MINIMUM STANDARDS

OF

OPERATION

FOR

HOSPICE

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CHAPTER 01 MINIMUM STANDARDS OF OPERATION FOR HOSPICE

PART I GENERAL

Every Hospice located inside the boundaries of a municipality shall comply with all local municipal codes and ordinances applicable thereto. In addition, each hospice shall comply with all applicable federal laws and state laws inclusive of Mississippi Code Annotated (41-85-1) through (41-85-25).

100 LEGAL AUTHORITY

100.01 **Adoption of Rules, Regulations, and Minimum Standards** – The Mississippi State Department of Health, Bureau of Health Facilities, Licensure and Certification adopts the following rule governing the licensing and regulation of hospices as authorized by the Mississippi Code Annotated Section 41-85-1 through 41-85-25 and in accordance with House Bill 379 enacted by the Regular 1995 Session of the Legislature of the State of Mississippi known as the "Mississippi Hospice Law of 1995". The Bureau of Health Facilities, Licensure and Certification amends the following regulations which will govern the licensing of hospice agencies licensed on or after adoption of this rule.

100.02 **Effective date of Rules, Regulations, and Minimum Standards for Hospice -** This rule shall replace and supersede the rule adopted on August 21, 1995, except that the rule adopted on August 21, 1995 and reference in the Mississippi Register shall continue to regulate those hospice agencies licensed on or before adoption of this rule, and shall continue to regulate these agencies for 90 days from adoption of this rule. Effective 30 days from the adoption of this rule, the provisions of this rule shall govern all hospice agencies, regardless of the date of issuance of license.

100.03 **Fire Safety** – No freestanding hospice may be licensed until it shows conformance to the safety regulations providing minimum standards for prevention and detection of fire as well as for protection of life and property against fire.

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101 DEFINITIONS

Unless a different meaning is required by the context, the following terms as used in these rules and regulations shall have the meaning hereinafter respectively ascribed to them:

101.01 **Administrator** - Means the person, designated by the governing body, who is responsible for the management of the overall operation of the hospice.

101.02 **Advance Directives** – Directive from the patient/family (see definition of family) such as a durable power of attorney for health care, a directive pursuant to patient self-determination initiatives, a living will, or an oral directive which either states a person's choices for medical treatment or, in the event the person is unable to make treatment choices, designates who shall make those decisions.

101.03 **Attending/Primary Physician** – A doctor of medicine or osteopathy licensed to practice medicine in the State of Mississippi, who is designated by the patient or responsible party as the physician responsible for his/her medical care.

101.04 **Bereavement Services** – Organized services provided under the supervision of a qualified counselor (see definition) to help the family cope with death related grief and loss.

101.05 **Autonomous** – Means a separate and distinct operational entity which functions under its own administration and bylaws, either within or independently of a parent organization.

101.06 **Bed Capacity** – Means the largest number which can be installed or set up in the freestanding hospice at any given time for use of patients. The bed capacity shall be based upon space designed and/or specifically intended for such use whether or not the beds are actually installed or set up.

101.07 **Bed Count** – Means the number of beds that are actually installed or set for patients in freestanding hospice at a given time.

101.08 **Branch Office/Alternate Site** –A location or site from which a hospice agency provides services within a portion of the total geographic area served by the parent agency. The branch is a part of the parent hospice agency and is located within the 50 mile

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radius of the parent agency and shares administration and supervision. No branch office site shall be opened unless the parent office has had full licensure for the immediately preceding 12 months and has admitted 10 patients within the last twelve (12) months. A branch office does not extend the Geographic Service Area of the Parent Agency.

101.09 **Bureau** – Mississippi State Department of Health, Bureaus of Health Facilities, Licensure and Certification.

101.10 **Care Giver** – The person whom the patient designates to provide his/her emotional support and/or physical care.

101.11 **Chaplain** – Means an individual representative of a specific spiritual belief who is qualified by education received through accredited academic or theological institutions, and/or experience thereof, to provide counseling and who serves as a consultant for and/or core member of the hospice care team.

101.12 **Change of Ownership** – Means but is not limited to, intervivos, gifts, transfers, leases, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (fifty percent (50%) or more) of the facility or service. Changes of ownership from partnerships, single proprietorships or corporations to another form of ownership are specifically included. Provided, however, "Change of Ownership" shall not include any inherited interest acquired as a result of a testamentary instrument or under the laws of descent and distribution of the State of Mississippi. The change of IRS exemption status also constitutes a change of ownership.

101.13 **Community** – A group of individuals or a defined geographic area served by a hospice.

101.14 **Continuous Home Care** – Care provided by the hospice during a period of crisis as necessary to maintain the terminally ill individual at home. A minimum of eight hours of care must be furnished on a particular day to be considered continuous home care. Nursing care must be provided for more than one-half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Services may be provided by a homemaker or hospice aide to supplement the nursing care. When determining the necessity for continuous home care, a registered nurse must complete/document a thorough assessment and plan of care that includes participation of all necessary

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disciplines to meet the patient's identified needs, prior to assigning a licensed practical nurse, homemaker, or a hospice aide to a patient requiring continuous home care. This assignment must comply with accepted professional standards of practice.

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

101.16 **Core Services** – Nursing services, physician services, medical social services, and counseling services, including bereavement counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

101.17 **Counselor** – Means an individual who has at least a bachelor's degree in psychology, a master's or bachelor's degree from a school of social work accredited by the Council on Social Work Education, a bachelor's degree in counseling; or the documented equivalent of any of the above in education, training in the spiritual care of the dying and end of life issues, and who is currently licensed in the state of Mississippi, if applicable. Verification of education and training must be maintained in the individual's personnel file.

101.18 **Criminal History Record Check**

1. **Affidavit** -For the purpose of fingerprinting and criminal background history checks, the term "affidavit" means the use of Mississippi State Department of Health (MDH) form #210, or a copy thereof, which shall be placed in the individual's personal file.

2. **Employee** -For the purpose of fingerprinting and criminal background history checks, employee shall mean **any individual employed by a covered entity**. The term "employee" also includes any individual who by **contract** with a covered entity provides patient care in a patient's, resident's, or client's room or in treatment rooms.

   The term employee does not include healthcare professional/ technical students, as defined in Section 37-

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29-232, performing clinical training in a licensed entity under contracts between their schools and the licensed entity, and does not include students at high schools who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied health course taught in the school if:

a. The student is under the supervision of a licensed healthcare provider; and

b. The student has signed the affidavit that is on file at the student's school stating that he or she has not been convicted of or plead guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offenses listed in section 45-33-23 (g), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

c. Further, applicants and employees of the University of Mississippi Medical Center for whom criminal history record checks and fingerprinting are obtained in accordance with Section 37-115-41 are exempt from application of the term employee under Section 43-11-13.

3. **Covered Entity -** For the purpose of criminal history record checks, "covered entity" means a licensed entity or a healthcare professional staffing agency.

4. **Licensed Entity -** For the purpose of criminal history record checks, the term "licensed entity" means a hospital, nursing home, personal care home, home health agency or hospice.

5. **Health Care Professional/Vocational Technical Academic Program** - For purpose of criminal history record checks, "health care professional/vocational technical academic program" means an academic program in medicine, nursing , dentistry, occupational therapy, physical therapy, social services, speech therapy, or other

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allied-health professional whose purpose is to prepare professionals to render patient care services.

6. **Health Care Professional/Vocational Technical Student** For purposes of criminal history record checks, the term means a student enrolled in a healthcare professional/ vocational technical academic program.

7. **Direct Patient Care or Services** - For the purposes of fingerprinting and criminal background history checks, the term "direct patient care" means direct hands-on medical patient care and services provided by an individual in a patient, resident or client's room, treatment room or recovery room. Individuals providing direct patient care may be directly employed by the facility or provides patient care on a contractual basis.

8. **Documented disciplinary action** - For the purpose of fingerprinting and criminal background history checks, the term "documented disciplinary action" means any action taken against an employee for abuse or neglect of a patient.

101.19 **Department** – Means the Mississippi State Department of Health (MDH).

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

101.21 **Dietitian** – Means a person who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training and/or experience.

101.22 **Do Not Resuscitate Orders (DNR)** – Orders written by the patient's physician which stipulate that in the event the patient has a cardiac or respiratory arrest, cardiopulmonary resuscitation will not be initiated or performed.

101.23 **Emotional Support** – Support provided to assist the person in coping with stress, grief and loss.

101.24 **Family Unit** – Means the terminally ill person and his or her family, which may include spouse, children, sibling, parents, and other with significant personal ties to the patient.

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101.25 **Freestanding Hospice**– Freestanding Hospice means a hospice that is not a part of any other type of health care provider.

101.26 **Geographic Service Area** – Area around the Parent Office, which is within 50 miles radius of the Parent Office premises. Each hospice must designate the geographic service area in which the agency will provide services. Should any portion of a county fall within a 50 mile radius of the Parent, then the entire county may fall within the geographic service area of the Parent. Nothing herein is intended to automatically expand the service area of any existing Parent. A hospice shall seek approval of the Department for any expansion of their service area. The full range of hospice services, as specified, must be provided to the entire designated geographic services area.

101.27 **Governing Body**- ~~Means the board of directors, trustees, partnership, or association, consisting of a minimum of seven (7) persons who are representative of the local community at large~~, A hospice program shall have a clearly defined organized governing body ~~which~~ that has autonomous authority for the conduct ~~and operation~~ of the hospice program. (Section: 41-85-19) This governing body is not required to meet more often than quarterly.

101.28 **Hospice Aide**-An individual who is currently qualified in the State of Mississippi to provide personal care services to hospice patients under the direction of a registered nurse of the hospice.

101.29 **Hospice Inpatient Facility** – Organized facilities where specific levels of care ranging from residential to acute, including respite, are provided on a 24-hour basis within the confines of a licensed hospital, nursing home, or freestanding hospice in order to meet the needs of the patient/family. A hospice inpatient facility shall meet the Condition of Participation for providing inpatient care directly as specified in Title 42, Section 418.100 of the Code of Federal Regulations.

101.30 **Hospice** – Means an autonomous, centrally administered, nonprofit or for profit medically directed, nurse-coordinated program providing a continuum of home, outpatient and homelike inpatient care for not less than four (4) terminally ill patients and their families. It employs a hospice care team (see definition of hospice care team) to assist in providing palliative and supportive care to meet the special needs arising out of the physical,

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emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. This care is available twenty-four (24) hours a day, seven (7) days a week, and is provided on the basis of need regardless of inability to pay. (Section 41-85-3)

101.31 **Hospice Physician** – A doctor of medicine or osteopathy who is currently and legally authorized to practice medicine in the State of Mississippi and is designated by the hospice to provide medical care to hospice patients, in coordination with the patient's primary physician.

101.32 **Hospice Premises** – The physical site where the hospice maintains staff to perform administrative functions, maintains its personnel records, maintains its client service records, and holds itself out to the public as being a location for receipt of client referrals. A hospice must be physically located within the State of Mississippi. A license for a hospice program shall not be issued if the hospice is to be located in an area in violation of any local zoning ordinance or regulation

101.33 **Informed Consent** – A documented process in which information regarding the potential and actual benefits and risks of a given procedure or program of care is exchanged between provider and patient.

101.34 **Inpatient Services** – Care available for General Inpatient Care or Respite Care that is provided in an Inpatient Hospice Facility, hospital, or SNF that meets the Condition of Participation for providing inpatient care directly as specified in Title 42, Section 418.100 of the Code of Federal Regulations.

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

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chooses to execute the establishment of policies governing the day-to-day provision of hospice care and services.

101.36 **Interdisciplinary Team Conferences** – Regularly scheduled periodic meetings of specific members of the interdisciplinary team (see 101.35) to review the most current patient/family assessment, evaluate care needs, and update the plan of care.

101.37 **Level of Care** – Hospice care is divided into four categories of care rendered to the hospice patient.

a. Routine home care

b. Continuous home care

c. Inpatient respite care

d. General inpatient care

101.38 **License (Hospice)** – A document permitting an organization to practice hospice care for a specific period of time under the rules and regulations set forth by the State of Mississippi.

101.39 **Licensing Agency**- Means the Mississippi State Department of Health.

101.40 **Life-Threatening** – Causes or has the potential to cause serious bodily harm or death of an individual.

101.41 **Medically Directed** – Means that the delivery of medical care is directed by a licensed physician who is employed by the hospice for the purpose of providing ongoing palliative care as a participating caregiver on the hospice care team.

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

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

a. Hospice aide and homemaker

b. Physical therapy services

c. Occupational therapy services

d. Speech-language pathology services

e. General inpatient care

f. Respite care

g. Medical supplies and appliances including drugs and biologicals.

101.44 **Nurse Practitioner** – Shall mean an individual who is currently licensed as such in the State of Mississippi and is performing duties in accordance with the Mississippi Nurse Practice Act.

101.45 **Occupational Therapist** – Means a person licensed to practice Occupational Therapy in the State of Mississippi.

101.46 **Outpatient Care**- Means any care rendered or coordinated by the hospice care team that is not "home care" or "inpatient care".

101.47 **Palliative Care** – Means the reduction or abatement of pain and other troubling symptoms by appropriate coordination of all elements of the hospice care team needed to achieve needed relief of distress.

101.48 **Parent Office** – The primary location or site from which a hospice agency provides services within a Geographic Service Area. The Parent Office is used to determine the base of the Geographic Service Area.

101.49 **Patient** – Shall mean the terminally ill individual who meets criteria as defined per State law.

101.50 **Period of Crisis** – A period in which a patient required predominately nursing care to achieve palliation or management of acute medical problems.

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101.51 **Physical Therapist** – Means an individual who is currently licensed to practice physical therapy in the State of Mississippi.

101.52 **Plan of Care (POC)** – A written document established and maintained for each individual admitted to a hospice program. Care provided to an individual must be in accordance with the plan. The plan must include a comprehensive assessment of the individual's needs and identification of the care/services including the management of discomfort and symptom relief.

101.53 **Primary Care person** – A person designated by the patient who agrees to give continuing support and/or care.

101.54 **Registered Nurse** – An individual who is currently licensed in the State of Mississippi or in accordance with criteria established per the Nurse Compact Act and is performing nursing duties in accordance with the Mississippi Nurse Practice Act.

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

101.56 **Residential Care**- Hospice care provided in a nursing facility or any residence or facility other than the patient's private residence.

