



**GEORGIA DEPARTMENT OF
COMMUNITY HEALTH**

F c x l f ' C O E q q m C o m m i s s i o n e r

P c v j e p ' F g e n G o v e r n o r

2 Peachtree Street, NW
Suite 31-447
Atlanta, GA 30303-3159
www.dch.georgia.gov

HOSPICE INITIAL LICENSURE PACKET

This letter is in response to your request for information about operating a hospice in Georgia. The Healthcare Facility Regulation Division (HFRD) is responsible for licensing hospices under Georgia State Law and for assisting the Centers for Medicare/Medicaid Services (CMS) in performing the certification function for those hospice providers wishing to participate in the Medicare Program. O.C.G.A. § 31-7-170 *et seq.* requires agencies to obtain a Georgia state license prior to providing hospice services. A state license is also a prerequisite to obtaining Medicare certification.

Enclosed are the hospice rules and regulations, an application for a hospice license, and a list of all the documents required by HFRD in order to consider your application complete. Please note that the document list is in a checklist format. Please use the checklist as an aid to ensure all documents are included with your application. HFRD staff will also utilize the checklist in determining if the application is complete

STATE LICENSURE APPLICATION PROCESS:

To begin the application process, you must first submit an application for a license to operate a hospice along with all required application documents. The application must be signed and dated by the hospice administrator or the executive officer of the governing body. Please refer to the attached document checklist for guidance with preparation and submission of the required documents which must accompany your application. HFRD will review your application upon receipt to determine if all documents were included. If all essential documents were included, your application will be considered complete and the initial review process will begin.

Submit the application packet to: Home Care Unit
 Healthcare Facility
 Regulation Division
 2 Peachtree St., NW Suite 31-447
 Atlanta, GA 30303

If any essential documents are determined to be absent, the application will be considered incomplete and the application and documents will be returned to you along with information identifying the missing documents. At that time the application will be considered to be voluntarily withdrawn, but you may reapply when you have assembled all of the required documents.

Once the application packet has been determined by HFRD staff to be complete, HFRD will begin an administrative review of your application and supporting documents for compliance with the hospice rules and regulations. This initial review may take up to thirty (30) days.

Hospice License Application
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If the documents are determined to contain all the information required to obtain an initial license, you will be considered in compliance with applicable hospice rules and regulations and issued an **initial license**. You can begin to provide hospice services upon receipt of your initial license.

If the documents you have submitted do not contain sufficient acceptable information for indicating compliance with the rules, you will be notified in writing as to which of the documents were determined to be unacceptable. You will be allowed a period of time in which to submit corrected or revised documents. *However, if you are unable to provide acceptable documents within 90 days of initial receipt of your application, your application for an initial license may be denied for failure to demonstrate compliance with the rules and regulations.*

INITIAL LICENSURE ON-SITE SURVEY

Once your agency has provided hospice services to two or more patients, and prior to the expiration date of the initial license, you must request an initial on-site survey. If HFRD surveyors determine that your agency has demonstrated substantial compliance with the rules and regulations, your hospice agency shall become eligible for and be issued a **regular license**. Your facility must have been issued a regular license to continue to serve patients beyond the expiration date of the initial license.

If all of your Medicare application documents are complete, including approval of your Provider Enrollment Application (855 form), the initial Medicare survey may be performed at the time of your initial licensure on-site survey. However, you must inform the Home Care Unit of HFRD in writing that you are ready for your initial Medicare survey. (Refer to separate instructions regarding the initial Medicare certification process).

Initial licenses are not renewable and expire within six (6) months from the date issued. If you are unable to become operational and obtain a regular license prior to the expiration of the initial license, you must contact the Home Care Unit of HFRD.

LABORATORY SERVICES: If you anticipate that your facility will be performing any clinical laboratory testing or specimen collection, you need to contact the **Diagnostic Services Unit at (404) 657-5450**. This unit will assist you in determining whether there are additional Federal and State laboratory requirements that your facility will have to meet.

Should you have any questions concerning the information in this letter, completion of the application or the required documents, please do not hesitate to contact the Healthcare Facility Regulation Division at (404) 657-1509.

Enclosures:

- Rules and Regulations for Hospices
- Application for a License to Operate as a Hospice
- Affidavit of Personal Identification
- Document Checklist

**Georgia Department Of Community Health
Healthcare Facility Regulation Division
Health Care Section
2 Peachtree Street, NW, Suite 31-447
Atlanta, Georgia 30303-3142**

APPLICATION FOR A LICENCE TO OPERATE A HOSPICE

(PLEASE TYPE OR PRINT)

Pursuant to provision of O.C.G.A § 31-7-170 et seq. application is hereby made to operate a Hospice which is identified as follows:

SECTION A: IDENTIFICATION

Date of Application:

Type of Application	<input type="checkbox"/> Initial <input type="checkbox"/> Change of Ownership (CHOW) <input type="checkbox"/> Change of Services	<input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Bed Capacity Change	Other
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Name of Hospice	County
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Street Address	City and Zip Code
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E-mail Address	Telephone: _____ FAX: _____
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Mailing Address (If different from Street Address)

Name of Administrator	Official Title
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Official Name and Address of Governing Body

Counties Served By Hospice

Section B: TYPE OF OWNERSHIP (Check Only One)

PROPRIETARY (Profit):		NON-PROFIT:	
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> State	<input type="checkbox"/> Hospital Authority
<input type="checkbox"/> Corporation	<input type="checkbox"/> LLC	<input type="checkbox"/> County	<input type="checkbox"/> Church
<input type="checkbox"/> Other(Specify)_____		<input type="checkbox"/> City	<input type="checkbox"/> Other(Specify)_____

Agent for Service – Name	Address and Telephone Number
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Proof of Ownership Attached:

Certificate of Incorporation (Copy)

Other: _____

SECTION C: SERVICES PROVIDED

<input type="checkbox"/> Home Care Only	<input type="checkbox"/> Free Standing Acute Inpatient Services # of Beds _____ Address: _____ _____ _____	<input type="checkbox"/> Acute & Residential Combined Services # of Beds _____ Address: _____ _____ _____	<input type="checkbox"/> Free Standing Residential Services # of Beds _____ Address: _____ _____ _____
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SECTION D: STATEMENT OF COMPLIANCE

I certify that this hospice will comply with the Rules and Regulations for Hospices, Chapter 290-9-43, pursuant to the Official Code of Georgia Annotated (O.C.G.A.) 31-7-170 *et seq.* I further certify that the information submitted on this application is true and correct to the best of my knowledge.

Signature of Administrator or Executive Officer of the Governing Body Title Date

TO BE FILLED OUT BY STATE AGENCY ONLY

DATE RECEIVED _____

LICENSE NUMBER ISSUED _____

EFFECTIVE DATE _____

APPROVED _____
HOME CARE SERVICE PROGRAM DIRECTOR

O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a **license, permit or registration**, as referenced in O.C.G.A. § 50-36-1, from the **Department of Community Health, State of Georgia**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

- 1) _____ I am a United States citizen.
- 2) _____ I am a legal permanent resident of the United States.
- 3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:
_____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____(state).

Signature of Applicant

Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DAY OF _____, 20___

NOTARY PUBLIC
My Commission Expires:

**INSTRUCTIONS FOR COMPLETING AFFIDAVIT
REQUIRED TO BECOME LICENSED**

In order to obtain a license from the Department of Community Health to operate your business, Georgia law requires every applicant to complete an affidavit (sworn written statement) before a Notary Public that establishes that you are lawfully present in the United States of America. This affidavit is a material part of your application and must be completed truthfully. Your application for licensure may be denied or your license may be revoked by the Department if it determines that you have made a material misstatement of fact in connection with your application to become licensed. If a corporation will be serving as the governing body of the licensed business, the individual who signs the application on behalf of the corporation is required to complete the affidavit. Please follow the instructions listed below.

1. Review the list of Secure and Verifiable Documents under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your identity, such as a U.S. driver's license or a U.S. passport. Locate one original document on the list to bring to the Notary Public to establish your identity.
2. Print out the affidavit. (If you do not have access to a printer, you can go to your local library or an office supply store to print out the document for a small fee.)
3. Fill in the blanks on the Affidavit above the signature line only—**BUT DO NOT SIGN THE AFFIDAVIT at this time.** (You will sign the affidavit in front of the Notary Public.) Fill in the name of the secure and verifiable document (for example, Georgia driver's license, U.S. passport) that you will be presenting to the Notary Public as proof of your identity. **CAUTION: Put your initials in front of only ONE of the choices listed on the affidavit and described here below:**
 - Option 1) is to be initialed by you if you are a United States citizen; or
 - Option 2) is to be initialed by you if you are a legal permanent resident of the United States. You are not a U.S. citizen but you have a green card; or
 - Option 3) is to be initialed by you if you are a qualified alien or non-immigrant (but not a U.S. citizen or a legal permanent resident) with an alien number issued by the Department of Homeland Security or other federal immigration agency. Fill in the alien number, as well.
4. Find a Notary Public in your area. Check the yellow pages, the internet or with a local business, such as a bank.
5. Bring your affidavit and the identification you selected (from the list of Secure and Verifiable Documents) to appear before the Notary Public.

