. It is optional for level III NICUs to provide transports. If the unit performs transports, the unit shall have a qualified transport team and provide for and coordinate neonatal transport with level I and level II units throughout the state.

b. Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' section on neonatal and pediatric transport and in accordance with applicable Louisiana statutes.

5. Quality Improvement Collaborative

a. Facilities with level III NICUs and above shall participate in a quality improvement collaborative and a database selected by the Medicaid quality committee, neonatology sub-committee.

b. Proof of current participation by the facility will be available from the LDH website.

D. Level III Surgical NICU

1. General Provisions

a. This unit shall have a transport team and provide for and coordinate neonatal transport with level I, level II units and level III NICUs throughout the state as requested. Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' section on neonatal and pediatric transport and in accordance with applicable Louisiana statutes.

NOTE: All provisions of level III NICUs are required of level IIIS and IV NICUs.

2. Personnel Requirements

a. For medical sub-specialty requirements refer to Table 1–Neonatal Medical Subspecialties and Transport Requirements.

EXCEPTION: Those hospitals which do not have a member of the medical staff who is a board certified/eligible pediatric anesthesiologist but whose anesthesiologist has been granted staff privileges to perform pediatric anesthesiology, such physician(s) may be grandfathered as satisfying the requirement of §9521.2.a when the hospital has documented evidence that the anesthesiologist was granted clinical staff privileges by the hospital prior to the effective date of this Rule. This exception applies only to such physician at the licensed hospital location and is not transferrable.

3. Equipment Requirements

a. This unit shall have the following support equipment, in sufficient number, immediately available as needed in the hospital that includes, but is not limited to:

i. a full range of respiratory support that incudes high frequency ventilation and inhaled nitric oxide.

E. Level IV NICU

1. General Provisions

a. This unit shall be located within an institution with the capability to provide surgical repair of complex conditions (e.g., congenital cardiac malformations that require cardiopulmonary bypass with or without extracorporeal membrane oxygenation).

2. Personnel Requirements

a. for medical sub-specialty requirements, refer to Table 1–Neonatal Medical Subspecialties and Transport Requirements;

NOTE: All provisions of level IIIS NICUs are required of level IV NICUs.

b. Neonatal Medical Subspecialties and Transport Requirements;

Table 1—Neonatal Medical Subspecialties and Transport Requirements

Text denoted with asterisks (*) indicates physician shall be available in person on-site as needed by the facility. Each higher level NICU unit shall meet the requirements of each lower level NICU unit.

Level I (Well Nursery)	Level II	Level III	Level IIIS	Level IV
Board Certified/Eligible Pediatric or Family Practice Physician	Board Certified/Eligible Pediatric or Family Practice Physician	Pediatric Cardiology[1]	Pediatric Surgery[4]	Pediatric Surgery[4]
	Board Certified Neonatologist	Ophthalmology[2]	Pediatric Anesthesiology[5] §9513(2)a—See Exception	Pediatric Anesthesiology[5]
	Social Worker		Neonatal Transport	Neonatal Transport
	Occupational Therapist	Social Worker Ratio 1:30	Ophthalmology[2*]	Ophthalmology[2*]
	Physical Therapist	OT or PT/neonatal expertise	Pediatric Cardiology*	Pediatric Cardiology*
	Respiratory Therapists	RD/training in perinatal nutrition	Pediatric Gastroenterology*	Pediatric Cardiothoracic Surgery*
	Registered dietician/nutritionist	RT/training in neonate ventilation	Pediatric Infectious Disease*	Pediatric Endocrinology*
	Laboratory Technicians	Neonatal feeding/swallowing-SLP/ST	Pediatric Nephrology*	Pediatric Gastroenterology*
	Radiology Technicians		Pediatric Neurology[3*]	Pediatric Genetics*

Table 1—Neonatal Medical Subspecialties and Transport Requirements				
Text denoted with asterisks (*) indicates physician shall be available in person on-site as needed by the facility. Each higher level NICU unit shall meet the requirements of each lower level NICU unit.				
Level I (Well Nursery)	**Level II**	**Level III**	**Level IIIS**	**Level IV**
			Pediatric Neurosurgery*	Pediatric Hematology-Oncology*
			Pediatric Orthopedic Surgery*	Pediatric Infectious Disease*
			Pediatric Otolaryngology[6*]	Pediatric Nephrology*
			Pediatric Pulmonology*	Pediatric Neurology[3*]
				Pediatric Neurosurgery
				Pediatric Orthopedic Surgery
				Pediatric Otolaryngology[7*]
				Pediatric Pulmonology*
				Pediatric Radiology*
				Pediatric Urologic Surgery*
			Transport note:	
[1]There shall be at least one board certified or board eligible pediatric cardiologist as a member of medical staff. For Level III facilities, staff using telemedicine shall be continuously available.			Transport shall be in accordance with national standards as published by the American Academy of Pediatrics' Section on neonatal and pediatric transport and in accordance with applicable Louisiana statutes.	
[2]There shall be at least one board certified or board eligible ophthalmologist with sufficient knowledge and experience in retinopathy or prematurity as a member of the medical staff. An organized program for monitoring retinotherapy of prematurity shall be readily available in Level III and for treatment and follow-up of these patients in Level IIIS and IV facilities.				
[3]There shall be at least one board certified or board eligible pediatric neurologist as a member of medical staff.				

Table 1—Neonatal Medical Subspecialties and Transport Requirements				
Text denoted with asterisks (*) indicates physician shall be available in person on-site as needed by the facility. Each higher level NICU unit shall meet the requirements of each lower level NICU unit.				
Level I (Well Nursery)	**Level II**	**Level III**	**Level IIIS**	**Level IV**
[4]For pediatric surgery, the expectation is that there is a board certified or eligible pediatric surgeon who is continuously available to operate at that facility.				
[5]There shall be at least one board certified or board eligible pediatric anesthesiologist as a member of the medical staff.				
[6]Board eligible or certified in Otolaryngology; special interest in Pediatric Otolaryngology or completion of Pediatric Otolaryngology Fellowship.				
[7]Board eligible or certified in Otolaryngology; completion of Pediatric Otolaryngology Fellowship.				
For specialties listed above staff shall be board eligible or board certified in their respective fields with the exception of otolaryngology as this field has not yet pursued certification.				

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2573 (October 2022), amended by the Department of Health, Health Standards Section, LR 50:1493 (October 2024).

§9523. Additional Support Requirements [Formerly LAC 48:I.9515]

A. A bioethics committee shall be available for consultation with care providers at all times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:2576 (October 2022).

Subchapter T. Pediatric Services (Optional)

§9525. General Provisions

A. Pediatric services shall be under the medical direction of a qualified physician who is a member of the medical staff with pediatric privileges and appointed by the governing body. Hospitals admitting children shall have proper facilities for their care apart from adult patients and the newborn, in accordance with hospital policies and procedures. Pediatric and adolescent patients, to the extent their condition permits, shall be grouped together in distinct units or district areas of general units separate from adults. Pediatric patients shall not be placed in rooms with adult patients.

B. The hospital shall ensure that there are policies and procedures in place and implemented in accordance with acceptable, nationally recognized standards of practice and/or guidelines, to promote the safety and security of pediatric patients. Subchapter J of these requirements. In hospitals with a separate designated pediatric unit subsequent to March 1, 1995, the maximum number of beds permitted in each pediatric room shall be four and shall meet the same spatial standards as specified in Subchapter J of these requirements.

C. In hospitals with a separate designated pediatric unit in existence prior to March 1, 1995, the maximum number of beds permitted in each pediatric room shall be eight and shall meet the same spatial standards as specified in Subchapter J of these requirements. In hospitals with a separate designated pediatric unit subsequent to March 1, 1995, the maximum number of beds permitted in each pediatric room shall be four and shall meet the same spatial standards as specified in Subchapter J of these requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1493 (October 2024).

§9527. Personnel

A. Every registered nurse who works in the pediatric unit shall be trained in an emergency pediatric nursing course that includes training in pediatric trauma and pediatric advanced life support and that has been conducted pursuant to guidelines established by the Louisiana State Board of Nursing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003).

§9529. Pediatric Intensive Care Units

A. There are two levels of pediatric care units: Level I; and Level II. If pediatric intensive care services are provided, the hospital shall satisfy the Level II PICU requirements.

B. Levels I and II units shall have a PICU Committee established as a standing committee of the hospital. It shall be composed of at least physicians, nurses, respiratory therapists and other disciplines as appropriate to the specific hospital unit. The committee shall participate in the delineation of privileges for all personnel (both MD and non-MD) within the unit. Policies and procedures shall be established by the medical director and the registered nurse manager in collaboration with the committee and with approval of the medical staff and the governing body. These written policies and procedures shall include, but not be limited to, safety procedures infection control, visitation, admission and discharge criteria, patient monitoring and record keeping, equipment preventive maintenance and repair.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003).