101.57 **Respite Care**- Short-term care provided in an Inpatient Hospice Facility, hospital, or SNF that meets the Condition of Participation for providing inpatient care directly as specified in Title 42, Section 418.100 of the Code of Federal Regulations. Respite care is short-term inpatient care provided to the patient only when necessary to relieve the family members or other persons caring for the patient. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

101.58 **Social Worker** – An individual who has a degree from a school of social work accredited by the Council on Social Work Education and is licensed by the State of Mississippi.

101.59 **Speech Pathologist** – Shall mean an individual who meets the educational and experience requirements for a Certificate of Clinical Competence granted by the American Speech and Hearing

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Association and is currently licensed as a Speech and Language Pathologist in the State of Mississippi.

101.60 **Spiritual Services** – Providing the availability of clergy, as needed, to address the patient's/family's spiritual needs and concerns.

101.61 **Terminally Ill**- A medical prognosis of limited expected survival of approximately six months or less, if the disease follows its normal course, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone is no longer appropriate.

101.62 **Volunteer** – Means a trained individual who provides support and assistance to the patient, family or organization, without remuneration, in accord with the plan of care developed by the hospice core team and under the supervision of a member of the hospice staff appointed by the governing body or its designee.

101.63 **Director of Volunteers** - Means a person who directs the volunteer program in accordance with the acceptable standards of hospice practice.

102 PROCEDURE GOVERNING ADOPTION AND AMENDEMENT

102.01 **Authority** – The Mississippi State Department of Health shall have the power to adopt, amend, promulgate and enforce such minimum standards of operation as it deems appropriate, within the law.

102.02 **Amendment** – The Minimum Standards of Operation for Hospice may be amended by the Mississippi State Department of Health as necessary to promote the health, safety and welfare of persons receiving services.

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PART II CLASSIFICATION OF HOSPICE

103 CLASSIFICATION

103.01 For the purpose of these rules, regulations, and minimum standards, hospice shall be classified as:

1. Freestanding Hospice
2. Hospital Hospice
3. Nursing Home Hospice
4. Home Health Agency Hospice

103.02 **Hospice Core Service**

To be classified as a Hospice these core services shall be provided but need not be limited to the following:

1. Physician Service
2. Nursing Service
3. Medical Social Service
4. Pastoral/Counseling Services

103.03 **Inpatient Hospice**

To be classified as an Inpatient Hospice that provides inpatient care, the core services (physician, nursing, medical, social and counseling) shall be provided on the premises. Inpatient Hospice must have a registered nurse on duty seven days a week, twenty-four hours a day to provide direct patient care. Other members and types of personnel sufficient to meet the total needs of the patient shall be provided.

PART III LICENSING

It shall be unlawful to operate or maintain a hospice without first obtaining a license from the department. The Mississippi State Department of Health is the licensing authority for hospice in the State of Mississippi.

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104 TYPES OF LICENSES

104.01 **Regular License** – A license shall be issued to each hospice that meets the requirements as set forth in these regulations. The license shall show the classification Home Health, Nursing Home, Hospital or Freestanding.

104.02 **Provisional License** – Within its discretion, the Mississippi State Department of Health may issue a provisional license when a temporary condition of non-compliance with these regulations exists in one or more particulars. A provisional license shall be issued only if the Department of Health is satisfied that preparations are being made to qualify for a regular license and that the health and safety of patients will not be endangered. One condition on which a provisional license may be issued is as follows: A new hospice agency may be issued a provisional license prior to opening and subsequent to meeting the required minimum staffing personnel. The license issued under this condition shall be valid until the issuance of a regular license or June 30 following date of issuance whichever may be sooner. A provisional license may be reissued only if it is satisfactorily proven to the Department of Health that efforts are being made to fully comply with these regulations by a specified time.

A hospice program against which a revocation or suspension proceeding is pending at the time of licensure renewal may be issued a conditional license effective until final disposition by the department of such proceedings. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional permit for the duration of the judicial proceeding.

105 APPLICATION FOR LICENSE

105.01 A Hospice shall not be operated in Mississippi without a valid license from Mississippi State Department of Health.

105.02 Any person or organization desiring to operate a hospice shall file with the Department of Health:

(a) Application on a form prescribed and furnished by the Department of Health; and

(b) Fees as applicable per State law

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105.03 The application shall include complete information concerning the address of the applicant; the ownership of the hospice; if organized as a corporation, the names and addresses of each officer and director of the corporation; if organized as a partnership, the names and addresses of each partner; membership of the governing body; the identities of the medical director and administrator; and any other relevant information which the Mississippi State Department of Health may require.

105.04 Ownership of the hospice shall be fully disclosed in the application. This disclosure shall include names and addresses of all corporate officers and any person(s) having a five percent (5%) financial interest.

105.05 A license shall be issued to the person(s) named only for the premises listed on the application for licensure. Separate applications and licenses are required for hospices maintained separately, even if they are owned or operated by the same person(s), business or corporation, and may be doing business under the same trade name. No hospices shall establish a branch/satellite facility outside a 50 mile radius from the Parent facility. However, existing satellite branch offices operating outside the described 50 mile radius referenced in 101.26 prior to the effective date of these regulations shall be permitted to remain satellite branch offices under their existing Parent facility.

105.06 Licenses are not transferable or assignable.

105.07 Each planned change of ownership or lease shall be reported to the Department at least thirty (30) days prior to such change along with an application from the proposed new owners/lessees for a new license.

105.08 The application is considered a continuing application. A written amendment to the current application shall be filed when there is a change in any of the information reported in the application.

105.09 Fees: Prior to review for an initial license and prior to license renewal, the facility shall submit fees as established under Section 41-85-7 (1), (b), (c), Mississippi Code of 1972.

105.10 **Operational Requirements/Conditions of Operation** – In order for a hospice program to be considered operational, the program must:

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a. Have admitted at least ten patients since the last annual survey;

b. Be able to accept referrals at any time;

c. Have adequate staff to meet the needs of their current patients;

d. Have required designated staff on the premises at all times during business hours;

e. Be immediately available by telecommunications 24 hours per day. A registered nurse must answer calls from patients and other medical personnel after hours;

f. Be open for business of providing hospice services to those who need assistance.

105.11 **License Renewal Process**

a. A license issued for the operation of a hospice program, unless sooner suspended or revoked, shall expire automatically on June 30 of each calendar year.

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

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

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

2. Complete all forms and return to bureau at least 30 days prior to license expiration;

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

105.12 **Notification of Changes**

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Mississippi State Department of Health shall be notified, in writing, of any of the following within five working days following the occurrence:

a. Address/location (An Inpatient Hospice facility must notify and receive approval by Mississippi State Department of Health prior to a change of address/location);

b. Agency name;

c. Phone number;

d. Hours of operation/24 hour contact procedure;

e. Change in address or phone number of any branch office;

f. Administrator;

g. Director of nursing; and

h. Cessation of business.

105.13 **Name of Institution** – Every hospice shall be designated by a permanent and distinctive name which shall be used in applying for a license and shall not be changed without first notifying the licensing agency in writing and receiving written approval of the change from the licensing agency. Such notice shall specify the name to be discontinued as well as the new name proposed. Only the official name by which the institution is licensed shall be used in telephone listing, on stationery, in advertising, etc. Two or more facilities shall not be licensed under similar names in the same vicinity.

105.14 **Number of Beds** – Each application for license shall specify the maximum number of inpatient beds in the hospice as determined by these regulations. The maximum number of inpatient beds for which the facility is licensed shall not be exceeded.

105.15 A license for a hospice program shall not be issued if the hospice is to be located in an area in violation of any local zoning ordinances or regulations.

105.16 Following inspection and evidence of compliance with these regulations, the Mississippi State Department of Health may issue

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a license. Only licensed hospices shall be authorized to use the name "hospice."

105.17 A license shall be displayed in a prominent place in the hospice's administrative offices.

105.18 **Inspections**

1. Observation and examination of the hospice operation shall be available at all reasonable hours to properly identified representatives of the Department.

2. The Department shall conduct inspections of all Parent and Branch units annually.

3. Hospice inspections shall include personal contacts with recipients of the hospice service.

105.19 **Change of Ownership**
Should a hospice program/facility wish to undergo a change of ownership, the facility must:

1. Submit a written request to Mississippi State Department of Health to obtain a Change of Ownership (CHOW) Package.

2. Submit the following with the request for CHOW within five (5) working days after the act of sale:

   a. A new license application and the current licensing fee. The purchaser of the agency must meet all criteria required for initial licensure for hospice;

   b. Any changes in the name and or address of the agency;

   c. Any changes in administrative personnel;

   d. Copy of the Bill of Sale and/or legal document reflecting change;

   e. Copy of Articles of Incorporation.

106 DENIAL, SUSPENSION, OR REVOCATION OF LICENSE

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106.01 **Denial or Revocation of License: Hearing and Review** –
The licensing agency is authorized to deny, suspend, or revoke a license. Any of the following actions shall be grounds for action by the department against a hospice program.

1. A violation of the provisions of the Mississippi Hospice Law of 1995 or any standard or rule of these regulations, including but not limited to, in any case the Department finds that there has been substantial failure to comply with the requirements established under the law and these regulations. These are inclusive of the following:

a. Fraud on the part of the licensee in applying for license.

b. Willful or repeated violations by the licensee of any of the provisions of the Mississippi Law of 1995, as amended, and /or of the rules, regulations, and minimum standards established by the Department of Health.

c. Addiction to narcotic drug(s) by the licensee or the management staff of the hospice.

d. Use of alcoholic beverages by the licensee or other personnel of the hospice to the extent which threatens the well being or safety of the patient or resident.

e. Conviction of the licensee of a felony.

f. Publicly misrepresenting the hospice and/or its services.

g. Permitting, aiding, and abetting the commission of any unlawful act.

h. Misappropriation of the money or property of a patient or resident.

2. An intentional or negligent act materially affecting the health and safety of a patient. These acts include but are not necessarily limited to:

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a. Cruelty to patient or resident or indifference to their needs which are essential to their general well-being and health.

b. Failure to provide food adequate for the needs of the patient or resident, when residing in an inpatient facility.

c. Inadequate staff to provide safe care and supervision of patient or resident.

d. Failure to call a physician when required by patient's or resident's condition.

e. Failure to notify next of kin or designated individual when patient's or resident's conditions become critical.

f. Failure to provide appropriate level of care.

3. If, three (3) months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the home-care component of hospice care, the department shall immediately revoke the license of such hospice.

4. If, twelve (12) months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the outpatient and homelike inpatient components of hospice care, the department shall immediately revoke the license of such hospice.

107 PROVISION OF HEARING AND APPEAL FOLLOWING DENIAL OR REVOCATION OF LICENSE; PENALTIES

107.01 **Administrative Decision** – The Mississippi State Department of Health will provide an opportunity for a fair hearing to every applicant or licensee who is dissatisfied with administrative decisions made in the suspension, denial or revocation of license.

1. The licensing agency shall notify the applicant or licensee by registered mail or personal service the particular reasons for the suspension, denial or revocation of license. Upon written request of applicant or licensee within ten (10) days of the date of notification the licensing agency shall fix a date not less than thirty (30) days from the date of such

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service at which time the applicant or licensee shall be given an opportunity for a prompt and fair hearing.

2. On the basis of such hearing or upon default of the applicant or licensee, the licensing agency shall make a determination specifying its findings of fact and conclusions of law. A copy of such determination shall be sent by registered mail to the last known address of the applicant or licensee or served personally upon the applicant or licensee.

3. The decision revoking, suspending, or denying the application or license shall become final thirty (30) days after it is so mailed or served unless the applicant or licensee, within such thirty (30) day period, appeals the decision to the State court having jurisdiction and such court issues a conditional permit for the duration of the judicial proceedings. An additional period of time may be granted at the discretion of the licensing agency including a conditional license.

107.02 **Penalties** – Any person establishing, conducting, managing, or operating a hospice without a license shall be declared in violations of these regulations and State law. Penalties shall be assessed in accordance with §41-85-25 of the Mississippi Code of 1972.

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108 TERMINATION OF OPERATION

108.01 **General** – In the event that a Hospice ceases operation, voluntarily or otherwise, the agency shall:

1. Inform the attending physician, patient, and persons responsible for the patient's care in ample time to provide for alternate methods of care;

2. Provide the receiving facility or agency with a complete copy of the clinical record;

3. Inform the community through public announcement of the termination;

4. Ensure the safekeeping, confidentiality, and storage of all clinical records for a period of five (5) years, following discharge, and notify Mississippi State Department of Health, in writing, the location of all records;

5. Return the license to the licensing agency.

PART IV ADMINISTRATION

109 ADMINISTRATION

109.01 **Governing Body** – A hospice shall have a governing body (See Definition) that assumes full legal responsibility for compliance with these regulations and for setting policy, appointing persons to carry out such policies, and monitoring the hospice's total operation.

109.02 **Medical Director**

1. Each hospice shall have a Medical Director, who, on the basis of training, experience and interest, shall be knowledgeable about the psychosocial and medical aspects of hospice care.

2. The Medical Director shall be appointed by the governing body or its designee.

3. The Medical Director is expected to play an integral role in providing medical supervision to the hospice interdisciplinary group and in providing overall

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coordination of the patient's plan of care. The Medical Director's expertise in managing pain and symptoms associated with the patient's terminal disease is necessary, regardless of the setting in which the patient is receiving services to assure that the hospice patient has access quality hospice care.

The duties of the Medical Director shall include, but not be limited to:

a. Determination of patient medical eligibility for hospice services in accordance with hospice program policy;

b. Collaboration with the individual's attending physician to assure all aspects of medical care are taken into consideration in devising a palliative plan of care;

c. Review, revise and document the plan at intervals specified in the plan, but no less than every 14 calendar days;

d. Acting as a medical resource to the hospice care team and as a medical liaison with physicians in the community; and

e. Coordination of efforts with each attending physician to provide care in the event that the attending physician is unable to retain responsibility for patient care.

109.03 **Administrator** – A person shall be designated by the governing body or its designee to be responsible for the management of the hospice program in matters of overall operation. This person may be a member of the hospice care team.

109.04 **Advertising** – If a hospice advertises its services, such advertisement shall be factual and not contain any element which might be considered coercive or misleading. Any written advertising describing services offered by the hospice shall contain notification that services are available regardless of ability to pay.