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G. A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind/ex.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

GEORGIA HFRD HOSPICE LICENSURE RULES VERSION 5

TAGS	RULE	IG
0000 INITIAL COMMENTS.		
0101 TITLE AND PURPOSE. 111-8-37-.01	<p>These rules shall be known as the Rules and Regulations for Hospices. The purpose of these rules is to provide for the inspection and issuance of licenses for hospices and to establish minimum requirements for facilities operating under hospice licenses.</p> <p>Authority O.C.G.A. Sec. 31-7-170 et seq. History. Original Rule entitled "Title and Purpose" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	
0201 AUTHORITY. 111-8-37-.02	<p>The legal authority for this Chapter is O.C.G.A § 31-7-170 et seq., the "Georgia Hospice Law" and O.C.G.A. § 31-2-4 et seq.</p> <p>Authority O.C.G.A. Sec. §§ 31-2-4 and 31-7-170 et seq. History. Original Rule entitled "Authority" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	
0301 DEFINITIONS. 111-8-37-.03(a)	<p>Unless the context otherwise requires, these identified terms mean the following when used in these rules:</p> <p>(a) "Administrator" means the person, by whatever title used, to whom the governing body has delegated the responsibility for the day-to-day administration of the hospice, including the implementation of the policies and procedures adopted by the governing body. ...</p>	
0302 DEFINITIONS. 111-8-37-.03(b)	<p>"Advanced and progressive disease" means a serious life-threatening medical condition which is irreversible and which will continue indefinitely, where there is no reasonable hope of recovery, but where the patient's medical prognosis is one in which there is a life expectancy of up to two years. The term does not include terminally ill patients as defined in paragraph (ee) of this rule.</p>	
0303 DEFINITIONS. 111-8-37-.03(c)	<p>"Attending physician" means the physician identified by the hospice patient or the patient's representative as having primary responsibility for the hospice patient's medical care and who is licensed to practice medicine in this state.</p>	

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0304 DEFINITIONS. 111-8-37-.03(d)	"Bereavement services" means the supportive services provided to the family unit to assist it in coping with the patient's death, including follow-up assessment and assistance through the first year after death.	
0305 DEFINITIONS. 111-8-37-.03(e)	"Clergy" means an individual representative of a specific spiritual belief who has documentation of ordination or commission by a recognized faith group and who has completed at least one unit of clinical pastoral education from a nationally recognized provider.	Best practice would be for the clergy to have four units of clinical pastoral education and a letter of endorsement from a hospice. Nationally recognized providers include the Association of Clinical Pastoral Education.
0306 DEFINITIONS. 111-8-37-.03(f)	"Counseling" means those techniques used to help persons learn how to solve problems and make decisions related to personal growth, vocation, family, social, and other interpersonal concerns.	
0307 DEFINITIONS. 111-8-37-.03(g)	"Department" means the Georgia Department of Community Health.	
0308 DEFINITIONS. 111-8-37-.03(h)	"Dietitian" means a specialist in the study of nutrition who is licensed as required by O.C.G.A. Sec. 43-11A-1 et seq., the "Dietetics Practice Act."	In accordance with O.C.G.A. Chapter 43-11A, the "Dietetics Practice Act," dietitians may be licensed by the Georgia Board of Examiners of Licensed Dietitians upon the presentation of satisfactory evidence that the dietitian is registered by the Commission on Dietetic Registration of the American Dietetic Association.
0309 DEFINITIONS. 111-8-37-.03(i)	"Family unit" means the terminally ill person or person with an advanced and progressive disease and his or her family, which may include spouse, children, siblings, parents, and other relatives with significant personal ties to the patient.	
0310 DEFINITIONS. 111-8-37-.03(j)	"Governing body" means the board of directors, trustees, partnership, corporation, association, or person or group of persons who maintain and control the operation of the hospice and who are legally responsible for its operation.	
0311 DEFINITIONS. 111-8-37-.03(k)	"Home care" means hospice care primarily delivered in the residence of the hospice patient, whether that place is the patient's permanent or temporary residence. A hospice patient who considers his or her residence to be a licensed assisted living community, licensed nursing home, licensed	

TAGS	RULE	IG
	intermediate care home, licensed personal care home, or residential hospice setting is considered to be receiving home care while a resident of that facility.	
0312 DEFINITIONS. 111-8-37-.03(l)	"Hospice" means a public agency or private organization or unit of either providing to persons terminally ill and to their families, regardless of ability to pay, a centrally administered and autonomous continuum of palliative and supportive care, directed and coordinated by the hospice care team primarily in the patient's home but also on an outpatient and short-term inpatient basis and which is classified as a hospice by the Department. In addition, such public agency or private organization or unit of either may also provide palliative care to persons with advanced and progressive diseases and to their families, directed and coordinated by the hospice care team.	
0313 DEFINITIONS. 111-8-37-.03(m)	"Hospice care" means both regularly scheduled care and care available on a 24 hour on-call basis, consisting of medical, nursing, social, spiritual, volunteer, and bereavement services substantially all of which are provided to the patient and to the patient's family regardless of ability to pay under a written care plan established and periodically reviewed by the patient's attending physician, by the medical director of the hospice program, and by the hospice care team.	
0314 DEFINITIONS. 111-8-37-.03(n)	"Hospice care team" means an interdisciplinary working unit composed of members of the various helping professions (who may donate their professional services), including but not limited to: a physician licensed or authorized to practice in this state, a registered professional nurse, a social worker, a member of the clergy or other counselors, and volunteers who provide hospice care.	An interdisciplinary working unit is characterized by a variety of disciplines participating in the assessment, planning, and/or implementation of a patient's plan of care, where there is close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals.

TAGS	RULE	IG
0315 DEFINITIONS. 111-8-37-.03(o)	"Inpatient care" means short-term, 24-hour medically supervised care for the purpose of adjusting and monitoring the terminally ill patient's medications for pain control or managing acute or chronic symptoms that cannot be managed in another setting. Inpatient care is provided within the confines of a licensed hospital, a licensed skilled nursing facility, or a licensed inpatient hospice facility.	
0316 DEFINITIONS. 111-8-37-.03(p)	"Inpatient hospice facility" means a facility that is licensed to provide acute inpatient care for hospice patients in beds that are not included in the certified bed capacity of another licensed facility.	
0317 DEFINITIONS. 111-8-37-.03(q)	"License" means a license issued by the Department to the governing body to operate a hospice.	
0318 DEFINITIONS. 111-8-37-.03(r)	"Medical director" means a physician licensed in this state who is a member of the hospice care team and is responsible for the direction and quality of the medical component of the care rendered by the hospice to patients.	The medical director may utilize the services of other physicians to meet the medical needs of the hospice patients, but there shall be only one medical director.
0319 DEFINITIONS. 111-8-37-.03(s)	"Palliative care" means those interventions by the hospice care team which are intended to achieve relief from, reduction of, or elimination of pain and of other physical, emotional, social, or spiritual symptoms of distress to achieve the best quality of life for the patients and their families.	
0320 DEFINITIONS. 111-8-37-.03(t)	"Patient" means a terminally ill individual receiving the hospice continuum of services, regardless of ability to pay and also means an individual with an advanced and progressive disease.	"Terminally ill" means that the individual is experiencing an illness for which therapeutic intervention directed toward cure of the disease is no longer appropriate, and the patient's medical prognosis is one in which there is a life expectancy of six months or less.
0321 DEFINITIONS. 111-8-37-.03(u)	"Patient representative" means an individual who, under applicable laws, has the authority to act on behalf of the patient where the patient is incapable of making decisions related to health care.	The patient representative's power to act on behalf of the patient under these rules shall be consistent with Chapter 36 of Title 31 of the Official Code of Georgia Annotated, the "Durable Power of Attorney for Health Care Act."