§9531. Facilities

A. The Levels I and II shall be distinct, separate units within the hospital. There shall be clean and soiled utility rooms, isolation room capabilities, medication and a conference area available on the units.

B. Level I units shall be located in the Category 1 facility as defined by the American Academy of Pediatrics.

C. The Emergency Department (ED) shall have a separate covered entrance. Two or more areas within the ED shall have the capacity and equipment to resuscitate any pediatric patient with any medical, surgical or traumatic illness within facilities with Level I units. Hospitals with Level II units only need one such area. The emergency room shall be staffed 24 hours a day in facilities with either Level I or Level II units.

D. There shall be an operating suite with one room available within 30 minutes and a second room within 45 minutes, 24 hours a day. Hospitals with Level I units shall have the capability of providing cardiopulmonary bypass, pediatric bronchoscopy, and radiography.

E. Clinical Laboratories

1. Clinical laboratories shall have microspecimen capability and the capability to perform clotting studies with one-hour turn around. There shall also be the capability to perform:

a. complete blood cell count;

b. differential count;

c. platelet count;

d. urinalysis;

e. electrolytes;

f. blood urea nitrogen;

g. creatinine;

h. glucose calcium;

i. prothrombin time;

j. partial thromboplastin time; and

k. cerebrospinal fluid cell counts.

2. Preparation of gram stains and bacteriologic cultures shall be available 24 hours per day. Blood gas values shall be available within 15 minutes. Results of drug screening and levels of serum ammonia, serum, and urine osmolarity, phosphorus and magnesium shall be available within three hours for Level I units.

F. There shall be a blood bank able to provide all blood components 24 hours a day in both Levels I and II. Cross matching shall allow for transfusions within one hour unless some unusual antibody is encountered.

G. Hospitals with Level I units shall have radiology services capable of radiography, fluoroscopy, computerized tomography scanning, ultrasonography, and nuclear scanning angiography.

H. Diagnostic cardiac and neurologic studies shall be available to both Levels I and II unit facilities.

I. A catheterization laboratory or angiography suite shall either be in the same building with a Level I units or available at another campus location of the hospital where these services are provided.

1. Policies and procedures shall be developed and implemented related to the staffing, transportation of PICU Level I patients requiring cardiac catheterizations at another of the hospital's campuses.

J. Level I units shall have the capability to provide hemodialysis 24 hours a day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2431 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1494 (October 2024).

§9533. Patient Rooms

A. The head of each bed and/or crib shall be rapidly accessible for emergency airway management.

B. Electrical power, oxygen, medical compressed air and vacuum outlets shall be available at each bed/crib.

C. There shall be walls or curtains available at each bedside to provide for full visual privacy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003).

§9535. Medical Staff

A. The medical director in Level I units shall be:

1. board certified in pediatrics and board certified or in the process of board certification in pediatric critical care medicine (certification shall be completed within five years);

2. board certified in anesthesiology with practice limited to infants and children with special qualifications (as defined by the American Board of Anesthesiology) in critical care medicine; or

3. board certified in pediatric care medicine (as defined by the American Board of Surgery). A Level II medical director shall meet the same criteria of Level I except the board certification in Pediatric Critical Medicine is not required. The medical director shall name a qualified alternate to serve in his or her absence.

B. In existing units, consideration will be given to waiving this requirement for board certified pediatricians with a minimum of five years experience in pediatric care who are currently serving as medical directors of Levels I and II units. The request for waiver shall be made in writing to the Office of the Secretary.

C. Levels I and II units shall have at least one physician of at least the postgraduate year two assigned to the PICU in-house 24 hours per day.

D. Other physicians including the attending physician or designee shall be available within 30 minutes.

E. Level I units shall have on staff a pediatric anesthesiologist, surgeon, cardiothoracic surgeon, neurosurgeon, intensivist, cardiologist, neurologist, pulmonologist, hematologist/oncologist, endocrinologist, gastroenterologist, allergist or immunologist, as well as a radiologist, pathologist, and psychiatrist or psychologist. Level II units shall meet the above medical staffing requirements, except the cardiothoracic surgeon and the pediatric subspecialties. There shall be a five-year phase in period with regard to staffing requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1494 (October 2024).

§9537. Staffing

A. Levels I and II shall have a unit manager dedicated to the unit who is a registered nurse with specific training and experience in pediatric critical care. The Level I manager shall be certified in critical-care nursing. The registered nurse manager shall name a qualified alternate to act in his/her absence.

1. The staff to patient ratio shall vary with the acuity of the patients; however, the minimum shall be 1:3.

2. There shall be an organized written orientation program as well as an ongoing in-service/continuing education program.

B. For the Level I units the respiratory therapy staff assigned to a unit shall be in-house 24 hours per day.

1. Biomedical technicians shall be available within one hour, 24 hours a day.

2. The unit clerk shall be readily available to the unit 24 hours a day.

3. A pharmacist and licensed radiographer shall be in-house 24 hours per day.

4. Social workers, physical therapists and nutritionists shall be assigned to the unit as applicable.

C. For Level II Units the respiratory therapist shall be in-house 24 hours a day.

1. The biomedical technician shall be available within one hour, 24 hours a day.

2. The pharmacist and radiologist shall be on call 24 hours a day.

3. Unit clerks, social workers, physical therapists and nutritionists shall be available as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003).

§9539. Supplies and Equipment

A. There shall be lifesaving, therapeutic and monitoring equipment present in Level I and II units. There shall be a complete "code" or "crash" cart available on both Level I and II units. The cart contents available on Level I and II units should include, but not be limited to, approved medications, a defibrillator/cardioverter, automated blood pressure apparatus devices. All equipment shall be of proper size for infants and children. Oxygen tanks are needed for transport and backup for both Levels I and II units.

B. There shall be additional equipment available to meet the needs of the patient population.

C. Level I units shall have the capability of ventilator support.

D. There shall be bedside monitoring in Level I and II PICUs with the capability for continuously monitoring heart rate and rhythm, respiratory rate, temperature, and one hemodynamic pressure. Level I units shall also have the ability to monitor systemic arterial, central venous, pulmonary arterial, and intracranial pressures. The monitors shall have alarms with both high and low settings, and they shall also have both audible and visible capability. There shall be a maintenance and calibration schedule maintained for all monitoring devices.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2432 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1494 (October 2024).

§9541. Miscellaneous

A. PICUs shall be integrated with the regional EMS system as available. Rapid access to a poison control center is essential. Each PICU shall have or be affiliated with a transport system and team to assist other hospitals in arranging safe patient transport.

B. Each Level I PICU shall offer pediatric critical care education for EMS providers, emergency department, and transport personnel as well as for the general public. The staff nurses and respiratory therapists shall also have basic life support certification.

C. Level I PICUs offering a fellowship program in pediatric critical care shall possess sufficient patient volume, teaching expertise, and research capability to support such a fellowship. Programs providing sub-specialty training in critical care shall possess approval by the residency review committee of the Accreditation Council on Graduate Medical Education.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2433 (November 2003), amended by the Department of Health, Health Standards Section, LR 50:1494 (October 2024).

Subchapter U. Alternative Birthing Units

§9551. General Provisions

A. An alternative birthing unit (ABU) is a unit that is housed within a licensed hospital that provides both obstetrical and neonatal intensive care unit (NICU) level one status at that location. The ABU shall be its own designated unit, separate and apart from any other unit within the hospital.

B. An ABU shall be in compliance with the:

1. American Midwifery Certification Board;

2. American Academy of Pediatrics; and

3. American College of Obstetrics and Gynecology guidelines.

C. An ABU shall be in compliance with all federal, state and local statutes, laws, rules, regulations and ordinances as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014).

§9553. Definitions

Active Labor—contractions resulting in progressive effacement and dilation of the cervix.

Alternative Birthing Unit (ABU)—a unit located within a hospital in which delivery is expected following a low risk, normal, and uncomplicated pregnancy. Care and services provided prior to, during, and following childbirth are under the direction of a certified nurse midwife.

Antepartum Care (Prenatal Care)—occurring or existing before birth. The prenatal period (also known as antenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. Prenatal care is a type of preventative care with the goal of providing regular check-ups that allow doctors or certified nurse midwives to treat and prevent potential health problems throughout the course of the pregnancy.

Certified Nurse Midwife (CNM)—an advanced practice registered nurse as defined in R.S. 37:913, or current law.

Complications—any condition as defined by the medical staff/governing body that contraindicates continued care in the alternative birthing center.

Doula—a nonmedical person, certified by Doula of North America (DONA) who assists a woman before, during or after childbirth, as well as her partner and/or family, by providing information, physical assistance and emotional support.

Family—individuals selected by the pregnant woman to be present and/or in attendance during her admission to the ABU.