109.05 **Annual Budget**

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1. The annual budget shall include income plus expenses related to overall cost of the program.
2. The overall plan and budget shall be reviewed and updated at least annually by the governing body.

3. The annual budget should reflect a comparative analysis of the cost savings of the volunteers.

PART V POLICIES AND PROCEDURES

110 GENERAL

110.01 The hospice shall maintain operational policies and procedures, which shall be kept current.

110.02 Such policies and procedures shall accurately reflect a description of the hospice's goals, methods by which these goals are sought, and mechanisms by which the basic hospice care services are delivered.

110.03 Policies and procedures shall be available to hospice team members, patients and their families/primary care person, potential applicants for hospice care, and the Department.

111 PERSONNEL POLICIES

111.01 **Personnel Policies** – Each licensed hospice agency shall adopt and enforce personnel policies applicable and available to all full and part time employees. These policies shall include but not be limited to the following:

1. Fringe benefits, hours of work and leave time;

2. Requirements for initial and periodic health examinations;

3. Orientation to the hospice and appropriate continuing education;

4. Job descriptions for all positions utilized by the agency;

5. Annual performance evaluations for all employees;

6. Compliance with all applicable requirements of the Civil Rights Act of 1964;

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7. Provision for confidentiality of personnel records.

111.02 **Personnel Records** – Each licensed hospice shall maintain complete personnel records for all employees on file at each licensed site. Personnel records for all employees shall include and application for employment including name and address of the employee, social security number, date of birth, name and address of next of kin, evidence of qualifications, (including reference checks), current licensure and/or registration (if applicable), performance evaluation, evidence of health screening, evidence of orientation, and a contract (if applicable), date of employment and separation from the hospice and the reason for separation. A Hospice that provides other services under arrangement through a contractual purchase of services shall ensure that these services are provided by qualified personnel; currently licensed and/or registered if applicable, and are under the supervision of the agency.

111.03 **Criminal History Record Checks**

1. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be performed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on:

   a. Every new employee of a covered entity who provides direct patient care or services and who is employed after or on July 01, 2003.

   b. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer.

2. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history check have revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal

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history record check by any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check.

3. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be eligible to be employed at the licensed facility:

   a. Possession or sale of drugs

   b. Murder

   c. Manslaughter

   d. Armed robbery

   e. Rape

   f. Sexual battery

   g. Sex offense listed in Section 45-33-23, Mississippi Code of 1972

   h. Child abuse

   i. Arson

   j. Grand larceny

   k. Burglary

   l. Gratification of lust

   m. Aggravated assault

   n. Felonious abuse and/or battery of vulnerable adult

4. Documentation of verification of the employee's disciplinary status, if any, with the employee's professional licensing agency as applicable, and evidence of submission of the employee's fingerprints to the licensing agency must be on file and maintained by the facility prior to the new

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employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee's disciplinary status from any applicable professional licensing agency and submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual's suitability for such employment.

5. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require every employee of a licensed facility employed prior to July 01, 2003, to sign an affidavit stating that he or she does not have a criminal history as outlined in paragraph (c) above.

6. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed the affidavit required by this section. The covered entity shall place the affidavit in the employee's personnel file as proof of compliance with this section.

7. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or plea has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility's policies and procedures.

8. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (g) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the licensed entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the **covered entity**. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime;

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(3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility.

9. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00).

10. Should results of an employee applicant's criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying, event provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi Department of Health without the necessity of an additional criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history record check as required in this subsection.

11. For individuals contracted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check.

12. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officers, employees, attorneys and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section. The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an

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allegation of discrimination is made regarding an employment decision authorized under this section.

111.04 **Employee Health Screening** – Every employee of a hospice who comes in contact with patients shall receive a health screening by a licensed physician, nurse practitioner or employee health nurse who conduct exams prior to employment and annually thereafter. The employee health screening shall include, but not be limited to, tuberculosis screening.

111.05 **Staffing Schedule** – Each hospice and alternate site shall maintain on site current staffing patterns for all health care personnel including full-time, part-time, contract staff and staff under arrangement. The staffing pattern shall be developed at least one week in advance, updated daily as needed, and kept on file for a period of one year. The staffing pattern shall indicate the following for each working day:

1. Name and position of each staff member.

2. Patients to be visited.

3. Scheduled on call after office hours.

112 CONTRACT SERVICES

112.01 **Contract Services** – Contract services may be provided when necessary to supplement hospice employees in order to meet the needs of patients during peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial and administrative responsibility for the services. The hospice must assure that the personnel contracted are legally and professionally qualified to perform the services.

112.02 The hospice must assure that contracted staff are providing care that is consistent with the Hospice philosophy and the patient's plan of care.

113 ORGANIZATION AND STAFFING PERSONNEL QUALIFICATIONS/RESPONSIBILITIES

113.01 **Administrator** – A person who is designated, in writing, by the Governing Body as administratively responsible for all aspects of hospice operations. When the administrator serves more than one licensed agency, he/she shall designate, in writing, an alternate to

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serve as administrator for each site where he/she is not physically housed continuously. The alternate shall be a full-time, on-site employee of the hospice and shall meet the same qualifications as the administrator. The administrator and the Director of Nurses/Alternates may be the same individual if that individual is dually qualified.

1. Qualifications – Licensed physician, a licensed registered nurse, a social worker with a Bachelor's degree, or a college graduate with a bachelor's degree and two (2) years of health care management experience or an individual with one (1) year of healthcare management experience and three (3) years of healthcare service delivery experience that would be relevant to managing the day-to-day operations of a hospice. EXEMPTION: Any person who is employed by a licensed Mississippi hospice as the administrator, as of the effective date of these regulations, shall be exempt from these requirements as long as he/she remains employed by that hospice as the administrator. If the hospice is sold to, acquired by, or merged into another legal entity, such transaction shall have no effect on the exemption provided in the preceding sentence.

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

   a. Ensure the hospice employs qualified individuals;

   b. Be on-site during business hours or immediately available by telecommunications when working within the geographic service area.

   c. Be responsible for and direct the day-to-day operations of the hospice;

   d. Act as liaison among staff, patients, and governing board;

   e Designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and

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f Designate in advance the IDT he/she chooses to establish policies governing the day-to-day provisions of hospice care.

113.02 **Counselor – Bereavement**

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

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

   a. Assess grief counseling needs;

   b. Provide bereavement information and referral services to the bereaved, as needed, in accordance with the POC;

   c. Provide bereavement support to hospice staff as needed;

   d. Attend hospice IDT meetings as needed; and

   e. Document bereavement services provided and progress of bereaved on a clinical progress note to be incorporated in the clinical record.

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113.03 **Counselor – Dietary**

1. Qualifications – A registered dietician licensed in the State of Mississippi who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association.

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

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

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

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

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

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

   f. Participate in IDT conference as needed.

113.04 **Counselor – Spiritual**

1. Qualifications – Documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training.

2. Responsibilities – The counselor shall provide spiritual counseling based on the initial and ongoing assessment of spiritual needs of the patient/family, in a manner consistent

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with standards of practice including, but not limited to, the following:

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

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

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

d. Attend IDT meetings.

113.05 **Director of Nurses (DON)**

A person designated, in writing, by the Governing Body to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and responsible for compliance with regulatory requirements. The DON or alternate, shall be on site or immediately available to be on site, at all times during operating hours. If the DON is unavailable he/she shall designate a Registered Nurse to be responsible during his/her absence. N**OTE**: The Director of Nurses is prohibited from simultaneous concurrent employment with any entity or any other licensed health care entity, unless such licensed healthcare agency is occupying the same physical office space as the hospice.

1. Qualifications – A registered nurse who is currently licensed to practice in the State of Mississippi.

a. With at least three years experience as a registered nurse. One of these years shall consist of full-time experience in:

1. Providing direct patient care in a hospice, home health, or oncology setting; or

2. The management of patient care staff in an acute care setting, hospice or home health; and

b. Be a full time employee of only the hospice agency.

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

   a. The POC;

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

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

   d. Ensure clinical staff compliance with the employee health program; and

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

      1. Resolve problems;

      2. Perform complaint investigations;

      3. Refer impaired personnel to proper authorities;

      4. Ensure appropriate orientation and in-service training to employees;

      5. Ensure the development and implementation of an orientation program for new direct health care personnel;

      6. Ensure the completion of timely annual performance evaluations of health care personnel or designate other supervisory personnel to perform such evaluations;

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7. Ensure participation in regularly scheduled appropriate continuing education for all health professionals, home health aides and homemakers;

8. Ensure that the care provided by the health care personnel promotes effective hospice services and the safety of the patient; and

9. Ensure that the hospice policies are enforced.

113.06 **Governing Body**

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

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

3. The governing body shall:

   a. Designate an individual who is responsible for the day to day management of the hospice program;

   b. Ensure that all services provided are consistent with accepted standards of practice;

   c. Develop and approve policies and procedures which define and describe the scope of services offered;

   d. Review policies and procedures at least annually revise them as necessary; and

   e. Maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

113.07 **Hospice Aide**

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A qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse. The facility shall ensure that each hospice aide is appropriately trained and competent to meet the needs of the patient per the plan of care. Documentation must be maintained on-site of all training and competency in accordance with patient plan of care.

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

    a. Provide assistance with mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, toileting, and/or housekeeping needs.

    b. Complete a clinical note for each visit, which must be incorporated into the record at least on a weekly basis.

2. Restrictions – The hospice aide shall not:

    a. Perform any intravenous procedures, procedures involving the use of Levine tubes or Foley catheters, or any other sterile or invasive procedures.

    b. Administer medications.

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

    a. Policies and objectives of the agency;

    b. Duties and responsibilities of a hospice aide;

    c. The role of the hospice aide as a member of the healthcare team;

    d. Emotional problems associated with terminal illness;

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e. The aging process;

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

g. Information on the emotional problems accompanying terminal illness;

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

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

j. Ethics; and

k. Confidentiality.

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

4. Training shall include the following areas of instruction:

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

b. Principles of nutrition and meal preparation;

c. Record keeping;

d. Procedures for maintaining a clean, healthful environment; and

e. Changes in the patients' condition to be reported to the supervisor.

5. In-service Training – The hospice aide must have a minimum of 12 hours of appropriate in-service training annually. In-service training may be prorated for employees working a portion of the year. However, part-time employee who worked throughout the year must attend all twelve (12) hours of in-service training.

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113.08 **Licensed Practical Nurse (LPN)**

The LPN must work under the direct supervision of a registered nurse and perform skilled services as delegated by the registered nurse.

1. Qualifications – A LPN must be currently licensed by the Mississippi State Board of Practical Nurse Examiners with no restrictions:

   a. With at least one year full time experience as an LPN. Two years of full time experience is preferred;

   b. Be an employee of the hospice agency.

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

   a. Observe, record, and report to the registered nurse or director of nurses on the general physical and mental conditions of the patient;

   b. Administer prescribed medications and treatments as permitted by State regulations;

   c. Assist the physician and/or registered nurse in performing procedures as per the patient's plan of care.

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

   e. Assist the patient with activities of daily living;

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

   g. Perform wound care and treatments as specified per nursing practice and if training competency is documented;

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h. Accepts verbal/written orders from the physician or nurse practitioner or physician's assistant in accordance with facility policies; and

i. Attend hospice IDT meetings.

3. Restrictions – An LPN shall not:

a. Access any intravenous appliance for any reason;

b. Perform supervisory aide visit;

c. Develop and/or alter the POC;

d. Make an assessment visit;

e. Evaluate recertification criteria;

f. Make aide assignments; or

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

113.09 **Medical Director/Physician Designee**

A physician, currently and legally authorized to practice medicine in the State, and knowledgeable about the medical and psychosocial aspects of hospice care. The Medical Director reviews, coordinates, and is responsible for the management of clinical and medical care for all patients.

NOTE: The Medical Director or Physician Designee may be an employee or a volunteer of the hospice agency. The hospice agency may also contract for the services of the Medical Director or Physician Designee.

1. Qualifications – A Doctor of Medicine or Osteopathy licensed to practice in the State of Mississippi.

2. Responsibilities – The Medical Director or Physician designee assumes overall responsibility for the medical component of the hospice's patient care program and shall include, but not be limited to:

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a. Serve as a consultant with the attending physician regarding pain and symptom control as needed;

b. Serve as the attending physician if designated by the patient/family unit;

c. Review patient eligibility for hospice services;

d. Participate in the review and update of the POC for each patient at a minimum of every 14 calendar days, unless the plan of care has been reviewed/updated by the attending physician who is not also the Medical Director or Physician Designee. These reviews must be documented.

e. Document the patient's progress toward the outcomes specified in the plan of care.

f. Serve as a medical resource for the hospice interdisciplinary group and as a liaison to physicians in the community;

g. Develop and coordinate procedures for the provision of emergency care;

h. Provide a system to assure continuing education for hospice medical staff as needed;

113.10 **Occupational Therapist**

1. Qualifications – An occupational therapist must be licensed by the State of Mississippi.

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

a. Provide occupational therapy in accordance with a physician's orders and the POC;

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

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c. Observe, record, and report to the physician and/or interdisciplinary group the patient's reaction to treatment and any changes in the patient's condition;

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

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

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

g. Prepare written discharge summary when applicable, with a copy retained in patient's clinical record.

3. Supervision of an Occupational Therapy Assistant

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

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

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

d. The supervising occupational therapist is responsible for assessing the competency and experience of the occupational therapy assistant;

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113.11 **Occupational Therapy Assistant (OTA)**

1. Qualifications – The occupational therapist assistant must be licensed in the State of Mississippi to assist in the practice of occupational therapy under the supervision of a licensed Registered Occupational Therapist and have at least two years experience as a licensed OTA.

113.12 **Physical Therapist (PT)**

The physical therapist when provided must be available to perform in a manner consistent with accepted standards of practice.

1. Qualifications – The physical therapist must be currently licensed in the State of Mississippi.

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

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

   b. Observe, and report to the physician and the IDT, the patient's reaction to treatment and any changes in the patient's condition;

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c. Instruct and inform participating member of the IDT, the patient, family/care givers, regarding the POC, functional limitations and progress toward goals;

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

e. Participate in IDT conference as needed with hospice staff.

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

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

h. The physical therapist shall assess the final treatment rendered to the patient at discharge and write a discharge summary with a copy retained in the clinical record.