TAGS	RULE	IG
0322 DEFINITIONS. 111-8-37-.03(v)	"Personal care services" means assistance with activities of daily living, personal care, ambulation and exercise; provision of household services essential to health care at home; assistance with self-administration of medication; and preparation of meals.	Household services could include housecleaning, dishwashing, preparation of a meal, doing laundry, changing linens, or any such activity which supports maintenance of a clean and healthy environment in the home.
0323 DEFINITIONS. 111-8-37-.03(w)	"Physician" means an individual who is licensed to practice medicine in this state by the Georgia Composite Medical Board.	
0324 DEFINITIONS. 111-8-37-.03(x)	"Primary caregiver" means a person or entity designated in writing by the patient or the patient's representative who agrees to give and/or arrange for continuing support and care and who may advocate on behalf of the patient.	The primary caregiver may be an individual who has personal significance to the patient other than by blood or legal relationship.
0325 DEFINITIONS. 111-8-37-.03(y)	"Professional counselor" means a person licensed or certified as a professional counselor or associate professional counselor as required by O.C.G.A. § 43-10A-1 et seq., the "Professional Counselors, Social Workers, and Marriage and Family Therapists Licensing Law."	
0326 DEFINITIONS. 111-8-37-.03(z)	"Registered nurse" means an individual who is currently licensed to practice nursing under the provisions of Article 1 of Chapter 26 of Title 43 of the Official Code of Georgia Annotated.	
0327 DEFINITIONS. 111-8-37-.03(aa)	"Residential hospice facility" means a small home-like residential facility or unit that is a part of a licensed hospice program, designed, staffed, and organized to provide non-acute hospice care, 24-hours per day, seven days per week, under the supervision of the hospice physician and hospice registered nurses to terminally ill hospice patients and their family units.	
0328 DEFINITIONS. 111-8-37-.03(bb)	"Respite care" means short-term inpatient or residential care provided for the patient to provide relief for that patient's family unit from the stress of providing care.	

TAGS	RULE	IG
0329 DEFINITIONS. 111-8-37-.03(cc)	"Restraint" means any manual, physical, or mechanical method, device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or a drug or medication when it is used as a restriction to manage the patient ' s behavior or restrict the patient ' s freedom of movement and is not a standard treatment or dosage for the patient ' s condition.	
0330 DEFINITIONS. 111-8-37-.03(dd)	"Social worker" means an individual who is qualified by education, training, and experience and licensed as required by law to perform social work for hospice patients and their family units.	Social workers shall be licensed as required by Chapter 43-10A of the Official Code of Georgia Annotated, the "Professional Counselors, Social Workers, and Marriage and Family Therapists Licensing Law." Bachelor's level social workers may be utilized for some duties such as case management, but must be provided clinical supervision by another social worker with a bachelors or master's degree who has completed at least two years of post-degree social work practice.
0331 DEFINITIONS. 111-8-37-.03(ee)	"Terminally ill" means that the individual is experiencing an illness for which therapeutic intervention directed toward cure of the disease is no longer appropriate, and the patient's medical prognosis is one in which there is a life expectancy of six months or less.	
0332 DEFINITIONS. 111-8-37-.03(ff)	"Volunteer" means a lay or professional person who provides, without compensation, support and assistance to the patient and the patient's family under the supervision of a member of the hospice staff unit in accordance with the plan of care developed by the hospice care team. (2) As used in these rules and regulations, the singular indicates the plural and the plural the singular when consistent with the intent of these rules. Authority O.C.G.A. Sec. §§ 31-7-170 et seq. History. Original Rule entitled "Definitions" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	

TAGS	RULE	IG
0401 LICENSURE PROCEDURES. 111-8-37-.04(1)	Operating, establishing or maintaining a hospice in the State of Georgia without first obtaining a valid license from the Department is prohibited.	
0402 LICENSURE PROCEDURES. 111-8-37-.04(2)	Use of the term "hospice" to imply or indicate that a person or entity is providing hospice services to patients and their families unless the person or entity holds a valid license to provide hospice care is prohibited.	
0403 LICENSURE PROCEDURES. 111-8-37-.04(3)	<p>A governing body desiring to operate a hospice must file with the Department an initial application on forms prescribed and made available by the Department. The application must be complete, accurate, and signed by the hospice administrator or the executive officer of the hospice's governing body and must include:</p> <p>(a) The applicant ' s name, address, phone number, and business e-mail address for receiving inspection reports and communications concerning the license from the Department.;</p> <p>(b) Proof of ownership. In the case of corporations, partnerships, and other entities authorized by law, the applicant must provide a copy of its certificate of incorporation or other acceptable proof of its legal existence and authority to transact business within the state;</p> <p>(c) A list of counties proposed to be served by the hospice; and</p> <p>(d) A list of the locations of any additional hospice care facilities operated by the hospice on separate premises, as applicable, and the number of beds at such facilities.</p>	If, due to financial or other hardship, the hospice is unable to provide an e-mail address or other viable form of electronic communication, a secondary emergency contact number, i.e., a cellular telephone number, shall be deemed acceptable instead of the e-mail address.
0404 LICENSURE PROCEDURES. 111-8-37-.04(4)	Knowingly supplying materially false, incomplete, or misleading information is grounds for denial or revocation of a license.	
0410 LICENSURE PROCEDURES. 111-8-37-.04(5)	Following evidence of substantial compliance with these rules and regulations and any provisions of law as applicable to the construction and operation of the hospice, the Department may issue a license to provide hospice services primarily to terminally ill patients in their own homes.	The license issued may be an initial or a regular license.
0411 LICENSURE PROCEDURES.	An initial license may be issued for a period of six months to allow a new hospice to demonstrate its ability to comply with these rules and regulations.	The initial license is not a provisional license. The initial license shall be issued following the initial inspection and

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111-8-37-.04(6)	After becoming fully operational and demonstrating substantial compliance with the rules and regulations, the hospice shall become eligible for a regular license.	review of the facility's operational plans and structure, prior to the admission of patients, as long as that initial inspection and review find the facility in compliance with rules and regulations which apply.
0412 LICENSURE PROCEDURES. 111-8-37-.04(7)	Inpatient and residential services and palliative care services are not eligible to be licensed separately from hospice home care services.	
0413 LICENSURE PROCEDURES. 111-8-37-.04(8)	The license must be displayed in a prominent place in the hospice's administrative offices.	
0414 LICENSURE PROCEDURES. 111-8-37-.04(9)	Licenses are not transferable from one governing body to another or from one hospice location to another.	
0415 LICENSURE PROCEDURES. 111-8-37-.04(10)	Each planned change of ownership or lease or change of location must be disclosed to the Department at least 30 days prior to such change by submitting an application and the required fees from the proposed new owners or lessees for a new license.	The report must be submitted in writing in order to be accepted.
0416 LICENSURE PROCEDURES. 111-8-37-.04(11)	Changes in the hospice that require the submission of a new application and the issuance of a new license include a change in name, the addition of another service location, a change in the number of licensed beds if residential services are provided or a change in the scope of services provided. The new application that reflects the proposed change must be filed at least 30 days prior the proposed change. Hospices licensed before the effective date of these rules desiring to change their scope of service solely to include palliative care to patients with advanced and progressive diseases who are not terminally ill, will not be required to pay an application change processing fee to add palliative care if the Department receives the palliative care change request within 180 days of these rules taking effect.	Change in the scope of services' means a change to add residential or inpatient care to the provision of home care, to increase or decrease the number of beds, or to no longer provide residential or inpatient care. Home care services are core services, and must be provided by the hospice.

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0417 LICENSURE PROCEDURES. 111-8-37-.04(12)	A license is no longer valid and must be returned to the Department when the hospice ceases to operate, changes locations, is issued a new license, or the license is suspended or revoked. The facility must notify referring individuals and entities of the closure and patients' families regarding the location of medical records.	
0418 LICENSURE PROCEDURES. 111-8-37-.04(13)	<p>Temporary Inactive Status. If the hospice is closing for a period of less than 12 months, and plans to reopen under the same ownership, governing body, and name, the hospice may request to have the license placed on temporary inactive status. The hospice must submit its request in writing and provide a written plan for notifying referring individuals and entities of the closure and patients' families regarding the location of medical records.</p> <p>(a) When placed on temporary inactive status, the license must be returned to the Department within 10 days of closure and the hospice must not operate until the license has been reactivated.</p> <p>(b) The hospice must request in writing that the permit be reactivated at least 30 days prior to the desired date of reopening. Prior to reactivation of the license, the hospice may be subject to inspection by the Department. If the license is not reactivated within 12 months, the license is void.</p>	<p>The hospice should not wait until the closing has been effectuated to request temporary inactive status. The request should be made as soon as the facility anticipates closing and should include the plans for the orderly transfer of patients.</p> <p>The 12-month period begins at the official date of closure. This rule does not restrict the applicant from applying for a new license after the 12-month period has expired.</p>
0421 LICENSURE PROCEDURES. 111-8-37-.04(14)	<p>Multiple Hospice Locations. Separate applications and licenses are required for hospices operated at separate locations; however, the Department has the option of approving a single license for multiple hospice locations based on evidence that the hospice meets all of the following requirements:</p> <p>(a) All locations are owned and operated by the same governing body and conduct business under the same set of by-laws and the same trade name;</p> <p>(b) Each location is responsible to the same governing body and central administration managed together under the same set of policies and procedures;</p> <p>(c) The governing body and central administration demonstrate the capacity to adequately manage all locations and ensure the quality of care at all locations as evidenced by a prior history of satisfactory compliance with hospice regulations and appropriate staffing;</p> <p>(d) Supervision and oversight at additional locations is sufficient to ensure that hospice care and services meet the needs of patients and the patients' family units;</p> <p>(e) The medical director assumes responsibility for the</p>	<p>It is not required that all records be kept at the primary hospice location, but the records requested must be available within an hour (1 hour) of the request, whether electronically, by facsimile, or by physical transport of the record.</p>