Intrapartum—the period beginning with active labor to the expulsion of the placenta.

Licensed Practitioner—for purposes of this Rule refers to a licensed physician and/or a certified nurse midwife.

Low Risk Pregnancy—a normal uncomplicated term pregnancy as determined by a generally accepted course of prenatal care. The expectation of a normal uncomplicated birth as shall be defined by the medical staff/governing body.

Medical Director—a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners (LSBME), who is board certified as an obstetrician and gynecologist (OB/GYN) and credentialed and privileged for the hospital's obstetrical/gynecological services.

Postmature—gestational age of greater than 42 weeks.

Postpartum—the period beginning immediately after childbirth.

Preterm—prior to the thirty-seventh week of gestation.

Term—gestational age of greater or equal to 37 weeks.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR

40:1099 (June 2014), amended by the Department of Health, Health Standards Section, LR 50:1494 (October 2024).

§9555. Program Requirements

A. An ABU shall have policies/procedures and written criteria for the evaluation of risk status, admission, transfer, discharge, and complications requiring medical or surgical intervention. The policies/procedures and written criteria shall be developed, implemented, enforced, monitored, and reviewed annually by the clinical staff and approved by the governing body.

1. In order for a pregnant woman to be admitted to an ABU, the following admission requirements shall be met.

a. The pregnancy shall be deemed low-risk by the licensed practitioner with the expectation of a singleton, vertex, and spontaneous vaginal birth at term without complication.

b. The pregnant woman shall have had consistent prenatal care which began no later than 28 weeks gestation with consistent prenatal screening.

c. A maternal/fetal assessment performed by the CNM shall be completed and documented within one hour of admission to the ABU.

2. The facility shall have policies and procedures readily available in the event the condition of the mother and/or newborn require transfer to an acute care unit within the hospital or emergent transfer to another hospital.

3. The facility shall have policies and procedures for discharge planning of the mother and newborn.

B. A patient who meets any of the following criteria/conditions shall not be admitted for delivery in an ABU:

1. females below 18 years of age;

2. a patient with any of the below documented condition(s) in the maternal medical history, based on an assessment by a licensed practitioner:

a. cardiovascular disease;

b. pulmonary disease and/or history of pulmonary embolus;

c. renal disease;

d. insulin-dependent diabetes;

e. bleeding disorder or hemolytic disease;

f. fetal malpresentation;

g. placenta previa;

h. preeclampsia;

i. oligohydramnios;

j. polyhydramnios;

k. ruptured membranes greater than 18 hours prior to onset of labor;

l. previous Rh sensitization;

m. vaginal birth following C-section (VBAC);

n. multiple births;

o. preterm labor;

p. post-maturity; or

q. fetal abnormality; or

3. a patient with a high risk pregnancy as determined by a licensed practitioner.

C. The following services shall be prohibited in the ABU:

1. general, intravenous, and/or conductive analgesia/anesthesia to include spinal and epidural analgesia/anesthesia;

2. conscious sedation;

3. caesarean sections and operative obstetrics to include tubal ligations;

4. stimulation or augmentation with chemical agents, e.g., oxytocin during the first and second stages of labor; and

5. vacuum extractors and/or forceps.

D. Prenatal Screening Requirements

1. Pregnant women shall be screened by either/or an OB/GYN, a certified nurse midwife (CNM), or an advanced practice registered nurse (APRN). Documentation of the screening shall include, but not be limited to:

a. social, family, medical, reproductive, nutritional, drug and alcohol use;

b. violence screen, depression screen and mental health history;

c. physical examination to include Papanicolaou smear and assessment for sexually transmitted diseases as determined by a licensed practitioner;

d. a prenatal laboratory profile to include a:

i. complete blood count, blood type and Rh antibody screen;

ii. glucose tolerance test;

iii. urinalysis; and

iv. other diagnostic testing as medically indicated; and

e. a repeat evaluation of the hemoglobin or hematocrit between 28 and 36 weeks gestation.

E. Newborn Requirements. The ABU shall be in compliance with current state laws, rules and regulations for screening of newborn health conditions.

F. Patient and/or Patient's Family Educational Requirements. The following educational programs are required to be completed by the patient and/or patient's family as determined by the policy and procedures of the ABU prior to discharge:

1. anticipated physiological and psychological changes during pregnancy;

2. fetal development;

3. normal nutrition;

4. warning signs of pregnancy complications;

5. self-care to include:

a. information on the dangers of smoking, alcohol and substance abuse; and

b. the need for dental care;

6. stages of labor;

7. non-pharmacologic techniques to promote comfort and relaxation during labor;

8. delivery process;

9. newborn care;

10. normal postpartum;

11. bonding;

12. breast-feeding;

13. importance of immunization;

14. criteria for discharge from the center;

15. child safety to include the use of car seats and safe sleeping practices;

16. directions for obtaining laboratory tests for newborns as required by the Department of Health and Hospitals;

17. instruction as to the clothing/supplies needed at the time of discharge from the center; and

18. a family instructional program.

G. In order for the family to participate in the birth process in the ABU, the following requirements shall be met.

1. The number of individuals/family members present at the time of birth shall be determined by the ABU's policy which takes into account room size and the need for infection control.

2. Individuals/family members shall abide by the facility's infection control policies.

3. An adult not involved in the birthing process shall be in charge of all minor children.

4. Only service animals shall be allowed in the ABU.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1099 (June 2014), amended by the Department of Health, Health Standards Section, LR 50:1495 (October 2024).

§9557. Policies and Procedures

A. An ABU shall develop, implement, enforce, monitor, and review annually the policies and procedures specific to the care and services of the mother and newborn. The policies and procedures shall be jointly developed by the medical director and professional staff and adopted by the governing body. These policies and procedures shall include, but are not limited to:

1. staffing;

2. admission criteria;

3. educational services;

4. consent for medical treatment and care;

5. initial and continuing risk assessment by the CNM;

6. criteria for consultation with collaborative physicians;

7. water birth;

8. external fetal monitoring (EFM);

9. nursing assessments;

10. medication administration;

11. laboratory and diagnostic services;

12. dietary services;

13. obstetric and pediatric consultation services;

14. newborn care, including:

a. pulse oximetry heart disease screening; and

b. circumcision of a male newborn by a licensed OB/GYN or other qualified physician as determined by the governing body;

15. emergency procedures for the mother and/or newborn, including:

a. maternal emergent care policy;

b. newborn emergent care policy;

c. maternal transfer to an acute care unit within the hospital or transfer to another hospital;

d. newborn transfer to an acute care unit within the hospital or transfer to another hospital;

e. precipitous delivery; and

f. newborn abduction;

16. family support and participation, including:

a. criteria for labor and delivery attendance; and

b. doula;

17. unique identification for mother and newborn;

18. delivery log;

19. mother/baby couplet aftercare, including:

a. lactation support services;

b. social services; and

c. home health care services, if applicable;

20. maternal and newborn discharge, including:

a. length of stay; and

b. child passenger restraint system;

21. follow-up postpartum and newborn care; and

22. hospital staff on call policy and procedure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1101 (June 2014).

§9559. Physical Environment

A. An ABU shall submit, meet, and obtain approval for facility plan review from the OSFM prior to construction in accordance with Section 9305.N of this Rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1101 (June 2014), amended by the Department of Health, Health Standards Section, LR 50:1495 (October 2024).

§9561. Equipment

A. The governing body and medical staff shall specify the types of equipment that is required for an ABU. This shall include at a minimum:

1. emergency equipment including:

a. an adult emergent care cart labeled and stocked accordingly; and

b. a neonatal emergent care cart labeled and stocked accordingly;

2. equipment and supplies used for labor and delivery including:

a. fetal heart rate doppler, fetoscope, and/or external fetal monitor;

b. a birthing tub; and

c. a bed;

3. equipment and supplies used for the newborn including:

a. a newborn crib, bassinet or newborn examination unit; and

b. calibrated newborn scales;

4. oxygen and supplies;

5. pulse oximetry supplies;

6. suction and supplies for mother and newborn;

7. maternal and newborn airways;

8. a wall clock synchronized with hospital system;

9. supplies for unique identification of mother and newborn;

10. a secure medication dispensing system;

11. emergency call and lighting systems; and

12. ancillary support equipment as needed.

B. The facility shall have a newborn abduction emergency alert system.

C. All hand-washing facilities shall be equipped with hands-free handles, disposable soap dispenser, paper towel dispenser and trash receptacle.

D. Vertical and horizontal transport systems shall be operated and maintained in a manner to provide for safe transport.

E. The facility shall have functional emergency communication, including:

1. telephone;

2. nurse call; and

3. internal/external paging system.

F. An ABU shall have storage for hazardous cleaning solutions, compounds, and substances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9563. Services

A. The ABU shall have patient care services policies that delineate the organization of the unit, qualifications of the staff and requirements for staff to patient ratio.