3. Supervision of Physical Therapy Assistant (PTA)

a. The physical therapist shall make the initial visit with the PTA and conduct supervisory visits no later than every sixth treatment day.

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113.13 **Physical Therapy Assistant (PTA)**

1. Qualifications – A physical therapy assistant must be licensed by the Physical Therapy Board of Mississippi and supervised by a Physical Therapist.

2. Responsibilities – The physical therapy assistant shall:

   a. Provide therapy in accordance with the POC;

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

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

113.14 **Registered Nurse (RN)**

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

1. Qualifications – A licensed registered nurse must be currently licensed to practice in the State of Mississippi with no restrictions:

   a. Have at least one year full-time experience as a registered nurse or have been a licensed LPN employed for three years full-time working in a healthcare setting; and

   b. Be an employee of the hospice.

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

   a. Provide nursing services in accordance with the POC;

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

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c. Collaborate with the patient/family, attending physician and other members of the IDT in providing patient and family care;

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

e. Supervise ancillary personnel and delegate responsibilities when required;

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

g. Provide direct supervision of the Licensed Practical Nurse (LPN) in the home of each patient seen by the LPN at least once a month;

h. Make supervisory visits to the patient's residence at least every other week with the aide alternately present and absent, to provide direct supervision, to assess relationships and determine whether goals are being met. For the initial visit, the RN must accompany/assist the nurse aide;

i. If a hospice aide is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN;

j. Document supervision, to include the hospice aide relationships, services provided and instructions and comments given as well as other requirements of the clinical note;

k. Document annual performance reviews for the hospice aide. This performance review must be maintained in the individual's personnel record; and

l. Attend hospice IDT meetings.

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113.15 **Social Worker**

1. Qualifications – A minimum of a bachelor's degree from a school of social work accredited by the Council of Social Work Education. This individual must be licensed in the State of Mississippi.

   a. A minimum of one year documented clinical experience appropriate to the counseling and casework needs of the terminally ill.

   b. Must be an employee of the hospice.

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

   a. Assessment of the social and emotional factors having an impact on the patient's health status;

   b. Assist in the formulation of the POC;

   c. Provide services within the scope of practice as defined by state law and in accordance with the POC;

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

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

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

   g. Acts as a consultant to other member of the IDT;

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

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i. Attend hospice IDT meetings.

113.16 **Speech Pathology Services**

1. Qualifications – A speech pathologist must:

   a. Be licensed by the State of Mississippi; or

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

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

   a. Provide rehabilitative services for speech and language disorders;

   b. Observe, record and report to the physician and the IDT the patient's reaction to treatment and any changes in the patient's condition;

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

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

   e. Participate in hospice IDT meetings as needed;

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

g. Prepare written discharge summary as indicated, with a copy retained in patient's clinical record.

113.17 **Volunteers**

Volunteers that provide patient care and support services according to their experience and training must be in compliance with agency policies, and under the supervision of a designated hospice employee.

1. Qualifications – Volunteers who are qualified to provide professional services must meet all standards associated with their specialty area.

2. Responsibilities - The volunteer shall:

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

   b. Provide input into the plan of care and interdisciplinary group meetings, as appropriate;

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

   d. Maintain strict patient/family confidentiality; and

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

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

   a. An introduction to hospice;

   b. The role of the volunteer in hospice;

   c. Concepts of death and dying;

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d. Communication skills;

e. Care and comfort measures;

f. Diseases and medical conditions;

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

h. The concept of the hospice family;

i. Stress management;

j. Bereavement;

k. Infection control;

l. Safety;

m. Confidentiality;

n. Patient rights;

o. The role of the IDT; and

p. Additional supplemental training for volunteers working in specialized program (i.e. Nursing homes, AIDS facilities).

114 PATIENT CARE SERVICES

114.01 **Patient Care Standard**

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

2. Admission criteria – The hospice shall have written policies to be followed in making decisions regarding acceptance of patients for care. Decisions are based upon medical, physical, and psychosocial information provided by the patient's attending physician, the patient/family and the

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interdisciplinary group. The admission criteria shall include:

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

b. Certification of terminal illness signed by the attending physician and the medical director of the agency upon admission and recertification;

c. A documented assessment of the patient/family needs and desires for hospice services;

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

3. Admission Procedure – Patients are to be admitted only upon the order of the patient's attending physician.

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

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

1. Signed consent forms;

2. Documented evidence that a patient's rights statement has been given or explained to the patient and/or family;

3. Clinical data including physician's order for care;

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4. Patient Release of Information;

5. Orientation of the patient/care giver, which includes:

   a. Advanced directives;

   b. Agency services;

   c. Patient's rights; and

   d. agency contact procedures;

   e. Certification of terminal illness signed by the medical director and attending physician.

114.02 **Plan of Care (POC)**

1. Within 48 hours of the admission, a written plan of care must be developed for each patient/family by a minimum of two IDT members and approved by the full IDT and the Medical Director at the next meeting. The care provided to an individual must be in accordance with the POC.

   a. The IDT member who assesses the patient's needs must meet or call at least one other IDT member before writing the IPOC. At least one of the persons involved in developing the IPOC must be a registered nurse or physician.

   b. At a minimum the POC will include the following:

      1. An assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;

      2. In detail, the scope and frequency of services needed to meet the patient's and family's needs. The frequency of services established in the POC will be sufficient to effectively manage the terminal diagnosis of

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the patient, provide appropriate amounts of counseling to the family, and meet or exceed nationally accepted hospice standards of practice;

3. Identification of problems with realistic and achievable goals and objectives;

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

5. Patient/family understanding, agreement and involvement with the POC; and

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

c. The POC must be maintained on file as part of the individual's clinical record. Documentation of updates shall be maintained.

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

114.03 **Review and Update of the Plan of Care**

The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT and the attending physician.

1. Agency shall have policy and procedures for the following:

a. The attending physician's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between Hospice Staff and the attending physician;

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b. Physician orders must be signed and dated in a timely manner, but must be received before billing is submitted for each patient.

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

114.04 **Coordination and Continuity of Care**

1. The hospice shall adhere to the following additional principles and responsibilities:

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

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

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

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

e. Collaboration with other providers to ensure coordination of services;

f. Maintenance of professional management responsibility and coordination of the patient/family care regardless of the setting;

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

1. Radiation therapy;

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2. Infusion therapy;

3. Inpatient care;

4. Consulting physician.

h. Provision or access to emergency medical care;

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

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

k. Maintenance of appropriately qualified IDT health care professionals and volunteers to meet patients need;

l. Maintenance and documentation of a volunteer staff to provide administrative or direct patient care. The hospice must document a continuing level of volunteer activity;

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

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

o. Hospice care provided in accordance with accepted professional standards and accepted code of ethics;

p. The facility must proceed in accordance with written policy at the time of death of the patient.

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114.05 **Pharmaceutical Services**

1. Hospices must provide for the pharmaceutical needs of the patient as related to the terminal diagnosis.

2. The agency shall institute procedures which protect the patient from medication errors.

3. The Agency shall provide verbal and written instruction to patient and family regarding the administration of their medications, as indicated.

4. Drugs and treatments are administered by agency staff as ordered by the physician.

5. The hospice must ensure appropriate monitoring and supervision of pharmaceutical services and have written policies and procedures governing prescribing, dispensing, administering, controlling, storing and disposing of all biologicals and drugs in compliance with applicable laws and regulations.

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

7. The hospice must provide the IDT and the patient/family with coordinated information and instructions about individual drug profiles.

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114.06 **Pathology and Laboratory Services**

The hospice must provide or have access to pathology and laboratory services which comply with CLIA guidelines and that meets the patient's plan of care.

114.07 **Radiology Services**

The hospice must provide radiology services in accordance with the patient's plan of care.

114.08 **Discharge/Revocation/Transfer**

1. The hospice must provide adequate and appropriate patient/family information at discharge, revocation or transfer.

2. Discharge – The patient shall be discharged only in the following circumstance:

   a. The patient is determined to no longer be terminally ill with a life expectancy of six months or less;

   b. Patient relocates from the hospice's geographically defined service area;

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

   d. If the patient enters a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the patient chooses not to transfer to a facility with which the hospice has a contract, or to a hospice with which the SNF has a contract), the hospice shall then discharge the patient.

   e. The hospice must clearly document reasons for discharge.

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

   a. A recipient may revoke hospice care at any time;

   b. If a patient or representative chooses to revoke from hospice care, the patient must sign a statement which states that he or she is aware of the revocation and stating why revocation is chosen. The effective date of discharge cannot be earlier than the signed revocation date.

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

   a. The patient seeks or receives curative treatment for the illness;

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

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

5. Transfer – The hospice must document the reason for such transfer and an appropriate discharge plan/summary is to be written. Appropriate continuity of care is to be arranged prior to such transfer.

114.09 **Patient Rights and Responsibilities**

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

   a. Be cared for by a team of professionals who provide health quality comprehensive hospice services as needed and appropriate for patient/family;

   b. Have a clear understanding of the availability of hospice services and the hospice team 24 hours a day, seven days a week;

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c. Receive appropriate and compassionate care, regardless of diagnosis, race, age, gender, creed, disability, sexual orientation, place of residence, or the ability to pay for the services rendered;

d. Be fully informed regarding patient's status in order to participate in the POC. The hospice professional team will assist patient/family in identifying which services and treatments will help attain these goals;

e. Be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to patient/family personal wishes;

f. Refuse any treatment without severing his/her relationship with the hospice;

g. Choose his/her private physician as long as the attending physician agrees to abide by the policies of the hospice program;

h. Be treated with respect and dignity;

i. Confidentiality with regard to provision of services and all client records, including information concerning patient/family health status, as well as social, and/or financial circumstances. The patient information and/or records may be released only with patient/family's written consent, and/or as required by law;

j. Voice grievances concerning patient care, treatment and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the hospice; and

k. Be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible.

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2. The patient has the responsibility to:

   a. Participate in developing the POC and update as his or her condition/needs change;

   b. Provide hospice with his/her accurate and complete health information;

   c. Remain under a physician's care while receiving hospice services; and

   d. Assist hospice staff in developing and maintaining a safe environment in which patient care can be provided.

114.10 **Clinical Records**

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

2. All clinical records shall be safeguarded against loss, destruction and unauthorized use and shall be maintained at the hospice site issued the license. (S.O.M. 208.1)

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

4. Clinical records shall be kept in a safe and confidential area which provides convenient access to clinicians.

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

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6. Records shall be maintained from the patient's effective date of discharge, as per State law.

7. When applicable, the agency will obtain a signed "Release of Information" from the patient and /or the patient's family. A copy will be retained in the record.

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

   a. Initial and subsequent Plans of Care and initial assessment;

   b. Certifications of terminal illness;

   c. Written physician's orders for admission and changes to the POC;

   d. Current clinical notes (at least the past sixty (60) days;

   e. Plan of Care;

   f. Signed consent, authorization and election forms;

   g. Pertinent medical history; and

   h. Identifying data, including name, address, date of birth, sex, agency case number and next of kin.

9. Entries for all provided services must be documented in the clinical record and must be signed by the staff providing the service.

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

115 ADMINISTRATION

115.01 **Agency Operations**

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1. The hospice must have adequate space and resources for all operational and patient care needs.

2. The hospice shall not share office space with a non-healthcare related entity.

115.02 **Hours of Operation**

1. The hospice shall be required to have regular posted (in a prominent and easily accessible manner) business hours and be fully operational at least eight hours a day, five days a week between 7:00 a.m. and 6:00 p.m. Hospice services shall be available 24 hours per day, seven days a week, which include, at a minimum:

   a. Professional registered nurse services;

   b. Palliative medications;

   c. Other services, equipment or supplies necessary to meet the patient's immediate needs.

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

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115.03 **Policies and Procedures**

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

2. Must contain policies and procedures specific to the agency addressing personnel standards and qualifications, agency operations, patient care standards, problem and complaint resolution, purpose and goals of operation, management/operation of the hospice's defined service area and a formal disaster preparedness plan as referenced in Section 142.

115.04 **Contract Services**

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

2. The hospice shall not at any time use contract employees as administrator/alternate or for the provision of core services unless the facility provides documentation that a waiver has been granted in accordance with certification requirements.

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

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

   a. Identification of the services to be provided;

   b. A stipulation that services may be provided only with the express authorization of the hospice;

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

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

e. Requirements for documenting that services are furnished in accordance with the agreement;

f. The qualifications of the personnel providing the services;

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

h. Payment fees and terms; and

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

5. The hospice shall document review of its contract on an annual basis.

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

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

115.05 **Quality Assurance**

1. The hospice shall conduct an ongoing, comprehensive integrated self-assessment quality improvement process (inclusive of inpatient care, home care and respite care) which evaluates not only the quality of care provided, but also the appropriateness care/services provided and evaluations of such services. Findings shall be documented and used by the hospice to correct identified problems and to revise hospice policies.

2. The hospice shall have written plans, policies and procedures addressing quality assurance.

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3. The hospice shall designate, in writing, an individual responsible for the coordination of the quality improvement program.

4. The hospice shall conduct quality improvement meetings quarterly, at a minimum.

5. The Hospice's written plan for continually assessing and improving all aspects of operations must include:

   a. Goals and objectives;

   b. A system to ensure systematic, objective quarterly reports. Documentation must be maintained to reflect that such reports were reviewed with the IDT, the Medical Director, the Governing Body and distributed to appropriate areas;

   c. The method for evaluating the quality and the appropriateness of care;

   d. A method for resolving identified problems; and

   e. Application to improving the quality of patient care.

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

   a. Services provided by professional and volunteer staff;
   b. Outcome audits of patient charts;

   c. Reports from staff, volunteers, and clients about services;

   d. Concerns or suggestion for improvement in services;

   e. Organizational review of the hospice program;

   f. Patient/family evaluations of care; and

   g. High-risk, high-volume and problem-prone activities.

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7. The quality improvement plan must be reviewed at least annually and revised as appropriate.

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

9. The effectiveness of actions taken to improve services or correct identified problems must be evaluated/documented.

115.06 **Branch Offices**

1. No Branch Office may be opened without written approval from Mississippi State Department of Health.

2. No Branch Office shall be opened unless the parent office has had full licensure for a full twelve(12) months preceding the request and has admitted at least ten (10) patients within the last annual renewal cycle.