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	<p>medical component of the hospice's patient care at all locations;</p> <p>(f) Additional locations provide the same full range of services and the same level and quality of care including timely responses, that is provided by the primary location;</p> <p>(g) Each patient is assigned to a specific hospice care team responsible for ongoing assessment, planning, monitoring, coordination, and provision of care, which has ready access to the patient's clinical record;</p> <p>(h) All hospice patients' clinical records that are requested by the Department at the time of inspection must be available at the hospice's primary location; and</p> <p>(i) All locations maintain the same Medicare provider number, as applicable.</p>	
<p>0431 LICENSURE PROCEDURES. 111-8-37-.04(15)</p>	<p>Hospice Care Facilities. Hospices desiring to provide facilities for residential and/or acute inpatient hospice services as a part of the licensed hospice must submit an application to the Department requesting a change in service level. The Department will not approve the change in service level that includes residential and/or inpatient hospice services, unless the hospice:</p> <p>(a) Is licensed and in substantial compliance with these rules and regulations that apply to home care hospice services;</p> <p>(b) Submits a copy of the certificate of occupancy issued by local building officials for the facility or unit;</p> <p>(c) Submits evidence of compliance with the applicable provisions of the Life Safety Code®, as enforced by the state fire marshal;</p> <p>(d) Provides evidence to the Department of compliance or ability to comply with all the applicable requirements of paragraph (14) of this rule relating to multiple hospice locations; and</p> <p>(e) Demonstrates substantial compliance with all the applicable requirements of Rule 111-8-37-.24, Hospice Care Facilities, as evidenced by an on-site inspection by the Department.</p> <p>Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Licensure Procedures" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	<p>No requirements of paragraph (14) are applicable if the hospice services are provided out of one location.</p>
<p>0501 INSPECTIONS AND INVESTIGATIONS. 111-8-37-.05(1)</p>	<p>The hospice staff, any facilities where hospice care is being delivered, and the hospice patients must be accessible during all hours of operation to properly identified representatives of the Department for inspections and investigations relating to the hospice's license.</p>	<p>Where the patient chooses not to participate in the interview, the patient's wishes will be respected.</p>

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0502 INSPECTIONS AND INVESTIGATIONS. 111-8-37-.05(2)	The Department will periodically inspect each hospice to ensure that the licensee is providing quality care to its patients; provided, however, that a hospice is exempt from routine periodic on-site licensure inspection if it is certified as a hospice in accordance with federal regulations. Where the Department receives or becomes aware of a complaint alleging that the hospice is not acting in compliance with the requirements of these rules, the Department may conduct an inspection at any time to determine whether the licensed hospice is in compliance with these rules.	Where the patient chooses not to participate in the interview, the patient's wishes will be respected.
0503 INSPECTIONS AND INVESTIGATIONS. 111-8-37-.05(3)	For the purposes of any inspection, investigation, or survey conducted by the Department, the hospice must provide to properly identified representatives of the Department meaningful access to all books, records, papers, or other information related to the initial or continued licensing of the hospice.	
0504 INSPECTIONS AND INVESTIGATIONS. 111-8-37-.05(4)	The hospice must submit to the Department, in a format acceptable to the Department, a written plan of correction in response to any inspection report of violations identified by the Department. The plan of correction must specify what the hospice will do by a return date to correct each of the violations identified. The plan of correction must be submitted within 10 days of the hospice's receipt of the inspection report of violations. A plan of correction must be determined to be acceptable by the Department. Hospices may be allowed an additional 48 hours to revise any plan of correction deemed unacceptable by the Department. Failure to submit an acceptable plan of correction may result in the Department commencing enforcement procedures. The hospice must correct all violations cited. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Inspections and Investigations" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	If a statement of deficiencies results from the inspection, the hospice shall be made aware of the proper format for response.

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0601 REPORTS TO THE DEPARTMENT. 111-8-37-.06(1)(a)	Patient Incidents Requiring Report. The hospice must report to the Department, on forms made available by the Department, within 24 hours or the next business day, whenever any of the following incidents involving patients occurs or the hospice has reasonable cause to believe that an incident involving a patient has occurred: (a) Any death of a hospice patient not related to the natural course of the patient's terminal illness or advanced and progressive disease, or any identified underlying condition; ...	This would include, for example, deaths related to procedural or drug errors or omissions of services or deaths resulting from a fall or other accident while under the care of the hospice.
0602 REPORTS TO THE DEPARTMENT. 111-8-37-.06(1)(b)	The hospice must report to the Department, on forms made available by the Department, within 24 hours or the next business day, whenever any of the following incidents involving patients occurs or the hospice has reasonable cause to believe that an incident involving a patient has occurred: b. Any rape, assault, or any abuse, neglect or exploitation of a patient; ...	"Rape" is defined in O.C.G.A. 16-6-1. Suspicion of abuse or neglect by a patient's caregiver other than a hospice employee or volunteer should be reported to Adult Protective Services (APS) and/or local police. The toll-free number for reporting to APS is 1-888-774-0152. The hospice employee or volunteer should make the hospice administrator aware of any such suspicion immediately. The hospice should document every step of addressing such suspicion. See rule 290-9-43-.10(d) under Patient Rights regarding the requirement that hospice patients receive the hospice services in a manner free from abuse or neglect.
0603 REPORTS TO THE DEPARTMENT. 111-8-37-.06(1)(c)	The hospice must report to the Department, on forms made available by the Department, within 24 hours or the next business day, whenever any of the following incidents involving patients occurs or the hospice has reasonable cause to believe that an incident involving a patient has occurred: (c) Any time a patient, who is admitted to a residential or inpatient hospice facility cannot be located, where there are circumstances that place the health, safety, or welfare of the patient or others at risk and the patient has been missing for more than eight hours.	A patient leaving a hospice facility voluntarily, even if against medical advice, does not normally require a report unless the other criteria apply. For example, if the hospice knows the patient is confused or disoriented, and/or is functionally incompetent to care for himself or herself, and the patient has been missing for more than eight hours, the disappearance should be reported.
0604 REPORTS TO THE DEPARTMENT. 111-8-37-.06(2)	Where the hospice staff has reasonable cause to believe that a disabled adult or elder person has been the victim of abuse, other than by accidental means, or has been neglected or exploited, the hospice must report such information to an adult protection agency providing protective services as designated by the Department and to an appropriate law enforcement agency or prosecuting attorney.	

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0605 REPORTS TO THE DEPARTMENT. 111-8-37-.06(3)	The hospice, through its peer review committee, must submit the reports of patient incidents listed in subparagraph (1)(a) through (c) of this rule. The Department will receive and retain such peer review reports concerning the listed incidents in confidence.	
0606 REPORTS TO THE DEPARTMENT. 111-8-37-.06(4)	Reports of patient incidents made through the peer review process must include: (a) The name of the hospice, the name of the administrator or site manager, and a contact telephone number for information related to the report; (b) The date of the incident and the date the hospice became aware of the incident; (c) The type of incident, with a brief description of the incident; and (d) Any immediate corrective or preventative action taken by the hospice to ensure against the replication of the incident.	
0610 REPORTS TO THE DEPARTMENT. 111-8-37-.06(5)	The hospice must conduct an internal investigation of any of the patient incidents listed in subparagraph (1)(a) through (c) and must complete and retain on-site a written report of the results of the investigation within 45 days of the discovery of the incident. The complete report must be made available to the Department for inspection at the hospice office and contain at least: (a) An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or any other detailed system analysis; (b) Any findings or conclusions associated with the review; and (c) A summary of any actions taken to correct identified problems associated with the incident and to prevent recurrence of the incident, and also any changes in procedures or practices resulting from the investigation.	
0616 REPORTS TO THE DEPARTMENT. 111-8-37-.06(6)	The hospice must report to the Department any pending involuntary discharge of a hospice patient initiated by the hospice. The report must be made no later than the time of notification to the patient of the pending discharge.	See Rule 111-8-37-.14(4)(a), Admission, Transfers, and Discharges. The hospice may not discharge patients solely because their care has become costly or inconvenient. In most situations, discharge from a hospice will occur as a result of one of the following: 1. The patient decides to revoke the election to receive hospice services; 2. The patient moves away from the geographic area that the hospice