B. Unit Organization

1. Care in an ABU shall be under the direction of a CNM.

a. A CNM and a registered nurse shall be available per hospital on call policy to ensure 24-hour coverage for patient care.

b. Qualified professional clinical staff shall monitor the patient's progress in labor with ongoing assessments of maternal/fetal reactions to the process of labor, within accepted professional standards.

2. Authority and responsibilities of all patient care staff shall be clearly defined in written policies.

3. The functions of the ABU shall be under the direction of perinatal services. These functions shall include, but are not limited to:

a. the development, implementation, enforcement, monitoring, and annual review of policies and procedures related to patient care;

b. the orientation and training of qualified staff for provision of care; and

c. provisions for current educational and reference materials.

C. Staff Qualifications

1. The CNM shall provide documentation of current licensure and certification, as required by the Louisiana State Board of Nursing (LSBN). The documentation shall be maintained as part of the credential file for each CNM.

2. Licensed nursing personnel shall practice in accordance with the Louisiana State Nurse Practice Act and demonstrate current licensure by LSBN.

3. All clinical staff of the ABU shall be required to provide documentation of training and continued competence in Adult Basic Cardiopulmonary Life Support (BCLS) and Neonatal Resuscitation Program (NRP) or its equivalent.

4. Documented, dated, and signed demonstration of skills competencies shall be maintained in the personnel file for each staff member.

D. Requirements for Staff to Patient Ratio

1. A CNM shall be present at all times while a laboring patient is in the ABU.

2. A registered nurse (RN) shall provide 1:1 maternal care during labor, delivery and post-delivery.

3. There shall be sufficient professional and support staff on duty and on call to meet the following patient's needs:

a. for services routinely provided;

b. to assure patient safety and satisfaction; and

c. to ensure that no patient in active labor is left unattended.

4. During the second stage of labor, 2:1 patient care is required, with one of the clinical staff being a CNM and one other RN.

5. Staffing per shift shall be based on acuity and census of the ABU.

6. Each RN shall be responsible for 1:1 labor care and/or 1:2 couplet care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014), amended by the Department of Health, Health Standards Section, LR 50:1495 (October 2024).

§9565. Medical Records Requirements

A. The medical record of the mother and newborn shall include, but not be limited to, the following documentation:

1. informed consent signed by the patient and the CNM;

2. demographic and patient information;

3. family, medical, social, reproductive, nutrition and behavioral history;

4. initial maternal assessment and examination;

5. evaluation of maternal/fetal risk factors;

6. written orders for maternal/fetal and newborn care;

7. laboratory and/or diagnostic test results;

8. documentation of maternal/fetal and newborn monitoring;

9. postpartum assessments;

10. physical assessment of newborn, e.g., Apgar score, weights, measurements;

11. labor and discharge summaries; and

12. educational instructions for postpartum and newborn home care, follow ups, and referrals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1103 (June 2014).

§9567. Pharmaceutical Services

A. The ABU shall follow hospital policies and procedures for pharmaceutical services regarding the procurement, storage, distribution and control of all medications. The ABU shall be in compliance with all local, state, and federal regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1104 (June 2014).

Subchapter V. Newborn Safety Devices

§9573. General Provisions

A. In accordance with the Louisiana Children's Code (La. Ch. Code 1149 et seq.), a parent may leave an infant in a newborn safety device (NSD) that is physically located inside a facility which is licensed as a hospital in accordance with R.S. 40:2100 et seq., and has an emergency department that is staffed 24 hours per day.

B. Each NSD shall meet all of the following specifications:

1. voluntarily installed in the designated hospital;

2. installed in a location that ensures the anonymity of the relinquishing parent;

3. installed in a climate-controlled environment consistent with the internal temperature of the hospital;

4. installed by a licensed contractor in accordance with manufacturer's recommendations;

5. have an access door that locks automatically upon closure when an infant is in the device;

6. have a supporting frame that is anchored so as to align the bed portion of the NSD directly beneath the access door and prevent movement of the unit as a whole; and

7. feature a safe sleep environment which includes a firm, flat bassinet mattress and a sheet that fits snugly on and overlaps the mattress, and is free of pillows, bumpers, blankets and other bedding.

C. The hospital shall post appropriate signage approved by the Department of Children and Family Services at the site of the NSD that clearly identifies the NSD, and provides both written and pictorial instruction to the relinquishing parent to open the access door, place the infant inside the NSD and close the access door to engage the lock. The signage shall also clearly indicate all of the following:

1. the maximum age of the infant who may be relinquished in accordance with the Louisiana Children's Code;

2. that the infant must not have been previously subjected to abuse or neglect; and

3. that by placing an infant in the NSD, a parent is foregoing all parental responsibilities with response to the infant, and is giving consent for the state to take custody of the infant.

D. The hospital shall be responsible for:

1. the cost of the installation of the NSD;

2. installation of an adequate dual alarm system that shall be connected to the physical location of the NSD. The hospital shall ensure all of the following with respect to the alarm system:

a. the alarm system generates an audible alarm at a central location within the facility 60 seconds after the opening of the access door to the NSD;

b. the alarm system generates an automatic call to 911 if the alarm is activated and not turned off from within the hospital less than 60 seconds after the commencement of the initial alarm;

c. the alarm system is tested at least one time per week to ensure that it is in working order; and

d. the alarm system is visually checked at least two times per day to ensure that it is in working order.

3. obtaining Department of Health (LDH), Health Standards Section (HSS) approval prior to the use of the NSD; and

4. submission of written notification to the LDH, HSS of the hospital's intent to implement the use of the device.

E. Prior to use of the NSD, an onsite survey shall be conducted by the LDH, HSS.

F. The hospital shall ensure that the device is checked at least daily for debris and is cleaned and sanitized with a hospital-quality disinfectant at least weekly and after any infant relinquishment into the NSD.

G. The hospital shall maintain documentation of the testing of the alarm system and the cleaning and sanitation of the NSD.

H. The hospital shall install a cardholder adjacent to the NSD and shall keep the cardholder stocked with safe haven informational cards and other safe haven informational materials produced in accordance with La. Ch. Code 1160 and required by the Department of Children and Family Services.

I. The hospital shall develop and implement written policies and procedures that include, but are not limited to, receiving an infant who has been relinquished into the NSD, the use of an adequate NSD alarm system, testing of theNSD alarm system, cleaning of the NSD, documentation, and training of staff responsible for implementing the policies and procedures of the NSD, in accordance with La. Ch. Code 1149 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 48:498 (March 2022).

Subchapter W. Mobile Unit—Offsite Rural Health Clinic Services

§9575. General Provisions

A. All hospital providers with an offsite rural health clinic offering services via a mobile unit, shall notify the HSS prior to providing services via a mobile unit.

B. The mobile unit operated by the offsite rural health clinic shall be maintained in safe working order and in compliance with applicable state and federal regulations and laws, including but not limited to, those regulations and law relative to the safe and effective operation of motor vehicles.

C. Hospitals with an offsite rural health clinic that provides mobile services shall:

1. develop policies and procedures that address the health, safety, or welfare of the patients utilizing mobile units;

2. provide the vehicle identification number, license plate number, proof of insurance, vehicle registration, and copy of the inspection sticker for the mobile unit upon request;

3. develop a written schedule of locations the mobile units will be stationed and maintain site verifications for each of these locations;

4. provide secure storage for medications on the mobile unit;

5. store emergency equipment and emergency medications on the mobile unit;

6. provide a hand washing sink in the mobile unit; and

7. be handicap accessible.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1495 (October 2024).

Subchapter X. Burn Centers (Optional)

§9583. General Provisions

A. If the hospital provides burn center services, the services shall be well organized and provided in accordance with acceptable, nationally recognized standards of practice and/or guidelines from the American Burn Association.

B. The burn center shall ensure that there are policies and procedures in place, and that the policies and procedures are implemented in accordance with acceptable, nationally recognized standards of practice and/or guidelines, to promote the safety and security of the burn center patients.

C. The burn center shall have an internal registry for all inpatients and shall participate in an externally based registry. A member of the burn center or hospital staff shall be assigned to maintain data and develop statistics regarding the causes of injuries sustained by burn center inpatients.

D. Each burn center system shall participate in a public burn awareness program covering the prevention and immediate treatment of burn injuries.

E. There shall be a direct communication link between the prehospital system and the burn center. The contact point shall be either in the burn center or in the emergency department.

F. The burn center shall cooperate with the Louisiana Emergency Response Network (LERN), and the appropriate audit committees of the regional or state Emergency Medical Services (EMS) system, where they exist, by providing patient care data for system management, quality assessment, and operations research. Patient care data shall be provided, both routinely and in response to special requests, and by participating in local audits of the EMS system.