3. Each Branch must serve the same or part of the geographic service area approved for the parent.

4. Each Branch Office shall be open for business the same hours as required for the parent office, must have a registered nurse immediately available to be on site, or on site in the branch office at all times during operating hours.

5. All hospice patient's clinical records must be maintained at the hospice site issued the provider license (S.O.M. 208.1). Duplicate records may be maintained at the Branch Office.

6. Original personnel files are to be kept at the Parent office, but shall be made available, upon request, to federal/state surveyors during any review of the branch.

7. A statement of personnel policies is maintained in each Branch for staff usage.

8. Approval for Branch Offices will be issued, in writing, by Mississippi State Department of Health for one year and

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will be renewed at time of re-licensure, if the branch office meets the following criteria:

a. Is operational and providing hospice services;

b. Offer exact same services as the parent office; and

c. Parent office meets requirements for full licensure.

PART VI BASIC HOSPICE CARE

116 CORE SERVICES

116.01 Hospice care shall be provided by a hospice care team. Medical, nursing and counseling services are basic to hospice care and shall be provided directly (Medical Director only may be contract). Hospice care will be available twenty-four (24) hours a day, seven (7) days a week.

1. Medical services shall be under the direction of the Medical Director.

2. Nursing services shall be under the direction of a registered nurse and shall include, but not be limited to: assessment, planning and delivery of nursing care; carrying out physician's orders; documentation; evaluation of nursing care; and direction of patient care provided by non-professionals.

3. Counseling services shall be provided in a manner which best assists the patient and family unit to cope with the stresses related to the patient's condition. These services may be provided by a member of the clergy who is qualified through training and/or experience to provide such services, or by other qualified counselor(s). Such counselors shall be licensed, if applicable.

4. Social services shall be directed by a social worker, and shall consist primarily of assisting the patient and family unit to deal with problems of social functioning affecting the health or well-being of the patient.

117 OTHER SERVICES

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117.01 Coordination of patient care shall be the responsibility of a registered nurse of hospice care team. Duties include coordination of team meetings, care delivery, and evaluation of activities.

117.02 Spiritual services shall be available and offered to the patient and family unit; however, no value or belief system may be imposed.

117.03 Volunteer services shall be provided by the hospice. These services shall be provided according to written policies and procedures. These policies and procedures shall address at a minimum:

1. Recruitment and retention;
2. Screening;
3. Orientation;
4. Scope of function;
5. Supervision;
6. Ongoing training and support;
7. Documentation of volunteer activities.

117.04 Bereavement services shall be available for a period of at least one year following the patient's death. Such services shall be defined by policy. Documentation of such services shall be maintained.

117.05 Hospice aide services shall be available and adequate to meet the needs of the patient. The hospice aide shall meet the federal and state training requirements.

118 DISASTER PREPAREDNESS PLAN (Refer to Section 143)

119 MEDICAL WASTE (Refer to Section 138)

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120 RESPITE – INPATIENT CARE

120.01 If a hospice is not based in a licensed facility (hospital or nursing home); a contractual arrangement shall be made with one or more such facilities for provision of respite-inpatient services. Inpatient beds under such contract may be used by the hospice when needed or may remain otherwise available to the inpatient unit at other times without a change in licensing.

120.02 Such contract shall be maintained with an inpatient provider who contractually agrees to support the policies of hospice.

120.03 The hospice care team shall retain the responsibility for coordinating the patient's care during inpatient hospice care.

120.04 The aggregate number of inpatient days provided by a hospice through all contractual arrangements between the hospice and licensed health care facilities providing inpatient hospice care may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all patients receiving hospice care from the hospice during a twelve (12) month period.

120.05 The designation of a specific room or rooms for inpatient hospice care shall not be required if beds are available through contract between an existing healthcare facility and a hospice.

120.06 Licensed beds designated for inpatient hospice care through contract between an existing health care facility and a hospice shall not be required to be de-licensed from one type of bed in order to enter into a contract with a hospice, nor shall the physical plant of any facility be required to be altered, except that a homelike atmosphere may be required.

120.07 Staffing standards for inpatient hospice care provided through a contract may not exceed the staffing standards required under the license held by the contractee.

120.08 Under no circumstance may a hospice contract for the use of a licensed bed in a health care facility or another hospice that has, or has had within the last eighteen (18) months, a suspended, revoked or conditional license, accreditation or rating.

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121 IN-SERVICE TRAINING

121.01 The hospice shall provide ongoing, relevant in-service training for all members of the hospice care team. (For hospice aide training, refer to section titled Personnel Qualification/Responsibility.)

121.02 For each direct-care employee, the hospice shall require training of twelve (12) hours inservice education, at a minimum annually. Documentation of such training shall be maintained.

121.03 The hospice shall provide relevant inservice training on a quarterly basis for volunteers. Documentation of the offered inservices and attendees shall be maintained.

122 RECORDS

122.01 In accordance with acceptable principles of practice, the hospice shall establish and maintain a clinical record for every patient admitted for care and services. The records must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

122.02 **Content -** Each clinical record shall be comprehensive compilation of information. Entries shall be made for all services provided and shall be signed and dated within 7 days by the individual providing the services. The record shall include all services whether furnished directly or under arrangements made by the hospice. Each patient's record shall contain:

1. Identification data;
2. The initial and subsequent assessments;
3. The plan of care;
4. Consent and authorization forms;
5. Pertinent medical and psychosocial history;
6. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

122.03 **Protection of Information.** The hospice shall safeguard the clinical record against loss, destruction and unauthorized use.

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122.04 **Retention of Records**

Clinical records shall be preserved as original records, micro-films or other usable forms and shall be such as to afford a basis for complete audit of professional information. Complete clinical records shall be retained for a period after discharge of the patient of at least five (5) years. In the event the hospice shall cease operation, the Department shall be advised of the location of said records.

123 SUPPLIES AND EQUIPMENT

123.01 The hospice shall provide supplies and equipment related to the terminal illness.

124 DRUG ADMINISTRATION

124.01 The hospice shall have a written policy for procurement, administration and destruction of drugs.

124.02 Drug administration shall be in compliance with all applicable state and federal laws.

125 PHYSICAL FACILITIES

125.01 Each hospice office shall be commensurate in size for the volume of staff, patients, and services provided. Offices shall be well-lighted, heated and cooled. Offices shall be accessible to the individuals with disabilities.

126 ADMINISTRATIVE OFFICES

126.01 Each hospice shall provide adequate office space and equipment for all administrative and health care staff. An adequate number of desks, chairs, filing cabinets, telephones, tables, etc., shall be available.

127 STORAGE FACILITIES

127.01 Each Hospice shall provide sufficient areas for storage of:

1. Administrative records and supplies

2. Clinical Records

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3. Medical equipment and supplies

128 TOILET FACILITIES

128.01 Each hospice office shall be equipped with an adequate number of toilet rooms. Each toilet room shall include: lavatories, soap, towels, and water closets.

129 COMMUNICATION FACILITIES

129.01 Each Hospice Agency shall have an adequate number of telephones and extensions, located so as to be quickly accessible from all parts of the building. The telephone shall be listed under the official licensed name of the agency.

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PART VIII INPATIENT FACILITY

130 INPATIENT FACILITY

130.01 **Inpatient hospice staffing** – An inpatient hospice must maintain the coverage of a registered nurse twenty-four (24) hours a day. Other medical/nursing personnel must be available to meet the needs of the patients.

130.02 **Medical Director-Inpatient Services-**The hospice inpatient facility shall have a Medical Director who is a doctor of medicine or osteopathy and is currently licensed to practice medicine in Mississippi. The Medical Director must ensure and assume the overall responsibility for the medical component of the hospice's inpatient care services.

130.03 **Nursing Services-Inpatient Services-** The inpatient hospice facility shall provide an organized 24-hour nursing service.

130.04 The nursing service shall be under the direction of a Director of Nursing Services who is a registered nurse licensed to practice in Mississippi. The Director of Nurses is prohibited from simultaneous employment with more than one agency. Each facility shall provide a similarly qualified registered nurse available to act in the absence of the Director of Nursing Services. A registered nurse shall be responsible to assure the accurate assessment, development of a plan of care, implementation and evaluation of each patient's plan of care. Nursing care is administered and delegated in accordance with acceptable standards of nursing practice and the Mississippi Nurse Practice Act.

a) Nursing staff must be available on the premises twenty-four hours a day, seven days a week. There shall be a registered nurse on duty at all times when there are patients in the facility. When there are no patients in the facility, the hospice shall have a registered nurse on call to be immediately available. The facility shall provide sufficient nursing personnel to meet each patient's needs in accordance with the patient's plan of care.

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130.05 **Pharmaceutical Services of Inpatient Hospice**- The hospice shall provide pharmaceutical services in accordance with acceptable professional standards of nursing and pharmaceutical practice and State law. The hospice shall have policies and procedures that address receipt, storage, dispensing, labeling, medication administration, all aspects of controlled substance storage, usage, and disposal of controlled substances, the handling of medication errors and components for incorporating pharmacy practices into the facility's overall quality improvement plan.

1. Each inpatient pharmacy shall maintain a current pharmacy permit or registration, as applicable to the services offered.

131 FOOD SERVICE IN INPATIENT HOSPICE

131.01 **Direction and Supervision** – The inpatient hospice facility shall provide well-planned, attractive, and satisfying meals which will meet their nutritional, social, emotional, and therapeutic needs. The dietary department of a hospice shall be directed by a registered dietitian, certified dietary manager, or a qualified dietary manager. If a food service supervisor is the director, she must receive regularly scheduled consultation, at a minimum monthly, from a registered dietitian.

132 FOOD HANDLING PROCEDURES

132.01 **Clean Rooms** – Floors, walls, and ceilings of rooms in food service area shall be free of an accumulation of rubbish, dust, grease and dirt.

132.02 **Clean Equipment** – Equipment within the food service area shall be clean and free of dust, grease, and dirt.

132.03 **Tables and Counters** – Tables and counters which are used for food service shall be kept clean.

132.04 **Clean Utensils** – Service utensils shall be cleaned after each use. Utensils used for food storage shall be kept clean.

132.05 **Dish and Utensil Washing** – Dishes and utensils used for eating, drinking, and in preparation or serving food and drink shall be cleaned after each use in accordance with the regulations of the

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Mississippi State Department of Health governing food handling establishments.

132.06 **Ice** – Ice to be served shall be of sanitary quality. Ice shall be handled, crushed, and stored in clean equipment and shall not be served by direct contact of fingers or hands but only with spoons, scoops, or the like.

132.07 **Protection from Contamination** – All foods and food ingredients shall be so stored, handled, and served so as to be protected from dust, flies, roaches, rats, unsanitary handling, droplet infection, overhead leakage, sewage backflow and any other contamination. Sugar, syrup and condiment receptacles shall be provided with lids and shall be kept covered when not in use.

132.08 **Storage and Service of Milk and Ice Cream**

1. All milk and fluid milk products shall be stored and served in accordance with regulations of the Department of Health governing the production and sale of milk and milk products.

2. All ice cream and other frozen desserts shall be from an approved source. Ice cream shall be stored in covered containers. No contaminating substance shall be stored with ice cream.

132.09 **Kitchen Garbage and Trash Handling**

1. Kitchen garbage and trash shall be placed in suitable containers with tight-fitting lids and stored in a screened or refrigerated space pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals.

2. After being emptied, all garbage and trash cans shall be washed and dried before re-use.

132.10 **Employee Cleanliness**

1. Employees engaged in handling, preparation, and/or serving of food shall wear clean clothing at all times. They shall wear hair nets, head bands, or caps to prevent the falling of hair.

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2. Employee handling food shall wash their hands thoroughly before starting to work, immediately after contact with any soiled matter, and before returning to work after each visit to the toilet room.

3. Street clothing of employees shall be stored in lockers or dressing rooms.

132.11 **Smoking and Expectorating** – Smoking or expectorating within the food service area shall not be permitted.

132.12 **Dining in Kitchen** – Eating or dining in the food preparation area or kitchen shall not be permitted.

133 MEAL SERVICE

133.01 **Meals and Nutrition** – At least three (3) meals in each twenty-four (24) hours shall be provided. The daily food allowance shall meet the current recommended dietary allowances of the Food and Nutrition Board of National Research Council adjusted for individual needs.

133.02 **Menu** – The menu shall be planned and written at least one (1) week in advance. The current week's menu shall be signed by the dietitian, dated, posted in the kitchen and followed as planned. Substitutions and changes on all diets shall be documented in writing. Copies of menus and substitutions shall be kept on file for at least thirty (30) days.

133.03 **Timing of Meals** – A time schedule for serving meals to patients or residents and personnel shall be established. Meals shall be served approximately five (5) hours apart with no more than fourteen (14) hours between a substantial evening meal and breakfast. The time schedule of meals shall be posted with the menu on the board. Bedtime/in between meal snacks of nourishing quality must be offered to patients not on diets prohibiting such nourishment.

133.04 **Modification in Regular Diets** – Modified diets which are a part of medical treatment shall be prescribed in written orders by the physician, for example; sodium restricted diets; bland-low residue diets; and modification in carbohydrates, protein, or fat. All modified diets shall be planned in writing and posted along with regular menus. A current diet manual shall be available to

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personnel. The registered dietitian shall approve all modified diet menus and diet manual used in the facility.

133.05 **Food Preparation** – Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. The food shall be acceptable to the individuals served.

133.06 **Food Supply** – Supplies of perishable foods for at least a twenty-four (24) hour period and or non-perishable foods for a three (3) day period shall be on the premises to meet the requirements of the planned menus. The non-perishable foods shall consist of commercial type processed foods.

133.07 **Serving of Meals**

1. Tables should be made available for all patients. Patients who are not able to go to the dining room shall be provided sturdy tables (not TV trays) of proper heights. For those who are bedfast or infirm, tray service shall be provided in their rooms with the tray resting on a firm support.

2. Personnel eating meals or snacks on the premises shall be provided facilities separate from and outside of food preparation, tray service and dish washing areas.

3. Foods shall be attractively and neatly served. All foods shall be served at proper temperature. Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving.

4. All trays, tables, utensils and supplies such as china, glassware, flatware, linens and paper placemats or tray covers used for meal service shall be appropriate, sufficient in quantity and in compliance with the applicable sanitation standard.