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		<p>defines in its policies as its service area;</p> <ol style="list-style-type: none"> 3. The patient requests a transfer to another hospice; 4. The patient's condition improves and the patient is no longer considered terminally ill; or 5. The patient dies as a result of the terminal illness or underlying condition. <p>Those situations would not require report. It is those situations where the hospice initiates a discharge without any of the above conditions present which would require a report. The reasons for the discharge should be disclosed in the report.</p>
<p>0617 REPORTS TO THE DEPARTMENT. 111-8-37-.06(7)(a)</p>	<p>Other Events/Incidents Requiring Report. The hospice must report in an acceptable format to the Department whenever any of the following events involving hospice operations occurs or when the hospice becomes aware that any such events are likely to occur, to the extent that such events are expected to cause or causes a significant disruption of care for hospice patients:</p> <ol style="list-style-type: none"> 1. An external disaster or other community emergency situation; or 2. An interruption of services vital to the continued safe operation of a hospice facility, such as telephone, electricity, gas, or water services. 	<p>Events that cause significant disruption of care include events that may or do prevent hospice caregivers from reaching patients in their homes as well as need for evacuation for hurricane or chemical leak, etc. The hospice must have in place disaster preparedness plans to address such situations. See Rule 290-9-43-.11. The hospice must notify the Department if they have encountered or anticipate a need to implement those plans.</p>
<p>0620 REPORTS TO THE DEPARTMENT. 111-8-37-.06(7)(b)</p>	<p>The hospice must make a report of the event within twenty-four hours or by the next regular business day from when the reportable event occurred or from when the hospice has reasonable cause to anticipate that the event is likely to occur. The report must include:</p> <ol style="list-style-type: none"> 1. The name of the hospice, the name of the hospice administrator or site manager, and a contact telephone number for information related to the report; 2. The date of the event, or the anticipated date of the event, and the anticipated duration, if known; 3. The anticipated effect on care and services for hospice patients; and 4. Any immediate plans the hospice has made regarding patient management during the event. 	

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0625 REPORTS TO THE DEPARTMENT. 111-8-37-.06(7)(c)	Within 45 days of the discovery of the event, the hospice must complete an internal evaluation of the hospice's response to the event where opportunities for improvement related to the hospice's disaster preparedness plan were identified. The hospice must make changes to the disaster preparedness plan as appropriate. The complete report must be available to the Department for inspection at the hospice office.	
0626 REPORTS TO THE DEPARTMENT. 111-8-37-.06(8)	While self-reported incidents made through the hospice's peer review process are received by the Department in confidence and not considered open records, where the Department's internal review determines that a rule violation related to any self-reported incident or event has occurred, the Department shall initiate a separate complaint investigation of the incident. The complaint investigation report and the report of any rule violation compiled by the Department arising either from the initial report received from the hospice or an independent source shall be subject to disclosure in accordance with applicable laws. Authority O.C.G.A. §§ 31-7-130 et seq., 31-7-170 et seq. History. Original Rule entitled "Reports to the Department" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
0701 GOVERNING BODY. 111-8-37-.07(1)	The hospice must have an established and functioning governing body that is responsible for the conduct of the hospice and that provides for effective hospice governance, management, and budget planning.	
0702 GOVERNING BODY. 111-8-37-.07(2)	The governing body must appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with these rules and management policies established and approved by the governing body.	
0703 GOVERNING BODY. 111-8-37-.07(3)	The governing body must appoint a medical director and delegate to the medical director the authority to establish and approve, in accordance with current accepted standards of care, all patient care policies related to medical care.	

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0704 GOVERNING BODY. 111-8-37-.07(4)(a)	The governing body must ensure that no member of the governing body, administration, staff associated or affiliated with the hospice, or family member of staff causes, encourages, or coerces any patient or family member of a patient to: (a) name any person associated or affiliated with the hospice as a beneficiary under a will, trust, or life insurance policy or takes out or otherwise secures a life insurance policy on any patient, ...	Surveyors may look for what safeguards are in place to be sure this doesn't happen, such as including ethics as a part of the facility's employee and volunteer orientation. Surveyors may ask employees if they know this is wrong.
0705 GOVERNING BODY. 111-8-37-.07(4)(b)	The governing body must ensure that no member of the governing body, administration, staff associated or affiliated with the hospice, or family member of staff causes, encourages, or coerces any patient or family member of a patient to: (b) takes out or otherwise secures a life insurance policy on any patient, ...	
0706 GOVERNING BODY. 111-8-37-.07(4)(c)	The governing body must ensure that no member of the governing body, administration, staff associated or affiliated with the hospice, or family member of staff causes, encourages, or coerces any patient or family member of a patient to: (c) give or loan anything of value to a member of the governing body, administration, staff associated or affiliated with the hospice or family member of staff.	
0707 GOVERNING BODY. 111-8-37-.07(5)	The governing body must be responsible for determining, implementing, and monitoring the overall operation of the hospice, including the quality of care and services, management, and budget planning.	
0708 GOVERNING BODY. 111-8-37-.07(5)(a)	The governing body must: (a) Be responsible for ensuring the hospice functions within the limits of its current license granted by the Department; ...	If the hospice is Medicare-certified, substantially all core services (nursing, social services, physician services, and counseling) must be provided directly by the hospice rather than through contract.
0709 GOVERNING BODY. 111-8-37-.07(5)(b)	The governing body must: (b) Ensure that the hospice provides coordinated care that includes at a minimum medical, nursing, social, spiritual, volunteer, and bereavement services that meet the needs of the patients; ...	Bereavement services include, but are not limited to, grief support, group counseling, and coordination of support groups.

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0710 GOVERNING BODY. 111-8-37-.07(5)(c)	The governing body must: (c) Ensure that the hospice is staffed and equipped adequately to provide the services it offers to patients, whether the services are provided directly by the hospice or under contract; ...	
0711 GOVERNING BODY. 111-8-37-.07(5)(d)	The governing body must: (d) Develop and make available to patients and their families, a description of services offered by the hospice, including patient eligibility for the various services, and whether the hospice provides palliative care to patients who have not been determined to be terminally ill but have been diagnosed with an advanced and progressive disease; ...	
0712 GOVERNING BODY. 111-8-37-.07(5)(e)	The governing body must: (e) Ensure the development and implementation of effective policies and procedures that address the management, operation, and evaluation of the hospice, including all patient care services and those services provided by independent contractors; ...	
0713 GOVERNING BODY. 111-8-37-.07(5)(f)	The governing body must: (f) Ensure there is an individual authorized in writing to act for the administrator during any period the administrator is absent;	
0714 GOVERNING BODY. 111-8-37-.07(5)(g)	The governing body must: (g) Appoint an individual to assume overall responsibility for a quality assurance, utilization, and peer review program for monitoring and evaluating the quality and level of patient care in the hospice on an ongoing basis; ...	
0715 GOVERNING BODY. 111-8-37-.07(5)(h)	The governing body must: (h) Ensure that hospice advertisements are factual and do not contain any element that might be considered coercive or misleading; ...	
0716 GOVERNING BODY. 111-8-37-.07(6)(i)	The governing body must: (i) Ensure that hospice care to patients who have been determined to be terminally ill is provided regardless of the patient or the family unit's ability to pay; ...	

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0717 GOVERNING BODY. 111-8-37-.07(6)(j)	The governing body must: (j) Ensure that there are policies and procedures in place that specify the manner in which transitions across care sites and providers (e.g. hospital to home hospice) will be handled to ensure that communications are effective to address continuity of care issues for the patient. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Governing Body" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
0801 ADMINISTRATOR. 111-8-37-.08(1)	Each hospice must have a qualified administrator, designated by the governing body, who must be responsible for the ongoing and day-to-day operation of the hospice.	There should be evidence that the administrator is participating in the daily operation of the hospice.
0802 ADMINISTRATOR. 111-8-37-.08(2)	The hospice administrator must be either a Georgia-licensed health care professional, who has at least one year of supervisory or management experience in a hospice setting or an individual with education, training and experience in health services administration and at least two years of supervisory or management experience in a hospice setting. The term, licensed health care professional, includes the following who hold Georgia licenses: physicians, nurse practitioners, physicians' assistants, registered professional nurses, clinical social workers, physical therapists and psychologists, but does not include practical nurses.	'Licensed health care professional' may be, for example, a physician, a registered nurse, a psychologist, physician's assistant, or a licensed social worker. The 'license' refers to a Georgia professional license, not a business license.
0804 ADMINISTRATOR. 111-8-37-.08(3)(a)	The hospice administrator must ensure that the hospice: (a) Implements policies and procedures for the provision of hospice care and palliative care to persons with advanced and progressive diseases, if it offers such services, which have been developed with interdisciplinary participation from the hospice care team; ...	There must be evidence that representatives from disciplines which comprise the hospice care team participated in the development of policies and procedures for those activities or services in which they are involved. For example, dietitians must have participated in the development of policies and procedures related to nutritional assessment, dietary counseling, food services, etc.
0805 ADMINISTRATOR. 111-8-37-.08(3)(b)	The hospice administrator must ensure that the hospice: (b) Employs qualified staff, including physicians, practitioners, nurses, social workers, clergy, volunteers, or other persons providing services at the hospice; ...	Current licenses or certificates would be one evidence of 'qualified', along with education, training, and/or experience.