G. Hospitals without qualified personnel or equipment for the care of pediatric burn patients, shall transfer pediatric burn patients to a facility that has a pediatric intensive care unit or a pediatric unit with access to burn services.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1495 (October 2024).

§9585. Organization and Staffing

A. The organization of services shall be appropriate to the scope of burn center services offered. The burn center shall employ and define the leadership structure in accordance with the facility's administration. All staff shall be licensed and credentialed as required by their respective discipline.

B. Medical Director

1. The medical director of the burn center shall:

a. be designated by the institution, with the appropriate authority and responsibility, to direct and coordinate all medical services to patients admitted to the burn center;

b. be a currently licensed, board-certified general surgeon or plastic surgeon on the active medical staff of the institution responsible for the management of burn patients in a burn center, with at least two years' experience during the previous five years, or have completed a burn fellowship;

c. be responsible for regular communications with physicians and other authorities regarding referred patients, and for appropriate burn center management functions, including:

i. quality assurance;

ii. liaison with adjacent burn centers;

iii. internal and external education programs; and

iv. coordination with regional or state EMS programs, where they exist, and the Louisiana Emergency Response Network; and

d. direct the burn care of at least 50 inpatient or outpatient acutely burned patients annually over a three-year period. For facilities that treat acutely burned pediatric patients, the burn center director shall have directed the burn care of at least 25 inpatient or outpatient pediatric cases annually over a three-year period.

2. Medical care to burn center patients shall be provided by the burn center medical director, or other appropriately licensed, board-certified or board eligible physicians operating with the medical director's approval, and utilizing standard burn center patient care protocols.

3. The medical director shall designate one or more appropriately licensed, board-certified or board eligible physician(s) with at least six months experience in the management of the patient with burns, to be accessible for administrative and clinical decisions when the medical director is not available.

C. Nurse Manager

1. The nurse manager shall be a Registered Nurse (RN) who is currently licensed to practice in the state of Louisiana and has at least three years of experience as a RN. Two of these years shall consist of full-time experience in providing direct patient care in an intensive care setting, and one of these years shall consist of full-time experience in providing direct patient care in a burn center.

D. Registered Dietician

1. A registered dietitian, currently licensed to practice in Louisiana, with critical care and burn care experience, shall be available for consultation to burn center medical staff, nursing staff, and patients, as needed.

E. Registered Pharmacist

1. A clinical registered pharmacist, currently licensed to practice in Louisiana, shall be available for consultation to burn center medical staff, nursing staff, and patients, as needed.

2. The registered pharmacist licensed to practice in Louisiana, shall have critical care and burn care experience.

F. Respiratory Therapy

1. Respiratory therapists, currently licensed to practice in Louisiana, shall be available to participate in the assessment and treatment of all burn center patients, as needed.

G. Staff Specialists

1. Board certified and credentialed staff, currently licensed to practice in Louisiana in the following surgical specialties, shall be available as needed:

a. general;

b. cardiothoracic;

c. neurologic;

d. obstetric/gynecologic;

e. ophthalmologic;

f. oral;

g. orthopedic;

h. otorhinolaryngologic;

i. pediatric, where applicable;

j. plastics; and

k. urologic.

2. Board certified and credentialed staff, currently licensed to practice in Louisiana in the following nonsurgical specialties, shall be available as needed:

a. anesthesiology;

b. cardiology;

c. gastroenterology;

d. hematology;

e. infectious disease;

f. internal medicine;

g. nephrology;

h. neurology;

i. pathology;

j. pediatrics, where applicable;

k. physiatry;

l. psychiatry;

m. pulmonary; and

o. radiology.

3. A board certified surgeon, currently licensed to practice in Louisiana, shall be involved, as needed, in the management of patients with burns for a minimum of 150 annual inpatient admissions to the burn center.

4. Staff specialists shall be available, as needed, for consultation in the specialties listed above. The initial response may be provided by resident physician(s), designated nurse practitioner(s), or physician assistant(s) who are capable of assessing emergency situations in their respective specialties, with appropriate supervision, and who can provide any immediately indicated treatment.

5. The availability and accessibility of consultation by current licensed to practice in Louisiana, board certified physicians and surgeons in all specialties relevant to the care of the patient with burns shall be documented.

H. Other Staff

1. The following staff shall be available to the burn service, as needed:

a. clinical psychologist(s)and/or psychiatrist(s);

b. member(s) of clergy;

c. social worker;

d. case manager(s); and/or

e. child life specialist, where applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1495 (October 2024).

§9587. Ancillary Services

A. In addition to all other required hospital ancillary services provided in Sections 9361, 9371, and 9327 of these rules, the following additional ancillary services shall be required for burn centers:

1. Dialysis

a. There shall be provisions for renal dialysis 24-hours per day when required, or a written transfer agreement with an available and accessible dialysis facility in another hospital.

2. Operating Services

a. An operating room shall be readily accessible to the burn center 24-hours per day.

b. Equipment and supplies required in burn operating room(s) shall be determined by the burn center medical director.

c. Burn operating rooms shall be able to reach sufficient temperatures or have procedures to maintain patient normothermia.

B. Rehabilitation Program

1. The burn center shall provide the following:

a. recreational and educational services, as defined by institutional policy, during hospitalization for those patients able to utilize them;

b. evaluation of needs and support capabilities of patient’s family or other significant persons, and cooperative

planning with family or other significant persons for patient discharge;

c. documentation of need for and availability and accessibility of community resources to assist in meeting the patient's physical, psychosocial, educational, and vocational needs following discharge. The social worker assigned to the burn center shall coordinate these activities. A clinical psychologist or psychiatrist shall be available for consultation, as needed; and

d. plans for readmission for treatment of post medical/surgical complications, or rehabilitation and reconstruction.

C. Tissue Bank

1. The hospital's burn center policies and procedures regarding the use of allograft tissues shall be in compliance with all federal and state requirements, and when feasible and appropriate, with acceptable, nationally recognized standards of practice and/or guidelines of the American Association of Tissue Banks (or equivalent).

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1496 (October 2024).

§9589. Patient Rooms and Support Space

A. The burn center shall contain beds that shall be used predominantly for the care of patients with burn injuries, or those suffering from other injuries or skin disorders whose treatment requirements are similar to those of patients with burns. The maximum number of patient beds per room shall be one.

B. ICU patient rooms shall be designed as intensive care acuity adaptable with direct access to toilet/bathing room. Each room shall be equipped with heating equipment or have processes in place to maintain patient normothermia as required by building and construction guidelines.

C. All patient rooms shall be designed as protective environment rooms with consideration to provide airborne isolation infection/protective rooms in centers with suspected or confirmed airborne infections.

D. Where a hydrotherapy room is provided, it shall be readily accessible to the burn center patient.

E. A conference room/meeting room, a family room, and an adequate exercise area shall be available.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section LR 50:1497 (October 2024).

§9591. Education Program

A. Medical, nursing, and ancillary staff of the burn center shall participate in burn-specific educational programs or activities developed especially related to burn care, both at initial orientation and during planned, organized, and coordinated in-services.

B. Annual continuing education shall be required for all medical, nursing, and ancillary staff employed in the burn center with burn care content equivalent to approximately four continuing education units.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1497 (October 2024).

§9593. Conferences

A. Multi-disciplinary conferences shall be held at least weekly to review and evaluate the status of each burn center inpatient with representation by each clinical discipline regularly involved in burn center care. The conference shall include a review of each patient's:

1. progress in recovery;

2. necessity for surgery; and

3. rehabilitation needs, both physical and psychosocial.

B. A documented quality/performance improvement conference shall be held at least monthly, with input from peers to improve patient care.

AUTHORITY NOTE: Promulgated in accordance with R.S.36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:1497 (October 2024).

Chapter 96. Hospitals—Crisis Receiving Centers

Subchapter A. General Provisions

§9601. Introduction

A. A hospital crisis receiving center is a specialty unit of a hospital that provides health care services to individuals who are experiencing a behavioral health crisis.

B. Crisis receiving centers shall receive, examine, triage, refer or treat individuals that present to the unit and are in need of assistance with a behavioral health crisis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:554 (April 2019).

§9603. Licensure Requirements

A. All crisis receiving center specialty units shall be licensed by the department and shall comply with the provisions of §9333 of these hospital licensing standards.

B. A crisis receiving center specialty unit (CRC-SU) shall have approval from the Office of Behavioral Health (OBH) and/or the appropriate human service district or authority before applying to become licensed as part of the hospital.

C. Prior to securing licensure and operating the CRC-SU, the hospital shall submit architectural plans of the CRC-

SU to the Office of the State Fire Marshal (OSFM) for licensing approval.

D. A CRC-SU shall not operate until it has been licensed by the Health Standards Section (HSS) as a specialty unit of the hospital. No retroactive licenses shall be granted.