5. **Food Service personnel**- A competent person shall be designated by the administrator to be responsible for the total food service. Sufficient staff shall be employed to meet the established standards of food service. Provision should be made for adequate supervision and training of the employee.

134 PHYSICAL PLANT FACILITIES

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134.01 **Floors** – Floors in food service areas shall be of such construction so as to be easily cleaned, sound, smooth, non-absorbent and without cracks or crevices. Floors shall be maintained in good repair.

134.02 **Walls and Ceilings** – Walls and ceilings of food service areas shall be tight and of substantial construction, smoothly finished and painted in a light color. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows that will prevent the entrance of rain or dust during inclement weather.

134.03 **Screens on Outside Openings** – Openings to the outside shall be effectively screened. Screen doors shall open outward and be equipped with self-closing devices.

134.04 **Lighting** – The kitchen, dish washing area, and dining room shall be provided with well distributed and unobstructed natural light or openings. Artificial light properly distributed and of an intensity of not less than thirty (30) foot candles shall be provided.

134.05 **Ventilation** – The food service area shall be ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes, and prevent excessive condensations.

134.06 **Employee Toilet Facilities** – Toilet facilities shall be provided for employees. Toilet rooms shall not open directly into any room in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall have a lavatory and shall be well lighted and ventilated.

134.07 **Hand Washing Facilities** – Hand washing facilities with hot and cold water, soap dispenser and a supply of soap and disposable towels shall be provided in all kitchens. The use of a common towel is prohibited. Hands shall not be washed in sinks where food is prepared or where utensils are cleaned.

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134.08 **Refrigeration Facilities** – Adequate refrigeration facilities, automatic in operation, for the storage of perishable foods shall be provided. Where separate refrigeration can be provided, the recommended temperatures for storing perishable foods are thirty-two (32 degrees) to thirty-eight (38 degrees) Fahrenheit for meats, forty (40 degrees) Fahrenheit for dairy products, and forty-five (45 degrees) Fahrenheit for fruits and vegetables. All refrigerators shall be provided with thermometers. Facilities with more than twenty-four (24) beds shall have commercial or institutional type refrigeration.

134.09 **Equipment or Utensil Construction** – Equipment and utensils shall be constructed so as to be easily cleaned and shall be kept in good repair.

134.10 **Separation of Kitchen from Resident Rooms and Sleeping Quarters** – Any room used for sleeping quarters shall be separated from the food service area by a solid wall. Sleeping accommodations such as a cot, bed, or couch shall not be permitted within the food service area.

135 AREAS AND EQUIPMENT

135.01 **Location and Space Requirements** – Food service facilities shall be located in a specifically designated area and shall include the following rooms and/or spaces: kitchen, dishwashing, food storage, and dining room.

135.02 **Kitchen**

1. **Size and Dimensions** – The minimum area of kitchen (food preparation only) for less than twenty-five (25) beds shall be two hundred (200) square feet. In facilities with twenty-five (25) to sixty (60) beds, a minimum area of ten (10) square feet per bed shall be provided. In facilities with sixty-on (61) to eighty (80) beds, a minimum of six (6) square feet per bed shall be provided for each bed over sixty (60). In facilities with eighty-one (81) to one hundred (100) beds, a minimum of five (5) square feet per bed shall be provided for each bed over eighty (80). In facilities with more than one hundred (100) beds, proportionate space as approved by the licensing agency shall be provided. The kitchen shall be of such size and dimensions in order to:

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a. Permit orderly and sanitary handling and processing of food;

b. Avoid overcrowding and congestion of operations;

c. Provide at least three (3) feet between working areas and wider if space is used as a passageway;

d. Provide a ceiling height of at least eight (8) feet.

2. **Minimum equipment** in kitchen shall include:

a. Range and cooking equipment – Facility with more than twenty-four (24) beds shall have institutional type ranges, ovens, steam cookers, fryers, etc., in appropriate sizes and numbers to meet the food preparation needs of the facility. The cooking equipment shall be equipped with a hood vented to the outside as appropriate.

b. Refrigerator and freezers – Facilities with more than twenty-four (24) beds shall have sufficient commercial or institutional type refrigeration/freezer units to meet the storage needs of the facility.

c. Bulletin Board

d. Clock

e. Cook's table

f. Counter or table for tray set-up

g. Cans, garbage (heavy plastic or galvanized)

h. Lavatories, hand washing; conveniently located throughout the department

i. Pot, pans, silverware, dishes, and glassware in sufficient numbers with storage space for each.

j. Pot and pan sink – A three compartment sink shall be provided for cleaning pots and pans. Each compartment shall be a minimum of twenty-four

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(24) inches by twenty-four (24) inches by sixteen (16) inches. A drain board of approximately thirty (30) inches shall be provided at each end of the sink, one to be used for stacking soiled utensils and the other for draining clean utensils.

k. Food Preparation Sink – A double compartment food preparation sink shall be provided for washing vegetables and other foods. A drain board shall be provided at each end of the sink.

l. Fire extinguisher, 20 BC rated (sodium bicarbonate or potassium bicarbonate)

m. Ice machine – At least one ice machine shall be provided. If there is only one (1) ice machine in the facility, it shall be located adjacent to but not in the kitchen. If there is an ice machine located at nursing station, then the ice machine for dietary shall be located in the kitchen.

n. Office – An office shall be provided near the kitchen for the use of the food service supervisor. At a minimum, the space provided shall be adequate for a desk, two chairs and a filing cabinet.

o. Coffee, tea and milk dispenser – (Milk dispenser not required if milk is served in individual cartons.

p. Tray assembly line equipment with tables, hot food tables, tray slide, etc.

q. Ice Cream Storage

r. Tray cart – (Hot food carts are desirable but not specifically required.)

s. Mixer – Institutional type mixer of appropriate size for facility.

135.03 **Dishwashing** – Commercial or institutional type dishwashing equipment shall be provided in facilities with more than twenty-four (24) beds. The dishwashing area shall be separated from the food preparation area by a partition wall. If sanitizing is to be accomplished by hot water, a minimum temperature of one

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hundred eighty degrees (180o) Fahrenheit shall be maintained during the rinsing cycle. An alternate method of sanitizing through use of chemicals (chlorine) may be provided if sanitizing standards are observed in accordance with requirements as set forth by the Mississippi State Department of Health. Adequate counter space for stacking soiled dishes shall be provided in the dishwashing area at the most convenient place of entry from the dining room, followed by a disposer with can storage under the counter. There shall be a pre-rinse sink, then the dishwasher and finally a counter or drain for clean dishes. The dishwashing areas shall have a wall or partition separating soiled and clean dish areas.

135.04 **Food Storage** – A food-storage room with cross-ventilation shall be provided. Adequate shelving, bins and heavy plastic or galvanized cans shall be provided. The storeroom shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water leakage, or any other source of contamination. The food-storage room should be adjacent to the kitchen and convenient to the receiving area. There shall be sufficient food storage area to meet need of the facility.

136 SANITATION AND HOUSEKEEEPING IN PATIENT CARE

136.01 **Water Supply**

1. If at all possible, all water shall be obtained from a public water supply. If not possible to obtain water from a public water supply source, the private water supply shall meet the approval of the local county health department and/or the Department of Health.

2. Water under pressure sufficient to operate fixtures at the highest point during maximum periods shall be provided. Water under pressure of at least fifteen (15) pounds per square inch shall be piped to all sink, toilets, lavatories, tubs, showers, and other fixtures requiring water.

3. It is recommended that the water supply into the building can be obtained from two (2) separate water lines if possible.

4. A dual hot water supply shall be provided. The temperature of hot water to lavatories and bathing facilities shall not exceed one hundred ten degrees (110 degrees)

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Fahrenheit, nor shall hot water be less than one hundred degrees (100 degrees) Fahrenheit.

136.02 **Disposal of Liquid and Human Wastes**

1. There shall be installed within the building a properly designed waste disposal system connecting to all fixtures to which water under pressure is piped.

2. All liquid and human waste, including floor-wash water and liquid waste from refrigerators, shall be disposed of through trapped drains into a public sewer system where such system is available.

3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed of through trapped drains into a sewerage disposal system approved by the local county health department and/or the Department of Health. The sewerage disposal system shall be of a size and capacity based on the number of patients and personnel housed and employed in the facility. Where the sewerage disposal system is installed prior to the opening of the facility, it shall be assumed, unless proven otherwise, that the system was designed for ten (10) or fewer persons.

136.03 **Premises** –The premises shall be kept neat, clean, and free of an accumulation of rubbish, weeds, ponded water, or other conditions which would have a tendency to create a health hazard.

136.04 **Control of Insects, Rodents, Etc.** – The institution shall be kept free of ants, flies, roaches, rodents, and other insects and vermin. Proper methods of eradication and control shall be utilized through contract with a reputable licensed pest control company.

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136.05 **Toilet Room Cleanliness** – Floors, walls, ceilings and fixtures of all toilet rooms shall be kept clean and free of objectionable odors. These rooms shall be kept free of an accumulation of rubbish, cleaning supplies, toilet articles, etc.

136.06 **Garbage Disposal**

1. Garbage must be kept in water-tight suitable containers with tight fitting covers. Garbage containers must be emptied at frequent intervals and cleaned before using again.

2. Proper disposition of infectious materials shall be observed.

137 HOUSEKEEPING AND PHYSICAL PLANT MAINTENANCE

137.01 **Housekeeping Facilities and Services**

1. The physical plant shall be kept in good repair, neat and attractive. The safety and comfort of the patient shall be the first consideration.

2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store cleaning supplies and equipment. A separate janitor closet area and equipment shall be provided for the food service area.

137.02 **Bathtubs, Showers, and Lavatories** – Bathtubs, showers, and lavatories shall be kept clean and in proper working order. They shall not be used for laundering or for storage of soiled materials. Neither shall these facilities be used for cleaning mops, brooms, etc.

137.03 **Patient Bedrooms** – Patient bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. All sweeping should be damp sweeping. All dusting should be damp dusting with a good germicide or detergent-germicide.

137.04 **Storage**

1. Such items as beds, mattresses, mops, mop buckets, dust rags, etc. shall not be kept in hallways, corners, toilet or bathrooms, clothes closets, or patient bedrooms.

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2. The use of attics for storage of combustible materials is prohibited.

3. If basements are used for storage, they shall meet acceptable standards for storage and for fire safety.

138 MEDICAL WASTE

138.01 **Regulated Medical Waste** "Infectious Medical Wastes" includes solid or liquid wastes which may contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host has been proven to result in an infectious disease. For purposes of this Regulation, the following wastes shall be considered to be infectious medical wastes:

1. Wastes resulting from the care of patients and animals who have Class I and/or II diseases that are transmitted by blood and body fluid as defined in the rules and regulations governing reportable diseases as defined by the Mississippi State Department of Health;

2. Cultures and stocks of infectious agents; including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

3. Blood and blood products such as serum, plasma, and other blood components;

4. Pathological wastes, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

5. Contaminated carcasses, body parts, and bedding of animals that were exposed to pathogens in medical research;

6. All discarded sharps (e.g., hypodermic needles, syringes, Pasteur pipettes, broken glass, scalpel blades) which have come into contact with infectious agents;

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7. Other wastes determined infectious by the generator or so classified by the Mississippi State Department of Health.

138.02 **Medical Waste** – Means all waste generated in direct patient care or in diagnostic or research areas that is non-infectious but aesthetically repugnant if found in the environment.

138.03 **Medical Waste Management Plan** – All generators of infectious medical waste and medical waste shall have a medical waste management plan that shall include, but is not limited to, the following:

138.04 **Storage and Containment of Infectious Medical Waste and Medical Waste**

1. Containment of infectious medical waste and medical waste shall be in a manner and location which affords protection from animals, rain and wind, does not provide a breeding place or a food source for insects and rodents, and minimizes exposure to the public.

2. Infectious medical waste shall be segregated from other waste at the point of origin in the producing facility.

3. Unless approved by the Mississippi State Department of Health or treated and rendered non-infectious, infectious medical waste (except for sharps in approved containers) shall not be stored at a waste producing facility for more than seven days above a temperature of 60 C (38 degrees F). Containment of infectious medical waste at the producing facility is permitted at or below a temperature of 0 degrees C (32 degrees F) for a period of not more than 90 days without specific approval of the Department of Health.

4. Containment of infectious medical waste shall be separate from other wastes. Enclosures or containers used for containment of infectious medical waste shall be so secured so as to discourage access by unauthorized persons and shall be marked with prominent warning signs on, or adjacent to, the exterior of entry doors, gates, or lids. Each container shall be prominently labeled with a sign using language to be determined by the Department and legible during daylight hours.

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5. Infectious medical waste, except for sharps capable of puncturing or cutting, shall be contained in double disposable plastic bags or single bags (1.5 mills thick) which are impervious to moisture and have strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid waste during storage, handling or transport.

6. All sharps shall be contained for disposal in leak proof, rigid, puncture-resistant containers which are taped closed or tightly lidded to preclude loss of the contents.

7. All bags used for containment and disposal of infectious medical waste shall be of distinctive color or display the Universal Symbol for infectious waste. Rigid containers of all sharps waste shall be labeled.

8. Compactors or grinders shall not be used to process infectious medical waste unless the waste has been rendered non-infectious. Sharps containers shall not be subject to compaction by any compacting device except in the institution itself and shall not be placed for storage or transport in a portable or mobile trash compactor.

9. Infectious medical waste and medical waste contained in disposable containers, as prescribed above, shall be placed for storage, handling or transport in disposable or reusable pails, cartons, drums or portable bins. The containment system shall be leak proof, have tight-fitting covers and be kept clean and in good repair.

10. Reusable containers for infectious medical waste and medical waste shall be thoroughly washed and decontaminated each time they are emptied by a method specified by the Mississippi State Department of Health, unless the surfaces of the containers have been protected from contamination by disposable liners, bags, or other devices removed with the waste, as outlined in E.

11. Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with one or more of the following procedures:

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a. Exposure to hot water at least 180 F for a minimum of 15 seconds.

b. Exposure to a chemical sanitizer by rinsing with or immersion in one of the following for a minimum of 3 minutes:

1. Hypochlorite solution (500 ppm available chlorine).

2. Phenolic solution (500 ppm active agent).

3. Iodoform solution (100 ppm available iodine).

4. Quaternary ammonium solution (400 ppm active agent).

12. Reusable pails, drums or bins used for containment of infectious waste shall not be used for containment of waste to be disposed of as non-infectious waste or for other purposes except after being decontaminated by procedures as described in part (J) of this section.