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0806 ADMINISTRATOR. 111-8-37-.08(3)(c)	The hospice administrator must ensure that the hospice: (c) Has implemented policies and procedures related to the management, operation, and evaluation of the overall performance of the hospice; ...	Regular notes from meetings regarding an issue may be evidence of implementation of a policy or procedure.
0807 ADMINISTRATOR. 111-8-37-.08(3)(d)	The hospice administrator must ensure that the hospice: (d) Has a qualified director of nursing services along with sufficient qualified staff to meet the needs of patients admitted for hospice care and palliative care, if offered to persons with advanced and progressive diseases but who have not been determined to be terminally ill, and as outlined in the patients' plans of care; ...	
0808 ADMINISTRATOR. 111-8-37-.08(3)(e)	The hospice administrator must ensure that the hospice: (e) Provides an orientation, training, and supervision program for every employee and volunteer that addresses hospice care and palliative care for persons with advanced and progressive diseases, when offered and the performance of the specific job to which the employee or volunteer is assigned; ...	See Rule 290-9-43.13 Human Resources for description of required orientation components. Evidence of an employee supervision program could include regular performance evaluations, competency assessments, and documentation of disciplinary actions. See Rule 290-9-43-.18(3) regarding the minimum level of supervision required for personal care aides, who are not permitted to operate without such supervision.
0809 ADMINISTRATOR. 111-8-37-.08(3)(f)	The hospice administrator must ensure that the hospice: (f) Ensures that the staff members complete their annual training and education program; ...	See Rule 290-9-43-.13(4) Human Resources, for annual training and education requirements. The administrator would not be responsible for ensuring that licensed professionals complete the discipline-specific continued education required for keeping their license active, so long as there is assurance the license is current and active.
0810 ADMINISTRATOR. 111-8-37-.08(3)(g)	The hospice administrator must ensure that the hospice: (g) Ensures that there are effective mechanisms to facilitate communication among the hospice staff, hospice care team, and patients, their family units, and their legal guardians, if any. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Administrator" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	See Rule 290-9-43-.10(f) related to a hospice grievance process.

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0901 QUALITY MANAGEMENT. 111-8-37-.09(1)	The hospice must appoint an interdisciplinary quality management committee that reflects the hospice's scope of services. The committee must develop and implement a comprehensive, effective and ongoing quality management, utilization, and peer review program that evaluates, maintains and improves the quality of patient care provided, including the appropriateness of the level of service received by patients, and submits required patient incident reports to the Department.	
0902 QUALITY MANAGEMENT. 111-8-37-.09(2)	<p>The quality management, utilization, and peer review program must establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria must be based on accepted standards of care and must include, at a minimum, systematic reviews of:</p> <ul style="list-style-type: none"> (a) Appropriateness of admissions, continued stay, and discharge; (b) Appropriateness of professional services and level of care provided; (c) Effectiveness of pain control and symptom relief; (d) Patient injuries, such as those related to falls, accidents, and restraint use; (e) Errors in medication administration, procedures, or practices that compromise patient safety; (f) Infection control practices and surveillance data; (g) Patient and family complaints and on-call logs; (h) Inpatient hospitalizations; (i) Staff adherence to the patient's plans of care; and (j) Appropriateness of treatment. 	<p>'Discharge' here refers to the discharge of patients prior to death.</p> <p>'Level of care' review would include review of frequency and types of services to be sure they are individualized to each patient's needs.</p>
0913 QUALITY MANAGEMENT. 111-8-37-.09(3)	Findings of the quality management utilization, and peer review program must be utilized to correct identified problems, revise hospice policies, and improve the care of patients.	
0914 QUALITY MANAGEMENT. 111-8-37-.09(4)	<p>There must be an ongoing evaluation of the quality management, utilization, and peer review committee to determine its effectiveness, with the results of the evaluation presented at least annually for review and appropriate action to the medical staff and the governing body.</p> <p>Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Quality Management" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	

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1001 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)	The hospice must ensure that patients and their families receive hospice care and palliative care for persons with advanced and progressive diseases, when offered, in a manner that respects and protects their dignity and ensures all patients' rights [.]	
1002 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(a)	[The hospice shall ensure that patients and their families:] (a) Participate in the hospice voluntarily and sever the relationship with the hospice at any time; ...	
1003 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(b)	[The hospice shall ensure that patients and their families:] (b) Receive only the care and services to which the patient and/or the patient's family have consented; ...	
1004 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(c)	[The hospice shall ensure that patients and their families:] (c) Receive care in a setting and manner that preserves the patient's dignity, privacy, and safety to the maximum extent possible; ...	
1005 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(d)	[The hospice shall ensure that patients and their families:] (d) Receive hospice care in a manner that neither physically nor emotionally abuses the patient, nor neglects the patient's needs; ...	
1006 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(e)	[The hospice shall ensure that patients and their families:] (e) Receive care free from unnecessary use of restraints; ...	
1007 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(f)	[The hospice shall ensure that patients and their families:] (f) Receive education in the availability and use of the hospice's grievance process for all patients; ...	
1008 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(g)	[The hospice shall ensure that patients and their families:] (g) Communicate grievances, concerns or complaints to the hospice for prompt resolution; ...	
1009 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(h)	[The hospice shall ensure that patients and their families:] (h) Refuse any specific treatment from the hospice without severing the relationship with the hospice; ...	
1010 PATIENT AND FAMILY RIGHTS.	[The hospice shall ensure that patients and their families:]	

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RIGHTS. 111-8-37-.10(1)(i)	(i) Choose their own private attending physician, so long as the physician agrees to abide by the policies and procedures of the hospice; ...	
1011 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(j)	[The hospice shall ensure that patients and their families:] (j) Exercise the religious beliefs and generally recognized customs of their choice, not in conflict with health and safety standards, during the course of their hospice treatment and exclude religion from their treatment if they so choose; ...	
1012 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(k)	[The hospice shall ensure that patients and their families:] (k) Have their family unit, legal guardian, if any, and their patient representative present any time during an inpatient stay, unless the presence of the family unit, legal guardian, if any, or patient representative poses a risk to the patient or others; ...	
1013 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(l)	[The hospice shall ensure that patients and their families:] (l) Participate in the development of the patient's plan of care and any changes to that plan; ...	
1014 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(m)	[The hospice shall ensure that patients and their families:] (m) Have maintained as confidential any medical or personal information about the patient; ...	There should be evidence of policies and procedures related to protection of confidentiality. Individuals' medical records and information must not be accessible to unauthorized persons. Patient information must not be discussed between staff or with family members or patients in public areas where others may overhear.
1015 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(n)	[The hospice shall ensure that patients and their families:] (n) Continue hospice care and not be discharged from the hospice during periods of coordinated or approved appropriate hospital admissions; ...	Such inpatient hospital admission should be within a reasonable distance of the hospice's service area or the patient's hospice care should be transferred to a hospice nearer the hospital.
1016 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(o)	[The hospice shall ensure that patients and their families:] (o) Be provided with a description of the hospice services care provided and levels of care to which the patient is entitled depending upon whether the patient is terminally ill or suffering from an advanced and progressive disease, and any charges associated with such services; ...	Regardless of the source of payment, patients have the right to be informed of all charges for the services they receive.