E. A CRC-SU shall be located in a designated area of the hospital or offsite campus of the hospital. The CRC-SU shall not relocate to another location, even within the hospital, without prior written approval from HSS.

F. If the CRC-SU is located at the main campus of the hospital, the hospital shall have a dedicated emergency department which shall comply with all Emergency Medical Treatment and Active Labor Act (EMTALA) regulations.

G. If the CRC-SU is located at an offsite campus or is at a free-standing psychiatric hospital which does not have a dedicated emergency department, the CRC-SU shall be considered a dedicated emergency department. The CRC-SU shall comply with all EMTALA regulations if the unit meets one of the following criteria:

1. the entity is licensed by the state as an emergency department of the hospital;

2. holds itself out to the public as providing emergency care; or

3. during the preceding calendar year, the entity provided at least one-third of its outpatient visits for the treatment of emergency medical conditions.

H. The following levels of a CRC-SU may be licensed as an optional service of the hospital:

1. Level I CRC-SU only; or

2. Level I CRC-SU and Level II CRC-SU.

I. A CRC-SU shall maintain compliance with the:

1. Office of Public Health (OPH) regulations; and

2. Office of State Fire Marshal regulations.

J. The CRC-SU shall develop and implement policies and procedures regarding the segregation of child and adolescent patients from adult patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

ISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:554 (April 2019).

§9605. Licensing Process

A. The hospital shall submit the following items to the department in order to add a CRC-SU to its existing license:

1. a licensing application on the department's designated form;

2. the required licensing fee, if applicable;

3. a copy of the prerequisite approval from OBH and/or the appropriate human service district or authority; and

4. other documentation as required by the department, including a current Office of Public Health (OPH)/Sanitation approval and Office of State Fire Marshal approval for occupancy and licensing plan review.

B. Following receipt of the completed licensing application, the department shall conduct an on-site survey and inspection to determine compliance with the licensing laws, regulations, and standards.

1. For a Level I CRC-SU, the department may, in its sole discretion, allow a verified attestation by the licensed hospital to substitute for an on-site survey and inspection.

C. If the on-site inspection determines that the hospital is compliant with the requirements and licensing standards for a CRC-SU, the department shall issue the hospital a sub-license/certificate indicating that the CRC-SU is licensed as a specialty unit of the hospital.

1. The sub-license/certificate shall designate the level of the CRC-SU and the licensed capacity of the CRC-SU.

2. The sub-license/certificate shall be posted in a conspicuous place in the designated CRC-SU.

D. A hospital shall not operate a CRC-SU at a level higher than what has been licensed and designated by the department on the sub-license/certificate.

E. The expiration date of the sub-license/certificate shall coincide with the expiration date of the hospital license. The CRC-SU sub-license/certificate shall be renewed at the time the hospital's license is renewed. The licensing agency may perform an on-site survey and inspection for an annual renewal.

F. The sub-license/certificate shall be valid only for the designated geographic location and shall be issued only for the person/premises named in the application. The geographic location of the CRC-SU shall not be moved, changed, or relocated without notification to HSS, approval by HSS, and the re-issuance of the sub-license/certificate.

G. The department may conduct on-site surveys and inspections at the CRC-SU as necessary to ensure compliance with these licensing standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

§9607. Discharges, Referrals or Transfers

A. Patients who are discharged home from the CRC-SU shall be given verbal and written discharge instructions and any referral information, including information for appointments regarding follow-up care and treatment.

B. If it is deemed necessary that the patient be admitted for inpatient behavioral health services, the CRC-SU shall

provide an appropriate and immediate mechanism for transporting the individual to such inpatient facility. Copies of pertinent patient information shall be transferred to the treating facility.

C. The CRC-SU shall establish and implement a standard method of follow-up to ensure that the patient has been received and engaged in the referred service(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

§9609. Training Requirements

A. A CRC-SU shall ensure that all staff providing direct patient care has documentation of successful completion of crisis services and intervention training in accordance with this Chapter.

B. Crisis services and intervention training shall include, but is not limited to the following:

1. an organized training program that includes an initial 40 hours of training to be completed upon hire and a minimum of 12 hours of training to be completed annually thereafter. Required training includes, but is not limited to the following areas:

a. components of the crisis cycle;

b. recognizing the signs of anxiety and escalating behavior;

c. therapeutic communication;

d. high-risk behavior assessment techniques;

e. verbal de-escalation techniques;

f. positive behavior management and limit-setting;

g. nonviolent physical intervention techniques;

h. establishing a therapeutic rapport and professional boundaries;

i. levels of observation;

j. maintaining a safe and therapeutic milieu;

k. an overview of mental illness and substance abuse diagnoses and treatment;

l. safe application of physical and mechanical restraints;

m. physical assessment of the restrained individual;

n. statutes, regulations, standards and policies related to seclusion and restraint;

o. confidentiality and Health Insurance Portability and Accountability Act (HIPAA) regulations; and

p. an overview of behavioral health settings and levels of care.

C. All formal training shall be provided by a licensed mental health professional (LMHP) or other qualified licensed behavioral health personnel with extensive experience in the field in which they provide training. Nonviolent physical interventions shall be taught by a trainer with documented current certification by a nationally established crisis intervention program (e.g. Crisis Prevention and Intervention, Tactical Crisis Intervention, Crisis Intervention Training, etc.).

1. An LMHP is an individual who is currently licensed to practice independently 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:

a. medical psychologist;

b. licensed psychologist;

c. licensed clinical social worker (LCSW);

d. licensed professional counselor (LPC);

e. licensed marriage and family therapist (LMFT);

f. licensed addiction counselor (LAC);

g. advance practice registered nurse (APRN); or

h. licensed rehabilitation counselor (LRC).

D. In addition to the initial 40 hour crisis services and intervention training, nurses shall receive 24 hours of training focused on psychotropic medications, their side effects and adverse reactions as part of their initial training. At least four hours of nurses' annual training shall focus on psychopharmacology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

Subchapter B. Level I Crisis Receiving Centers

§9615. General Provisions

A. A Level I CRC-SU shall operate 24 hours per day, seven days per week.

B. The length of a patient stay for a Level I CRC-SU shall not exceed 24 hours, unless there is documented evidence of the CRC-SU's measures taken to transfer the patient to the appropriate level of needed care and the reasons the transfer of the patient exceeds 24 hours.

C. Services required of a Level I CRC-SU include, but are not limited to:

1. 24-hour telephone hotline;

2. triage and screening services;

3. assessment services, including medication management;

4. brief intervention and stabilization; and

5. linking and referral services.

D. The Level I CRC-SU shall develop and implement policies and procedures for instituting an increased level of supervision for patients at risk for suicide and other self-injurious behaviors.

E. The CRC-SU Level 1 shall comply with the provisions of the state Mental Health Law regarding the execution of emergency certificates pursuant to R.S. 28:53, or a successor law.

F. The CRC-SU shall maintain a policy manual that outlines the procedures to access CRC services and procedures for managing voluntary and involuntary commitments with specific focus on ensuring the patient's civil rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:555 (April 2019).

§9617. Level I Services

A. 24-Hour Telephone Hotline

1. A Level I CRC-SU shall either maintain a telephone hotline that operates 24 hours per day, seven days per week or enter into a formal cooperative agreement with an existing 24-hour hotline as specified in the region's crisis response systems plan.

2. The hotline shall be staffed at all times by trained crisis workers.

a. A trained crisis worker is one who is:

i. trained in the assessment and management of crisis phone calls;

ii. able to assess the priority of the call; and

iii. able to provide interventions that are appropriate to the level of acuity of the caller.

b. The trained crisis worker shall have resource data available whenever calls are answered in order to facilitate crisis intervention.

c. The trained crisis worker shall have the ability to provide active intervention (i.e. contacting emergency medical services, police, fire department, etc.) in life-threatening situations.

3. The CRC-SU shall have written procedures for handling crisis calls.

4. The telephone settings shall be set up so as to protect the confidentiality of callers.

5. The CRC-SU shall have well written procedures to expand the facility's capacity to handle multiple calls coming into the CRC-SU simultaneously.

B. Triage and Screening

1. The Level I CRC-SU shall conduct a triage/screening of each individual who applies for crisis assistance or is under an order for involuntary examination.

2. The triage/screening shall be available 24 hours per day and shall be conducted within 15 minutes of the individual presenting to the unit. The CRC-SU shall have procedures to prioritize imminently dangerous patients and to differentiate between medical emergencies and behavioral health emergencies.

3. Until a patient receives triage/screening, he or she shall wait in a location with restricted access and egress with constant staff observation and monitoring.

4. The triage/screening shall include:

a. an evaluation of the existence of a medical emergency;

b. an evaluation of imminent threat of harm to self or others;

c. an evaluation for the presence or absence of cognitive signs suggesting delirium or dementia;

d. an evaluation of the need for an immediate full assessment;

e. an evaluation of the need for an emergency intervention; and

f. a medical screening including at a minimum, vital signs and a medical history, as soon as the patient's condition permits.