13. Trash chutes shall not be used to transfer infectious medical waste.

14. Once treated and rendered non-infectious, previously defined infectious medical waste will be classified as medical waste and may be landfilled in an approved landfill.

138.05 **Treatment Or Disposal Of Infectious Medical Waste Shall Be by One Of the Following Methods:**

1. By incineration in an approved incinerator which provides combustion of the waste to carbonized or mineralized ash.

2. By sterilization by heating in a steam sterilizer, so as to render the waste non-infectious. Infectious medical waste so rendered non-infectious shall be disposable as medical waste. Operating procedures for steam sterilizers shall include, but not be limited to the following:

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a. Adoption of standard written operating procedures for each steam sterilizer including time, temperature, pressure, type of waste, type of container(s), closure on container(s), pattern of loading, water content, and maximum load quantity;

b. Check or recording and/or indicating thermometers during each complete cycle to ensure the attainment of a temperature of 121 C (250 degrees F) for one-half hour or longer, depending on quantity and density of the load, in order to achieve sterilization of the entire load. Thermometers shall be checked for calibration at least annually;

c. Use of heat sensitive tape or other device for each container that is processed to indicate the attainment of adequate sterilization conditions;

d. Use of the biological indicator Bacillus stearothermophilus placed at the center of a load processed under standard operating conditions at least monthly to confirm the attainment of adequate sterilization conditions;

e. Maintenance of records of procedures specified in (a), (b), (c) and (d) above for period of not less than a year;

3. By discharge to the approved sewerage system if the waste is liquid or semi-liquid, except as prohibited by the Mississippi State Department of Health.

4. Recognizable human anatomical remains shall be disposed of by incineration or internment, unless burial at an approved landfill is specifically authorized by the Mississippi State Department of Health.

Chemical sterilization shall use only those chemical sterilants recognized by the U. S. Environmental Protection Agency, Office of Pesticides and Toxic Substances. Ethylene oxide, glutaraldehyde, and hydrogen peroxide are examples of sterilants that, used in accordance with manufacturer recommendation, will render infectious waste non-infectious. Testing with Bacillus Subtilis Spores or other equivalent organisms shall be conducted quarterly to

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ensure the sterilization effectiveness of gas or steam treatment.

138.06 **Treatment and Disposal of Medical Waste Which Is Not Infectious Shall be By One Of The Following:**

1. By incineration in an approved incinerator which provides combustion of the waste to a carbonized or mineralized ash; or

2. By sanitary landfill, in an approved landfill which shall mean a disposal facility or part of a facility where medical waste is placed in or on land and which is not a treatment facility. All the requirements of these standards shall apply, without regard to the quantity of medical waste generated per month, to any generator of medical waste.

139 LAUNDRY- INPATIENT FACILITY

139.01 **Direction and Supervision** Responsibility for laundry services shall be delegated to a competent employee.

140 PHYSICAL FACILITY

140.01 **Location and Space Requirements** Each inpatient hospice shall have laundry facilities unless commercial laundries are used. The laundry shall be located in specifically designated areas and there shall be adequate room and space for sorting, processing and storage of soiled material. There should be a separate storage area for provided for soiled linens apart from the clean linens laundry. Laundry rooms or soiled linen storage areas shall not open directly into a patient bedroom or food service area. Soiled materials shall not be transported through the food service area. If commercial laundry is used, separate satisfactory storage areas shall be provided for clean and soiled linens.

140.02 **Ventilation** – Provisions shall be made to prevent the recirculation of air through the heating and air condition systems.

140.03 **Lint Traps** – Lint traps in driers shall be maintained free of lint and debris,

140.04 **Laundry Chutes** – When laundry chutes are provided they shall have a minimum diameter of two (2) feet; and they shall be installed with flushing ring, vent and drain.

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1. An automatic sprinkler shall be provided at the top of the laundry chute and in any receiving room for a chute.

2. A self-closing door shall be provided at the bottom of the chute.

140.05 **Laundry Equipment** –Laundry equipment shall be of the type to adequately perform the laundry needs of the facility. The equipment shall be installed to comply with all local and state codes.

141 PHYSICAL FACILITIES

141.01 DESIGN AND CONSTRUCTION ELEMENTS

141.02 **General**. Every institution subject to these Minimum Standards shall be housed in a safe building which contains all the facilities required to render the services contemplated in the application for license.

141.03 **Codes**. The term "safe" as used in Section 601 hereof shall be interpreted in the light of compliance with the requirements of the codes recognized by this agency on date of construction which are incorporated by reference as a part of these Minimum Standards; included are the Life Safety Code of the National Fire Protection Association, American National Standards Institute, Standards Number A-17.1, and A-17.3, Safety Code for Elevators and Escalators, the American Institute of Architects (AIA), Guidelines for Design and Construction of Hospital and Health Care Facilities, and references incorporated as body of all afore mentioned standards. Life Safety Code compliance relative to construction date:

1. Buildings constructed after October 17, 2007 shall comply with the edition of the Life Safety Code (NFPA 101) recognized by this agency on the date of construction.

2. Building constructed prior to October 17, 2007 shall comply with existing chapter of the Life Safety Code recognized by this agency.

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For minimum standards governing Heating, Ventilation, and Air Conditioning (HVAC), area design, space allocation, parking requirements, and other considerations not specifically addressed by local authority or standards referenced herein, compliance with the AIA guidelines will be deemed acceptable.

141.04 **Location** – All inpatient hospices established or constructed after the adoption of these regulations shall be located in an area free from undue noise, smoke, dust, or foul odors and shall not be located adjacent to disposal plants, cemeteries, etc.

141.05 **Site** – The proposed site for an inpatient hospice must be approved by the Department of Health. Prior to construction/renovation, all proposed plans and sites must be submitted and approved by the Mississippi State Department of Health, Fire Safety and Construction Branch. Factors to be considered in approving a site may be convenience to medical and hospital services, approved water supply and sewerage disposal, community services, services of a fire department, and availability to labor supply. Not more than 50% of a site shall be covered by a building(s) except by special approval of the Department of Health.

One example whereby approval may be granted is where the structure is to be placed in a very desirable location where the grounds are limited and very expensive. Where such approval is granted, the structure will be required to have a living room, day room, sun room, and recreational areas adequate to compensate for lack of required outside area.

141.06 **Local Restrictions** – The site and structure of all facilities shall comply with local building, fire and zoning ordinances. Evidence to this effect signed by local building, fire, and zoning officials shall be presented, where applicable.

141.07 **Transportation** – Facilities shall be located on streets or roads which are passable at all times. They should be located convenient to public transportation facilities, when applicable.

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141.08 **Communication** – There shall be at least one electrically interconnected hardwire telephone in the facility and such additional telephones as are necessary to summon help in the event of a fire or other emergency. The telephone shall be listed under the official licensed name or title of the facility.

141.09 **Occupancy** – No part of the facility may be rented, leased, or used for any commercial purpose not related to the operation of the facility.

141.10 **Basement** -No patient or resident shall be housed on any floor that is below ground level at any point.

141.11 **Call System** – Some type of signal for summoning aid shall be conveniently provided for each patient.

142 BUILDING REQUIREMENTS

142.01 **One-Story Building Non-Combustible Construction**

1. One-hour fire resistive rating generally. After adoption of these regulations, one-story buildings shall be of at least one-hour fire resistive rating throughout except as provided in subparagraph of this section ("hazardous areas and combustible storage").

2. Hazardous areas and combustible storage. All areas used for storage of combustible materials shall be classified as hazardous areas and shall be separated from other areas by construction having a fire resistive rating of at least two (2) hours.

142.02 **Multi-Story Building**

1. Fire resistive construction. After adoption of these regulations all institutions for the aged or infirm containing two (2) or more stories shall be of at least one-hour fire resistive construction throughout except as provided in 140.1 (2).

2. Elevator required. No patient shall be housed above the first floor unless the building is equipped with an elevator. The minimum cab size of the elevator shall be approximately five (5) feet four (4) inches by eight (8) feet

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no (0) inches and constructed of metal. The width of the shaft door shall be at least three (3) feet ten (10) inches. The load weight capacity shall be at least two thousand five hundred (2,500) pounds. The elevator shaft shall be enclosed in fire resistant construction of not less than two-hour fire resistive rating. Elevators shall not be counted as required exits. Elevators are subject to the requirements of the referenced standard listed in paragraph 139.2 of this chapter. Exceptions to sub-paragraphs 1 and 2 may be granted to existing facilities at the discretion of the licensing agency.

142.03 **Building Codes** – All construction shall be in accordance with applicable local building codes and regulations and with these regulations.

142.04 **Structural Soundness and Repair; Fire Resistive Rating** – The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted at sufficient intervals to be reasonably attractive inside and out. One-story structures shall have a one-hour fire resistance rating except that walls and ceilings of high fire hazard areas shall be of two-hour fire resistance rating in accordance with NFPA #220. Multi-storied buildings shall be of fire resistive materials.

142.05 **Temperature** – Adequate heating and cooling shall be provided in all rooms used by patients so that a minimum temperature of seventy-five (75 degrees) to eighty (80 degrees) Fahrenheit may be maintained.

142.06 **Lighting** – Each patient's room shall have artificial light adequate for reading and other uses as needed. All entrances, corridors, stairways, ramps, cellars, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service. Night lights shall be provided in all corridors, stairways, toilets, and bathing rooms.

142.07 **Emergency power / Lighting** – To provide electricity during an interruption of the normal electric supply that could affect the medical care, treatment and safety of the occupants, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. The source of the emergency electric service shall be an emergency generator, with a stand-by supply of fuel for 24 hours.

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142.08 **Screens** – All screen doors and non-stationary windows shall be equipped with tight fitting, full length, sixteen (16) mesh screens. Screen doors shall swing out and shall be equipped with self-closing devices.

142.09 **Floors** – All floors shall be smooth and free from defects such as cracks and be finished so that they can be easily cleaned. Floors in corridors, patient bedrooms, toilets, bathing rooms, kitchens, utility rooms, and other areas where frequent cleaning is necessary should be covered wall-to-wall with inlaid linoleum, resilient tile, hard tile, or the equivalent.

142.10 **Walls and Ceilings** –All walls and ceilings shall be of sound construction with an acceptable surface and shall be maintained in good repair. Generally the walls and ceilings should be painted a light color.

142.11 **Ceiling Height** – All ceilings shall have a height of at least eight (8) feet except that a height of seven (7) feet six (6) inches may be approved for corridors or toilets and bathing rooms where the lighting fixtures are recessed. Exception may be made for existing facilities.

142.12 **Handrails** – Handrails shall be installed on both sides of all corridors and hallways used by patients. The handrails should be installed from thirty-two (32) inches to thirty-six (36) inches above the floor. The handrails should have a return to the wall at each rail ending.

142.13 **Ramps and Inclines** – Ramps and inclines, where installed for the use of patients, shall not exceed one (1) foot of rise in ten (10) feet of run, shall be furnished with a non-slip floor, and shall be provided with handrails on both sides.

142.14 **Stairways**

1. Stairways shall have a minimum width of forty-four (44) inches with risers not to exceed seven and three-fourths (7¾) inches and treads not less than nine (9) inches. Treads shall be of uniform width and risers of uniform height in any one flight of stairs. All stairways and stairway landings shall be equipped with handrails on both sides.

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2. A landing with width not less than the width of the stairs shall be provided at the top and bottom of each flight of stairs.

3. Winding stairways or triangular treads are prohibited.

4. Stairways shall be enclosed with noncombustible materials of at least two-hour fire resistance rating.

5. Openings to stairways shall be equipped with doors with self-closing devices.

6. Doors to stairways shall open in the direction of exit travel and be equipped with a vision window of wired glass. The doors shall open on a landing of the same width as the stair width.

7. Stairways shall be individually enclosed and separated from any public hall.

142.15 **Corridors and Passageways**

1. Corridors in patient areas shall be not less than eight (8) feet wide. Exception may be granted to existing structures where it is structurally or feasibly impossible to comply.

2. Exit Passageways other than corridors in patient areas shall be not less than four (4) feet wide between handrails.

3. Corridors and passageways shall be kept unobstructed.

4. Corridors and passageways which lead to the outside from any required stairway shall be enclosed as required for stairways.

142.16 **Doors General**

1. All stairway doors; doors providing egress from corridors (other than to the exterior) and all doors to shafts, utility closets, boiler and incinerator rooms, in fire walls, and other spaces which are a possible source of fire shall be equal to Underwriters' Laboratories "Class B-1 ½ hour" self-closing doors.

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2. All corridor doors except doors to janitor closets, toilets, and bathrooms shall be 20 minute rated fire doors or solid wooden doors of the flush type of nominal thickness of at least one and three-fourths (1 3/4 inches)

3. Bedroom, patient bath, and toilet doors shall not be equipped with hardware that will allow a patient to lock himself within the room.

142.17 **Exit Doors** – Exit doors shall meet the following:

1. They shall be of a fire resistive rating equal to the stairway or passage.

2. Doors leading to stairways shall be not less than forty-four (44) inches wide.

3. Doors to the exterior shall be not less than forty-four (44) inches wide except where the capacity of a first floor exceeds sixty (60) persons or a floor above the first floor exceeds thirty (30) persons in which case wider doors maybe required.

4. Exit doors shall swing in the direction of exit and shall not obstruct the travel along any required exit.

5. Revolving doors shall not be used as required exits.

142.18 **Door Widths** – All exit doors shall be a minimum of forty-four (44) inches wide and open outward. Doors to patient bedrooms shall be a minimum of forty-four (44) inches wide. All other doors through which patients must pass (doors to living and day rooms, dining rooms, recreational areas, toilet and bathrooms, physical and occupational therapy rooms, etc.) shall be a minimum of thirty-six (36) inches wide. Doors to patient closets shall be not less than twenty (20) inches wide. Exception may be granted to existing facilities.

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142.19 **Door Swing**

1. Exit doors, other than from a living unit, shall swing in the direction of exit from the structure.

2. Patient bedroom doors. Patient bedroom doors opening from a corridor shall open to the inside of the room.

3. Toilet or bathroom doors. Doors to toilet and bathrooms accessible from the patient's bedroom shall open into the room. Doors to toilet or bathroom accessible from a corridor shall open into the toilet or bathroom.