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<p>1017 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(p)</p>	<p>[The hospice shall ensure that patients and their families:] (p) Review, upon request, copies of any inspection report completed by the Department within the two years preceding the request; ...</p>	<p>An advance directive may effectuate the right to self-determination. A hospice must provide patients with information about advance directives, and must honor the advance directives. One exception to the hospice having to honor the advance directive is if the patient's directive specifies "do not resuscitate" (DNR) and the hospice physician or the hospice facility maintains a conscientious objection to executing the DNR order. In such cases, the hospice should be clear about this policy with each patient and their families when the patient is considering admission, so that the patient may choose another hospice that would effectuate the DNR order if the patient so desired. A hospice may not require any patient to have a DNR as a part of their advance directive.</p>
<p>1018 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(q)</p>	<p>[The hospice shall ensure that patients and their families:] (q) Make self-determinations concerning medical care, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services; ...</p>	
<p>1019 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(r)</p>	<p>[The hospice shall ensure that patients and their families:] (r) Continue to receive appropriate hospice care when terminally ill without regard for the ability to pay for such care; ...</p>	
<p>1020 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(1)(s)</p>	<p>[The hospice shall ensure that patients and their families:] (s) Have communication of information provided in a method that is effective for the patient. If the hospice cannot provide communications in a method that is effective for the patient, attempts to provide such shall be documented in the patient's medical record</p>	<p>Best practice includes use of translator services rather than relying on friends or family to interpret. However, there is no requirement that a translator service be used.</p>
<p>1021 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(2)</p>	<p>The hospice must provide to the patient, the patient's representative, and/or the patient's legal guardian oral and written explanations of the rights of the patient and the patient's family unit while receiving hospice care for the terminally ill and palliative care for persons with advanced and progressive diseases. The explanation of rights must be provided at the time of admission into the hospice.</p>	

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1022 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(3)	At the time of admission, the hospice must provide to the patient, the patient's representative, and the patient's legal guardian the contact information, including the website address of the Department, for reporting complaints about hospice care to the Department.	Complaints about a hospice may be submitted on-line through the following website: http://dch.georgia.gov/hfr-file-complaint
1023 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(4)(a)	The hospice shall post the following information in a public area at the facility: (a) A copy of the patient rights as outlined in Rule 111-8-37-.10(1) in a public area at the facility; ...	
1024 PATIENT AND FAMILY RIGHTS. 111-8-37-.10(4)(b)	The hospice shall post the following information in a public area at the facility: (b) Contact information, including the website address of the Department, for reporting complaints about hospice care to the Department. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Patient and Family Rights" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
1101 DISASTER PREPAREDNESS. 111-8-37-.11(1)	Every hospice must have a current disaster preparedness plan that addresses potential situations where services to patients may be disrupted and outlines appropriate courses of action in the event a local or widespread disaster occurs including communications with patients and their families and emergency management agencies.	
1102 DISASTER PREPAREDNESS. 111-8-37-.11(2)	The disaster preparedness plan must include at a minimum plans for the following emergency situations: (a) Local and widespread severe weather emergencies or natural disasters, such as floods, ice or snow storms, tornados, hurricanes, and earthquakes; (b) Interruption of service of utilities, including water, gas, or electricity, either within the facility or patients' homes or within a local or widespread area; and (c) Coordination of continued care in the event of an emergency evacuation of the area.	

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1105 DISASTER PREPAREDNESS. 111-8-37-.11(3)	If the hospice offers residential and/or inpatient services, in addition to the procedures specified in paragraph (2) of this rule, the plan must also include: (a) Fire safety and evacuation procedures and procedures for the provision of emergency power, heat, air conditioning, food, and water; and (b) Plans for the emergency transport or relocation of all or a portion of the hospice patients, should it be necessary, in vehicles appropriate to the patients' conditions when possible, including written agreements with any facilities which have agreed to receive the hospice's patients in such situations, and notification of the patients' representatives.	Written agreements must include the signatures of representatives of receiving facilities and must address the possibility of a widespread catastrophe.
1108 DISASTER PREPAREDNESS. 111-8-37-.11(4)	The hospice must have plans to ensure sufficient staffing and supplies to maintain safe patient care during the emergency situation.	Disaster plans usually require sufficient supplies for three days, but the plan should include emergency contacts for those cases when a situation persists for longer than three days.
1109 DISASTER PREPAREDNESS. 111-8-37-.11(5)	The plan must be reviewed and revised annually, as appropriate, including any related written agreements.	
1110 DISASTER PREPAREDNESS. 111-8-37-.11(6)	Disaster preparedness plans for hospice care facilities must be rehearsed at least quarterly. Rehearsals must be documented to include staff and patient participants, a summary of any problems identified, and the effectiveness of the rehearsal. In the event an actual disaster occurs in any given quarter, the hospice may substitute the actual disaster's response in place of that quarter's rehearsal.	Internal facility review of the response to the actual disaster is required by Rule 290-9-43-.06(2)(c).
1111 DISASTER PREPAREDNESS. 111-8-37-.11(7)	Hospices must include emergency management agencies in the development and maintenance of their disaster preparedness plans and also provide copies of such plans to those agencies as requested.	Efforts to coordinate such planning with the local EMA should be documented. The Department recognizes that the hospice cannot compel the participation of other agencies. Surveyors may contact local EMS to verify coordination efforts where questions arise.
1112 DISASTER PREPAREDNESS. 111-8-37-.11(8)	The Department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared that a state of emergency or disaster exists as a result of a public health emergency. Authority O.C.G.A. §§ 31-7-170 et seq., 50-13-4. History. Original Rule entitled "Disaster Preparedness" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	The Department will provide direction and guidance to facilities should there be an emergency suspension of a rule.

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1201 INFECTIO N CONTROL. 111-8-37-.12	Infection Control. The hospice must have an effective infection control program designed to reduce the transmission of infections in patients, health care workers, caregivers, families, visitors and volunteers.	An effective infection control program would include evidence of strategies in place across the organization to control the transmission of infections. The Association for Professionals in Infection Control and Epidemiology (APIC) published a book and other resources related to infection control in the hospice setting.
1202 INFECTIO N CONTROL. 111-8-37-.12(a)	The hospice must develop an infection control surveillance plan that is tailored to meet the needs of the hospice and the hospice patients and includes both outcome and process surveillance.	Surveillance plans for home care may differ from the surveillance plans for a residential or acute inpatient hospice facility. For any surveillance plan, the hospice should select those types of infections which place patients at highest risk and for which the hospice is likely to be able to put measures in place for prevention. Examples include catheter-related bloodstream infections, decubitus ulcers, and multiple-resistant organisms.
1203 INFECTIO N CONTROL. 111-8-37-.12(b)	<p>The hospice must develop and implement effective policies and procedures that address infection control issues in all components of the hospice. These policies and procedures shall be based on accepted standards of infection control, approved by the administrator and the medical director, and shall address at least the following:</p> <ol style="list-style-type: none"> 1. Hand hygiene; 2. Wound care; 3. Urinary tract care; 4. Respiratory therapy; 5. Enteral therapy; 6. Infusion therapy; 7. Cleaning, disinfecting, and sterilizing patient care equipment; 8. Isolation precautions; 9. Handling, transport, and disposal of medical waste and laboratory specimens; 10. Requirements for initial and annual health screenings for staff, including tuberculosis surveillance and required immunizations; 11. Use of personal protective equipment and exposure reporting/follow-up; 12. Work restrictions for staff with potentially infectious diseases; 13. Evaluation of the patient and the home environment related to infection control risks; 14. Outbreak investigation procedures; 	<p>The Centers for Disease Control (CDC) has developed infection control guidelines for many of these topics. They can be accessed through the CDC website at www.cdc.org</p> <p>(9) Methods for handling and transport of medical waste should comply with the Bloodborne Pathogens Rule issued by the Occupational Safety and Health Administration (OSHA) and applicable state environmental agency regulations.</p> <p>(16) O.C.G.A. 31-12-2 requires that healthcare providers notify the Georgia Division of Public Health of outbreaks or detection of certain communicable diseases, as specified by the Department. The list of diseases or conditions requiring notification are available from the Georgia Notifiable Disease Unit, Division of Public Health (404) 657-2588 (or from the county health department). Information about notifiable diseases and the notification process may also be accessed through their website at http://health.state.ga.us</p>

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	<p>15. Dietary practices in hospice care facilities; and</p> <p>16. Reporting of communicable diseases, as required by law.</p>	
<p>1220 INFECTION CONTROL. 111-8-37-.12(c)</p>	<p>The infection control program must be evaluated at least annually to ensure effectiveness of the program related to the prevention of the transmission of infections to patients, health care workers, caregivers, families, visitors and volunteers.</p> <p>Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Infection Control" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	<p>An effective program would include presentation of the data to the governing body and the facility's quality management committee.</p>
<p>1301 HUMAN RESOURCES. 111-8-37-.13(1)</p>	<p>All persons providing services for a hospice must be qualified by education, training, and experience to carry out all duties and responsibilities assigned to them.</p>	<p>This rule applies to contracted employees as well as all other employees, medical staff, and volunteers. 'Qualified ...by experience' may include having demonstrated competency for tasks.</p>
<p>1302 HUMAN RESOURCES. 111-8-37-.13(2)</p>	<p>All persons providing services for a hospice must receive an orientation to the hospice to include, but not be limited to:</p> <p>(a) Hospice concepts and philosophy;</p> <p>(b) Patient rights including abuse reporting requirements; and</p> <p>(c) Hospice policies and procedures, including, but not limited to, disaster preparedness, fire safety and emergency evacuations, and reporting abuse and neglect.</p>	<p>At no time may a staff member be allowed to work alone with patients until all minimum required training, as enumerated in these rules, has been completed</p>
<p>1305 HUMAN RESOURCES. 111-8-37-.13(3)</p>	<p>Where a patient does not have a do-not-resuscitate order, the hospice must ensure that all persons providing hands-on care directly to that patient on behalf of the licensed hospice have current certification in basic cardiac life support (BCLS) or cardiopulmonary resuscitation.</p>	<p>Social workers and chaplains are not typically considered hands-on caregivers for the purpose of this rule, when functioning in those roles.</p>
<p>1306 HUMAN RESOURCES. 111-8-37-.13(4)</p>	<p>The hospice must have an effective annual training and education program for all staff and volunteers who provide hands-on care to patients that addresses at a minimum:</p> <p>(a) Emerging trends in infection control;</p> <p>(b) Recognizing abuse and neglect and reporting requirements;</p> <p>(c) Patient rights; and</p> <p>(d) Palliative care.</p>	<p>Where the hospice makes use of contracted employees, the hospice shall include in those contracts the provisions for the training and education of such contracted employees.</p> <p>Emerging trends in infection control includes patterns of problems or opportunities for improvement identified by the hospice's quality management</p>