5. The triage/screening shall be conducted by licensed professionals in the medical or behavioral health fields that have the training and experience to triage/screen individuals for both behavioral and medical emergent needs in accordance with the scope of practice of their licensed discipline.

6. When emergency medical services are not available onsite at the Level I CRC-SU, the staff shall be prepared to render first-responder healthcare (basic cardiac life support, first aid, etc.) at all times. A CRC-SU shall also ensure that access to emergency transportation services to the nearest emergency department is available.

7. A Level I CRC-SU shall have procedures in place to ensure that based on the triage/screening, patients are prioritized for further assessment and services according to their risk level, or they are referred to other resources for care.

C. Assessments

1. After the triage/screening is completed, patients who have not been referred to other resources shall receive a full assessment.

2. Assessments shall be conducted based on the priority level determined by the triage/screening. Every patient under the age of 18 shall be assessed by staff with appropriate training and experience in the assessment and treatment of children and adolescents in a crisis setting.

3. The assessment shall be initiated within two hours of the triage/screening evaluation and shall include:

a. a full psychiatric assessment;

b. a physical health assessment; and

c. an assessment for possible abuse and/or neglect.

4. A full psychiatric assessment shall include:

a. patient interviews by board certified/eligible licensed psychiatrist(s) or psychiatric nurse practitioner(s) trained in emergency psychiatric assessment and treatment;

b. a review of the medical and psychiatric records of current and past diagnoses, treatments, medications and dose response, side-effects and compliance, if available;

c. contact with current behavioral health providers whenever possible;

d. a psychiatric diagnostic assessment;

e. identification of social, environmental, and cultural factors that may be contributing to the crisis;

f. an assessment of the patient's ability and willingness to cooperate with treatment;

g. a general medical history that addresses conditions that may affect the patient's current state (including a review of symptoms) and is focused on conditions that may present with psychiatric symptoms or that may cause cognitive impairment, e.g., a history of recent physical trauma; and

h. a detailed assessment of substance use, abuse/ and misuse; and

i. an assessment for possible abuse and neglect; such assessment shall be conducted by an LMHP trained in how to conduct an assessment to determine abuse and neglect. The CRC-SU shall ensure that every patient is assessed for sexual, physical, emotional, and verbal abuse and/or neglect.

5. All individuals shall be seen by a licensed psychiatrist or a licensed APRN within eight hours of the triage/screening. The board certified/eligible psychiatrist or APRN shall formulate a preliminary psychiatric diagnosis based on review of the assessment data collected.

a. The APRN must be a nurse practitioner specialist in adult psychiatric and mental health, family psychiatric and mental health, or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, or child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice.

6. A physical health assessment shall be conducted by a licensed physician, licensed advanced nurse practitioner, or a licensed physician's assistant and shall include the following:

a. vital signs;

b. a cognitive exam that screens for significant cognitive or neuropsychiatric impairment;

c. a neurological screening exam that is adequate to rule out significant acute pathology;

d. medical history and review of symptoms;

e. pregnancy test in all women of child-bearing age, as applicable;

f. urine toxicology evaluation;

g. blood levels of psychiatric medications that have established therapeutic or toxic ranges; and

h. other testing or exams as appropriate and indicated.

D. Brief Intervention and Stabilization

1. If an assessment reveals that immediate stabilization services are required, the Level I CRC-SU shall provide behavioral health interventions and stabilization which may include the use of psychotropic medications.

2. Following behavioral health interventions and stabilization measures, the Level I CRC-SU shall assess the patient to determine if referral to community based behavioral health services is appropriate or a higher level of care is required.

E. Linking/Referral Services

1. If an assessment reveals a need for emergency or continuing care for a patient, the Level I CRC-SU shall make arrangements to place the patient into the appropriate higher level of care. Patients in a Level I CRC-SU shall be transitioned out of the Level I CRC-SU within 24 hours unless there is documented evidence of the CRC-SU's measures taken to transfer the patient to the higher level of needed care and the reasons the transfer of the patient exceeds 24 hours.

2. If the assessment reveals no need for a higher level of care, the Level I CRC-SU shall provide:

a. referrals, and make appointments where possible, to appropriate community-based behavioral health services for individuals with developmental disabilities, addiction disorders, and mental health issues; and

b. brief behavioral health interventions to stabilize the crises until referrals to appropriate community-based behavioral health services are established or contact is made with the individual's existing provider and a referral is made back to the existing provider in the form of a follow-up appointment or other contact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:515 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:556 (April 2019).

§9619. Staffing Requirements

A. A Level I CRC-SU shall be under the direction of a qualified member of the medical staff of the hospital.

B. A Level I CRC-SU shall have the following staff on duty at all times:

1. a registered nurse in charge of the unit who meets the following criteria:

a. currently licensed in Louisiana and in good standing;

b. has one year of experience in the field of behavioral health; and

c. has documented crisis services and intervention training in accordance with the provisions of this Chapter; and

2. at least one additional worker with documented crisis services and intervention training.

C. A Level I CRC-SU shall have the following staff on call at all times and available to be onsite at the CRC-SU within one hour and who meets the following criteria:

1. is a licensed mental health professional (LMHP) who has one year of documented crisis services and intervention experience; or

2. a licensed practical nurse (LPN) or RN who meets the following criteria:

a. currently licensed in Louisiana and in good standing;

b. has one year of experience in the field of behavioral health; and

c. has documented crisis services and intervention training in accordance with this Chapter.

D. A psychiatrist shall be on call at all times to fulfill these licensing requirements and to meet the needs of the patient(s).

E. A Level I CRC-SU shall have sufficient numbers and types of qualified staff on duty and available at all times to provide necessary care and safety, based on the acuity of the patients, the mix of the patients present in the Level I CRC-SU, and the need for extraordinary levels of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:516 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:556 (April 2019).

§9621. Physical Environment

A. A Level I CRC-SU shall be located in an exterior area of the hospital which is easily accessible to patients seeking CRC-SU services. Patients shall not be required to go through other areas of the hospital to get to a Level I CRC-SU. The CRC-SU may share an entrance with an emergency department.

1. A Level I CRC-SU may also be located in a licensed offsite location of the hospital.

B. The CRC-SU shall give special design considerations to prevent injury and suicide in all patient care areas.

C. The layout, design details, equipment, and furnishings shall be such that patients shall be under continuous visual observation at all times and shall not be afforded opportunities for hiding, escape or injury to themselves or others.

D. Interior finishes, lighting, and furnishings shall conform to applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

E. Grab bars, if provided, shall meet the following specifications:

1. of an institutional type;

2. shall not rotate within their fittings;

3. shall be securely fastened with tamper-proof screw heads;

4. shall be free of any sharp or abrasive elements; and

5. if mounted adjacent to a wall, the space between the wall and the grab bar shall be filled completely to prevent a cord or string being tied around the grab bar and used for hanging.

F. Towel racks, closet and shower curtain rods are not permitted.

G. Plastic bags and trash can liners shall not be used in patient care areas.

H. Electrical receptacles shall be of the safety type or protected by 5 milli ampere ground-fault-interrupters.

I. A Level I CRC-SU shall have at least two rooms that afford privacy for the triage/screening and/or assessment of individuals presenting to the unit. Rooms for triage/screening, and/or assessment shall have:

1. a minimum area of 120 square feet and shall be located within the CRC-SU unit; and

2. doors to these rooms shall swing outward or be double hinged.

J. A Level I CRC-SU shall have at least one designated area for the holding and monitoring of patients who are in the process of being triaged/screened, assessed and awaiting referral.

K. A Level I CRC-SU shall have at least one seclusion room. The seclusion room shall be intended for the short-term occupancy by violent or suicidal patients and provide an area for patients requiring security and protection. The seclusion room shall:

1. enable direct staff supervision of the patient by direct visualization or through the use of electronic monitoring;

a. if electronic monitoring equipment is used, it shall be connected to the hospitals' emergency electrical source;

2. be designated for single occupancy and contain at least 80 square feet;

3. be constructed to prevent patient hiding, escape, injury or suicide;

4. contain a restraint bed;

5. have a minimum ceiling height of 9 feet;

6. have ceiling construction that is monolithic or tamper proof;

7. be located in close proximity to a toilet room;

8. not contain protruding edges or corners;

9. have doors that:

a. are 3 feet, 8 inches wide;

b. swing out; and

c. permit staff observation of the patient while also maintaining provisions for patient privacy; and

10. not have electrical switches and receptacles.

L. There shall be a locked storage area to secure a patient's personal items and to secure contraband.

1. The CRC-SU shall have policies and procedures for the handling of such items.

2. The locked storage area shall be accessible only to authorized personnel.

M. The CRC-SU shall have a minimum of two single-use toilet rooms accessible to patients and at least one toilet room for CRC-SU staff.