142.20 **Floor levels** – All differences in floor levels within the building shall be accomplished by stairs of not less than three (3) six-inch risers, ramps, or inclines; and they shall be equipped with handrails on both sides.

142.21 **Space Under Stairs** – Space under stairs shall not be used for storage purposes. All walls and doors shall meet the same fire rating as the stairwell.

142.22 **Interior Finish and Decorative Materials** – All combustible, decorative, and acoustical material shall be rendered and maintained flame resistant. It is recommended that curtains be of fiberglass or other flame resistant material.

142.23 **Fire Extinguishers**- Fire extinguishers of number, type, and capacity appropriate to the need shall be provided for each floor and for special fire hazard areas such as kitchen, laundry, and mechanical room. All extinguishers shall be of a type approved by the licensing authority of the Department of Health. A vaporizing liquid extinguisher (such as carbon tetrachloride) will not be approved for use inside the building. Extinguishers shall be inspected and serviced periodically as recommended by the manufacturer. The date of inspection shall be entered on a tag attached to the extinguisher and signed by a reliable inspector such as the local fire chief or representative of a fire extinguisher s servicing company.

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142.24 **Fire Detection and Fire Protection System**

1. If an automatic sprinkler-alarm system is installed, it shall meet the requirements as a recommended by the National Fire Protection Association according to NFPA, No. 13.

2. If an automatic fire detection system is installed, it shall meet the following requirements:

   a. It shall be an Underwriters' Laboratories approved system.

   b. A smoke detector unit shall be installed upon the ceiling or on the side walls near the ceiling throughout all parts of the premises including all rooms, halls, storage areas, basements, attics, and lofts and inside all closets, elevator shafts, enclosed stairways and dumbwaiter shafts, chutes, and other enclosures.

   c. The system shall be electrically supervised so that the occurrence of a break or a ground fault of its installation writing circuits, which present the required operation of system or failure of its main power supply source, will be indicated by a distinctive trouble signal.

   d. The conductors of the signaling system power supply circuit shall be connected on the line side of the main service of a commercial light or power supply circuit. A circuit disconnecting means shall be so installed that it will be accessible only by authorized personnel.

142.25 **Smoke Barrier or Fire Retardant Walls** Each building shall be divided into areas not exceeding five thousand (5,000) square feet between exterior walls or smoke barrier walls. The barrier walls shall be constructed from floor to roof decking with no openings except in corridors or other areas specifically approved by the licensing agency. Self-closing "B" label fire doors with fusible linkage shall be installed in the barrier walls in corridors. All air spaces in the walls shall be filled with noncombustible material.

142.26 **Exit Signs** – Exits shall be marked with plainly lettered illuminated signs bearing the word "Exit" or "Fire Escape" in

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letters at least four and one-half (4 ½) inches high. Exit signs shall be illuminated at all times and wired in front of the electrical panel with fuse control in a locked box. Additional signs shall be placed in corridors and passageways wherever necessary to indicate the direction of exit.

142.27 **Fire Escapes and Ladders**

1. The use of ladders (metal or otherwise) in lieu of escapes or fire stairways shall not be permitted on any facility licensed under these regulations.

2. The use of open fire escapes shall not be permitted on facilities opened or established after the effective date of these regulations.

3. Open fire escapes will be permitted on existing institutions provided such fire escapes meet the following requirements:

   a. They must be of non-combustible material.

   b. They must have railing or guard at least four (4) feet high on each unenclosed side.

   c. Wall openings adjacent to fire escapes shall be protected with fire resistive doors and windows.

   d. Doors leading to fire escapes shall open in the direction of exit.

4. Fire escapes on facilities licensed after adoption of these regulations should generally meet requirements for stairways.

142.28 **Required Fire Exits**

1. At least two (2) exits, remote from each other, shall be provided for each occupied story of the building. Dead-end corridors are undesirable and in no even shall exceed thirty (30) feet.

2. Exits shall be of such number and so located that the distance of travel from the door of any occupied room to an exit from that floor shall not exceed one hundred (100) feet.

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In buildings completely protected by a standard automatic sprinkler system, the distance may be one hundred fifty (150) feet.

3. Each occupied room shall have at least one (1) door opening directly to the outside or to a corridor, stairway, or ramp leading directly to the outside.

4. Doors on fire exits shall open to the outside.

5. Building Exits Code, NFPA, No. 101, shall be the governing code for exit items which are not covered in the regulations.

142.29 **Mechanical and Electrical Systems**

1. Mechanical, electrical, plumbing, heating, air-conditioning, and water systems installed shall meet the requirements of local codes and ordinances as well as the applicable regulation of the Department of Health. Where there are no local codes or ordinances, the following codes and recommendations shall govern:

   a. National Electrical Code.

   b. National Plumbing Code.

   c. American Society of Heating, Refrigerating, and Air-Conditioning Engineers, Inc.

   d. Recommendations of the American Society of Mechanical Engineers.

   e. Recommendations of American Gas Association.

   f. National Board of Fire Underwriters.

2. The heating of institutions for the aged or infirm licensed after adoption of these regulations shall be restricted to steam, hot water, or warm air systems employing central heating plants or Underwriters' Laboratories approved electric heating. The use of portable heaters of any kind is prohibited with the following exceptions for existing homes:

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a. Portable type gas heaters provided they meet all the following:

1. A circulating type with a recessed enclosed flame so designed that clothing or other flammable material cannot be ignited;

2. Equipped with a safety pilot light;

3. Properly vented to the outside;

4. Approved by American Gas Association or Underwriters' Laboratories.

b. An approved type of electrical heater such as wall insert type.

1. Lighting (except for emergency lighting) shall be restricted to electricity. No open flame lighting such as by kerosene lamps, gas lamps, or candles shall be permitted.

2. The Department of Health may require, at its discretion, inspection of mechanical, plumbing and electrical systems installed prior to effective date of these regulations by building, electrical plumbing officials or other competent authorities, a certification of adequacy and safety presented to the Department of Health.

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143 EMERGENCY OPERATIONS PLAN (EOP)

143.01 The licensed entity shall develop and maintain a written preparedness plan utilizing the "All Hazards" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency Preparedness and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Preparedness and Response Plan." Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by the Office of Emergency Preparedness and Response. The six (6) critical areas of consideration are:

- Communications – Facility status reports shall be submitted in a format and a frequency as required by the Office of EOP.
- Resources and Assets
- Safety and Security
- Staffing
- Utilities
- Clinical Activities.

Emergency Operations Plans (EOPs) must be exercised and reviewed annually or as directed by the Emergency Preparedness and Response. Written evidence of current approval or review of provider EOPs, by the Office of Emergency Preparedness and Response, shall accompany all applications for facility license renewals.

144 Facility Fire Preparedness

144.01 Fire Drills. Fire drills shall be conducted one (1) per shift per quarter. Employees shall participate in a fire drill at least four (4) times per year.

144.02 Written Records. Written records of all drills shall be maintained, indicating content of and attendance at each drill.

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144.03 A fire evacuation plan shall be posted in each facility in a conspicuous place and kept current.

145 NURSING UNIT

145.01 **Nursing Unit** – Medical, nursing, and personal services shall be provided in a specifically designated area which shall include bedrooms, special care room(s), nurses' station, utility room toilet and bathing facilities, linen and storage closets and wheelchair space.

145.02 The maximum nursing unit shall be twenty-five (25) beds.

145.03 **Bedrooms**

1. **Location**

   a. All patient bedrooms shall have an outside exposure and shall not be below grade. Window area shall not be less than one-eighth (1/8) of the floor area. The window sill shall not be over thirty-six (36) inches from the floor.

   b. Patient bedrooms shall be located so as to minimize the entrance of unpleasant odors, excessive noise and other nuisances.

   c. Patient bedrooms shall be directly accessible from the main corridor of the nursing unit providing that accessibility from any public space other than the dining room will be acceptable. In no case shall a patient bedroom be used for access to another patient bedroom.

   d. All patient bedrooms shall be so located that the patient can travel from his/her bedroom to a living room, day room, dining room, or toilet or bathing facility without having to go through another patient bedroom.

2. **Floor Area** – Minimum usable floor area per bed shall be as follows:

   Private room 100 square feet

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Multi-bed room 80 square feet

3. **Provision for Privacy** – Cubicle curtains, screens or other suitable provisions for privacy shall be provided in multi-bed patient bedrooms.

4. **Accommodations for Patients** – The minimum accommodations for each patient shall include:

   a. Bed – The patient shall be provided with either an adjustable bed or a regular single bed, according to needs of the patient, with a good grade mattress at least four (4) inches thick. Beds shall be single except in case of special approval of the licensing agency. Cots and roll-away beds are prohibited for patient use. Full and half bedrails shall be available to assist in safe care of patients.

   b. Pillows, linens, and necessary coverings.

   c. Chair.

   d. Bedside cabinet or table.

   e. Storage space for clothing, toilet articles, and personal belongings including rod for clothes hanging.

   f. Means at bedside for signaling attendants.

   g. Bed pan and urinal for patients who need them.

   h. Over-bed tables as required.

5. **Bed Maximum** – Effective from the approval date of these regulations, each newly renovated or newly constructed hospice facility shall contain only private patient rooms. There shall be no multi-patient wards.

145.04 **Isolation Room** – Each hospice facility shall have one isolation room which shall be a single bedroom with at least a private half bath (lavatory and water closet).

145.05 **Nurses' Station**

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1. Each inpatient hospice shall have a nurses' station for each nursing unit. The nurses' station shall include as a minimum the following:

   a. Annunciator board or other equipment for patient's call;

   b. The minimum areas of the medicine storage/preparation room shall be seventy-five (75) feet;

   c. Storage space for patients' medical records and nurses' charts.

   d. Lavatory or sink with disposable towel dispenser;

   e. Desk or counter top space adequate for recording and charting purposes by physicians and nurses.

2. The nurses' station area shall be well-lighted.

3. It is recommended that nurses' lounge with toilet be provided for nursing personnel adjacent to the station. A refrigerator for the storage of drugs shall be provided at each nurses' station. Drugs, food and beverages may be stored together only if separate compartments or containers are provided for the storage of drugs.

145.06 **Utility Room** – Each inpatient hospice shall provide a separate utility room for soiled and clean patient care equipment such as bedpans, urinals, et cetera. The soiled utility room shall contain, as a minimum, the following equipment:

1. Provision for cleaning utensils such as bed pans, urinal, et cetera;

2. Utensil sterilizer;

3. Lavatory or sink and disposable towel dispenser;

The utility room for clean equipment shall have suitable storage.

145.07 **Toilet and Bathing Facilities**

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1. Separate toilet and bathing facilities shall be provided on each floor for each sex in the following ratios as a minimum:

Bathtubs or showers	1 per 12 beds or fraction thereof
Lavatories	1 per 8 beds or fraction thereof
Toilets	1 per 8 beds or fraction thereof

2. As a minimum, showers shall be four (4) feet by four (4) feet without curbing.

3. Handrails shall be provided for all tubs, showers, and commodes.

4. A lavatory shall be provided in each patient bedroom or in a toilet room that is directly accessible from the bedroom.

5. A water closet shall be located in a room directly accessible from each patient bedroom. The minimum area for a room containing only a water closet shall be three (3) feet by six (6) feet.

145.08 **Other Rooms and Areas** – In addition to the above facilities, each nursing unit shall include the following rooms and areas: linen closet, storage closet and wheelchair space.

145.09 **Required Rooms and Areas**

1. **Clean linen storage** – Adequate area shall be provided for storing clean linens which shall be separate from dirty linen storage.

2. **Wheelchair area** – Adequate area shall be provided for storage of wheelchairs.

3. **Dining Room** – The dining area shall be large enough to accommodate needs of the hospice patients/families.

4. **Food Storage** – A food storage room shall be provided convenient to the kitchen in all future licensed homes. It should have cross ventilation. All foods must be stored a minimum of twelve (12) inches above the floor.

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5. **Day Room or Living Room** – Adequate day or living room area shall be provided for patients or residents and guests. These areas shall be designated exclusively for this purpose and shall not be used as sleeping area or otherwise. It is recommended that at least two (2) such areas be provided and more in larger facilities.

6. **Counseling Room-** The hospice shall provide a defined quiet room or place that will accommodate families and where consoling and/or counseling can be offered.

7. **Janitor Closet** – At least one (1) janitor's closet shall be provided for each floor. The closet shall be equipped with a mop sink and be adequate in area to store cleaning supplies and equipment. A separate janitor's closet shall be provided for the food service area.

8. **Garbage** – Garbage can cleaning and storage area.

9. **General Storage** – A minimum area equal to at least (5) square feet per bed shall be provided for general storage.

10. **Laundry** – If laundry is done in the institution, a laundry room shall be provided. The laundry shall be enclosed by two-hour fire resistive construction. Adequate equipment for the laundry load of the home shall be installed. The sorting, washing, and extracting process should be separated from the folding and ironing area – preferably in separate rooms.

11. **A separate toilet room** (lavatory and water closet) **with lockers** shall be provided for male and female employees.

12. **A separate toilet room** shall be provided for each sex of the public.

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PART X CONCLUSION

146 GENERAL

146.01 General

1. Conditions which have not been covered in the Standards shall be enforced in accordance with the best practices as interpreted by the Licensing Agency. The Licensing Agency reserves the right to:

   a. Visit hospice patients in their place of residence in order to evaluate the quality of care provided.

   b. Review the payroll records of each hospice agency for the purpose of verifying staffing patterns.

2. Information obtained by the licensing agency through filed reports, inspection, or as otherwise authorized, shall not be disclosed publicly in such manner as to identify individuals or institutions, except in proceedings involving the question of licensure.

147 VARIANCES AND WAIVERS

The Department, upon application, may grant variances or waivers of specific rules and regulations when it has been shown that the rule or regulation is not applicable or to allow experimentation and demonstration of new and innovative approaches to delivery of services.

The Department may exempt classes of facilities from regulation, as provided, when regulation would not permit the purpose intended or the class of facilities is subject to similar requirements under other rules and regulations.

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CERTIFICATION OF REGULATION

This is to certify that the above ***Minimum Standards of Operation for Hospice*** were adopted by the Mississippi State Board of Health on **July 9, 2008** to become effective **August 09, 2008**.

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F. E. Thompson, Jr., MD, MPH
State Health Officer
Mississippi State Department of Health

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