1. All toilet rooms shall contain a toilet and a lavatory.

2. All plumbing and piping connections to fixtures shall be enclosed and not accessible to tampering by patients.

3. The doors on the bathroom/toilet rooms shall swing out or be double hinged.

4. If mirrors are located in the toilet rooms, they shall be fabricated with laminated safety glass or protected by polycarbonate laminate or safety screens.

5. Bathroom/toilet room hardware and accessories shall be of special design to give consideration to the prevention of injury and suicide.

N. The CRC-SU shall have at least one single-use shower facility for the use of patients within the confines of the CRC-SU.

1. Shower sprinkler heads shall be recessed or of a design to minimize patient tampering.

O. All windows in the CRC-SU shall be fabricated with laminated safety glass or protected by polycarbonate laminate or safety screens.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:516 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:556 (April 2019).

Subchapter C. Level II Crisis Receiving Centers

§9631. General Provisions

A. A Level II CRC-SU is an intermediate level of care unit that provides for:

1. an increased opportunity for observation;

2. improved diagnostic accuracy;

3. brief interventions;

4. psychotropic medications;

5. the ability to denote response to intervention; and

6. an appropriate referral and coordination of care for extended services as necessary

B. The goal of a Level II CRC-SU is to stabilize the patient and prevent the need for admission to a higher level of psychiatric care.

C. A Level II CRC-SU shall meet all of the requirements of a Level I CRC-SU and shall operate 24 hours per day, seven days per week.

D. The length of a patient stay at a Level II CRC-SU shall not exceed 72 hours.

E. The Level II CRC-SU shall be located adjacent to the Level I CRC-SU.

F. The licensed capacity in a Level II CRC-SU shall not be licensed as hospital beds and shall not be counted in the aggregate number of licensed hospital beds.

G. A Level II CRC-SU shall not be included, considered or certified as a portion or part of a distinct part psychiatric unit.

H. Patients may be directly admitted to a Level II CRC-SU from:

1. a Level I CRC-SU after the triage/screening and assessment has been completed;

2. an emergency department of a hospital, provided that the patient has undergone an emergency medical screening; or

3. an outpatient setting, provided that the outpatient setting has within the previous 24-hour period completed a triage/screening and assessment that meets the established criteria under the Level I CRC-SU provisions of this Chapter.

NOTE: If the required components of triage/screening and/or assessment have not been completed by the transferring hospital or outpatient setting, then immediately upon entry, the Level II CRC-SU shall conduct the additional components of the assessment prior to admitting the patient.

I. The Level II CRC-SU shall develop and implement policies and procedures for the use of psychotropic medications and pharmacy services.

J. The Level II CRC-SU shall develop and implement policies and procedures to utilize behavior management and

therapeutic interventions to stabilize the behavioral health crisis in the least restrictive manner.

K. The Level II CRC-SU shall develop and implement policies and procedures on seclusion and restraint in accordance with federal requirements. All staff shall be trained on seclusion and restraint policies and procedures, and shall utilize the least restrictive method.

1. Policies shall include procedures and performance improvement measures to minimize the use of seclusion and restraints.

L. The Level II CRC-SU shall develop and implement policies and procedures for instituting an increased level of supervision for patients at risk for suicide and other self-injurious behaviors.

M. When a Level II CRC-SU receives a patient with a properly executed emergency certificate, the CRC-SU shall immediately notify the coroner's office.

1. If an emergency certificate is issued by appropriately licensed personnel of the CRC-SU, the CRC-SU shall immediately notify the coroner's office or physician as applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:517 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

§9633. Level II Services

A. In addition to the services required in §9617 of this Chapter, the Level II CRC-SU shall provide the following services.

1. A Level II CRC-SU shall provide continuous observation of the patient in order to determine the following:

a. adherence to the initial service plan;

b. response to medications;

c. response to therapeutic interventions; and

d. evidence of deterioration or stabilization of behaviors.

2. The Level II CRC-SU shall assure access to necessary medical supports and services in order to stabilize acute medical conditions.

3. The Level II CRC-SU shall provide therapeutic milieu that encompasses:

a. a calming physical environment;

b. staff members knowledgeable of therapeutic communication; and

c. an atmosphere conducive to enhancing the mental health of the patients being served.

4. The Level II CRC-SU shall conduct a psychosocial assessment on each patient within 24 hours of admission. This assessment shall be conducted by a licensed LMHP who has one year of documented crisis services and intervention experience:

5. The Level II CRC-SU shall develop an initial service plan for each patient admitted based on their individual needs that includes, but is not limited to the following:

a. continued reassessments;

b. brief behavioral health interventions;

c. family or support system involvement;

d. substance abuse treatment and relapse prevention, as indicated;

e. peer support services;

f. psychotropic medications; and

g. discharge planning and referral.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

§9635. Staffing Requirements

A. A Level II CRC-SU shall meet all of the staffing requirements of the Level I CRC-SU in addition to the following requirements.

1. A Level II CRC-SU shall have an RN in charge of the unit at all times. This RN may be the same nurse in charge of the Level I CRC-SU, providing he/she is not assigned to provide patient care to patients in the Level II CRC-SU.

2. The Level II CRC-SU shall have sufficient numbers and types of qualified staff on duty and available at all times to provide necessary care, services, treatment and safety, based on the acuity of the patients, the mix of the patients present in the CRC-SU, the need for extraordinary levels of care and to meet the needs of the patient throughout the length of any patient stay in the CRC-SU.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:557 (April 2019).

§9637. Physical Environment

A. A Level II CRC-SU shall meet the physical requirements of a Level I CRC-SU unless otherwise specified herein.

B. A Level II-CRC-SU may be located in an interior area of the hospital provided that it is immediately adjacent to the Level I CRC-SU.

1. A Level II CRC-SU may be located in a licensed offsite location of the hospital.

C. A Level II CRC-SU shall not be required to have the triage/screening rooms within the area of the Level II CRC-SU.

D. The Level II CRC-SU shall have patient rooms that meet the following requirements:

1. single occupancy rooms;

2. minimum of 100 square feet of space;

3. monolithic or tamper-proof ceilings;

4. have closet or storage space for personal belongings; and

5. electrical receptacles shall be of the safety type or protected by 5 milli ampere ground-fault-interrupters; and

6. doors that swing outward or are double hinged.

E. Electric patient beds shall not be used.

F. An electronic nurse call system is not required, but if it is included, provisions shall be made for easy removal and for covering call button outlets. The CRC-SU shall have policies and procedures to address calls where no electronic system is in place.

G. Bathrooms

1. The Level II CRC-SU shall have a minimum of two bathrooms that contain all of the following:

a. toilet;

b. shower; and

c. lavatory;

i. if the lavatory is in the patient room and not contained within the bathroom, the lavatory shall be adjacent to the bathroom.

2. If the Level II CRC-SU has more than a capacity for 12 patients, there shall be one additional bathroom for each additional capacity for four patients.

3. The bathrooms shall be outfitted as follows.

a. All plumbing and piping connections to fixtures shall be enclosed and not accessible to tampering by patients.

b. The doors on the toilet rooms shall swing out or be double hinged.

c. If mirrors are located in the toilet rooms, they shall be fabricated with laminated safety glass or protected by polycarbonate laminate, or safety screens.

d. Bathroom/toilet room hardware and accessories shall be of special design to give consideration to the prevention of injury and suicide.

4. Shower sprinkler heads shall be recessed or of a design to minimize patient tampering.

H. The Level II CRC-SU shall have a separate bathroom and a break room designated for staff use.

I. Separate and apart from the seclusion room required in a Level I CRC-SU, the Level II CRC-SU shall have a minimum of one seclusion room for each capacity for 12 patients.

1. The seclusion room in the Level II CRC-SU shall meet the same requirements specified for the seclusion room in the Level I CRC-SU.

2. The patient rooms in the Level II CRC-SU may be used as seclusion rooms provided they meet the same requirements as specified for the seclusion room in the Level I CRC-SU.

J. The Level II CRC-SU shall have separate consultation room(s) with a minimum floor space of 100 square feet each, provided at a room-to-bed ratio of one consultation room for each capacity for 12 patients. Consultation rooms within the unit shall be available for use for interviews with the patient and/or their families. The consultation room(s) shall be designed for acoustical and visual privacy.

K. The Level II CRC-SU shall have a room with a minimum of 225 square feet for group therapy, treatment team planning and conferencing.

L. The Level II CRC-SU shall have a room within the unit with a minimum of 120 square feet for examination and treatment of patients.

M. The Level II CRC-SU shall have an area for accommodation of charting, storage of records, and the storage and preparation of medications. Provisions shall be made for securing patient records and medications in this area.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

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