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		<p>and infection control program, as well as emerging changes in applicable infection control standards of care.</p> <p>Georgia Tuberculosis Reference Guide is available at http://health.state.ga.us/epi/tuber.asp</p>
<p>1310 HUMAN RESOURCES. 111-8-37-.13(5)</p>	<p>The administrator and each staff member and volunteer who has direct contact with patients or their family units must receive an initial and annual health screening evaluation, performed by a licensed health care professional in accordance with accepted standards of practice, sufficient in scope to ensure that the staff and volunteers screened are free of communicable and health diseases that pose potential risks to patients, their family units, and other staff and volunteers.</p>	<p>The accepted standards of practice for screening are those identified by the Centers for Disease Control (CDC), which includes tuberculosis (TB) screening in those areas of the country where TB is prevalent, such as in Georgia. Also, screening must include screening for Hepatitis B antibodies for those employees whose duties may bring them in contact with blood or blood products (refer to OSHA requirement 29 CFR 1910.1030).</p>
<p>1311 HUMAN RESOURCES. 111-8-37-.13(6)</p>	<p>Human resource files must be maintained for the following individuals delivering services associated with the written plan of care: each staff member, independent contractor, and volunteer. The file must contain the person's application, employment history, emergency contact information, evidence of qualifications, job description, evidence of initial and annual health screening, yearly skills competency assessments, evidence of verified licensure or certification, as appropriate, and evidence of orientation, education, and training. These files must be available for inspection by the appropriate enforcement authorities on the premises.</p>	<p>Human resource files may be stored in different locations and managed by different individuals, but the hospice must be able to make the files available to surveyors within a reasonable time (no longer than one hour from the time of request).</p>
<p>1312 HUMAN RESOURCES. 111-8-37-.13(7)</p>	<p>Where the hospice contracts with a staffing agency to provide any services specified in a plan of care, the written contract must require the contracting agency to verify licensing credentials, where applicable, of contract workers to ensure that such workers meet the same qualifications and licensure requirements as specified for hospice employees providing such services directly. The hospice must retain a copy of the contract.</p> <p>Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Human Resources" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	

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1401 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(1)	Admissions. The hospice must not admit any patients unless the hospice believes that it is capable of meeting the care needs of the patients. The hospice must have written criteria that address the eligibility for admission into home hospice care, residential, or inpatient hospice care and palliative care for persons with advanced and progressive diseases, if such palliative care is offered.	
1402 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(a).	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (a) The patient has a referral from a physician who has personally evaluated the patient and diagnosed the patient as terminally ill, where the medical prognosis is less than six months of life if the terminal illness takes its normal course, and in need of hospice care;...	
1403 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(b)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (b) The patient has received from the hospice an initial assessment, performed by an appropriate representative of the hospice care team, that reflects a reasonable expectation that the patient's medical, nursing, and psychological needs can be met adequately by the hospice and further reflects that the patient has a need for and can benefit from hospice care; ...	
1404 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(c)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (c) The patient has been given a description of the scope of services and has personally or through an authorized patient representative given informed consent in writing to receive hospice care; ...	Informed consent implies that the patient understands his or her diagnosis and prognosis and that hospice care is palliative, not curative. The patient should also be aware of the scope of services provided by the hospice as such services relate to the patient's diagnosis.
1405 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(d)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (d) The patient has been certified in writing by the hospice to have an anticipated life expectancy of six months or less if the terminal illness takes its normal course; ...	To be certified for admission, Medicare requires written certification from the patient's physician and the hospice medical director.

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1406 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(e)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (e) The patient lives within the hospices service area; ...	The hospice is required to designate the service area, by counties served, in their application for licensure. See Rule 290-9-43-.04(3)(c).
1407 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(f)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (f) The patient has identified a primary caregiver. In the absence of a primary caregiver, the hospice must develop a detailed plan for meeting the daily care and safety needs of the patient. ...	The designation of a primary caregiver is not necessary for patients in residential or inpatient hospice settings.
1408 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(g)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (g) The hospice must ensure the development of an initial plan of care, within 24 hours of admission to the hospice, based on the initial assessment and with appropriate input from a physician or registered nurse to meet the immediate needs of the patient. ...	In addition to medical, nursing, and psychosocial elements, the initial plan of care, to be considered appropriate, should address the pharmacological history, including herbal and over-the-counter medications, of the patient.
1409 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(2)(h)	The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria: (h) The hospice must ensure that no terminally ill patient person is excluded from participation in, or denied benefits of any hospice care because of an inability to pay for such hospice care.	
1410 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(3)	Inpatient Hospice Admissions. Hospices must admit to acute inpatient hospice care only those terminally ill patients who meet the following criteria: (a) The patient has an order from a physician to be transferred to inpatient status and requires of any of the following: 1. Nursing care supervised by a registered nurse that cannot feasibly be provided in another hospice setting; 2. Procedures that are necessary for pain control or acute or chronic symptom management; 3. Medication adjustment, observation, or other stabilizing treatment; or 4. Psycho-social monitoring; or (b) Respite care.	

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<p>1415 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(4)</p>	<p>Residential Hospice Admissions. In addition to the home care admissions, hospices that elect to offer residential services must admit to a residential facility only those terminally ill patients who do not require acute management of symptoms or stabilization in an inpatient care setting and who meet the following criteria:</p> <p>(a) The patient lacks a sufficient number of capable and willing caregivers; or</p> <p>(b) The patient's care needs are too complex and difficult for non-medical caregivers to perform confidently; or</p> <p>(c) The patient's primary home is not suitable or available and/or the home cannot be adapted to meet the patient's needs; or</p> <p>(d) The patient has no other home available or desires not to live at home.</p>	
<p>1420 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(5)</p>	<p>Palliative Care Admission Requirements. Hospices that elect to provide palliative care to persons with advanced and progressive diseases in any setting, other than an inpatient or residential hospice, must admit only those persons who meet the following criteria:</p> <p>(a) have an order from a physician indicating the patient has an advanced and progressive disease;</p> <p>(b) request the intervention of a hospice care team to alleviate suffering and achieve relief from physical, emotional or spiritual symptoms of distress to achieve the best quality of life for the person and his or her family; and</p> <p>(c) have stated needs that the hospice believes it has the capability to meet.</p>	
<p>1421 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(a)</p>	<p>Discharge Requirements. Once a hospice admits a patient who is terminally ill for hospice care, the hospice at its discretion must not discharge the patient unless either the patient freely and voluntarily requests the discharge or the hospice determines that an involuntary discharge is necessary in accordance with these rules.</p>	<p>The hospice may not discharge patients solely because their care has become costly or inconvenient, per O.C.G.A. § 31-7-172.</p> <p>In most situations, discharge from a hospice will occur as a result of one of the following:</p> <ol style="list-style-type: none"> 1. The patient decides to revoke the election to receive hospice services; 2. The patient moves away from the geographic area that the hospice defines in its policies as its service area; 3. The patient requests a transfer to another hospice; 4. The patient's condition improves and the patient is no longer considered

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		terminally ill; or 5. The patient dies as a result of the terminal illness or underlying condition.
1422 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(b)	No hospice is permitted to require or demand that a terminally ill patient request voluntary discharge from the hospice or require or demand a hospice patient to execute a request for voluntary discharge from the hospice as a condition for admission or continued care.	
1423 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(c)	In situations where the hospice identifies issues where the safety of the terminally ill patient, the patient's family unit, or a hospice staff member or volunteer is compromised, the hospice must make every effort to resolve the issues before considering the option of involuntary discharge.	
1424 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(c)1. .	All such efforts for resolution by the hospice must be documented in the patient's record.	
1425 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(c)2.	If involuntary discharge is the elected option, the hospice must give no less than 14 days' notice of discharge to the terminally ill patient and the patient's representative, except in cases of imminent danger or immediate peril to the terminally ill patient, other terminally ill patients, or staff.	This rule clarifies that the notification to the Department must be made at the same time as the notification of the patient, not at a later date. Facilities may wish to make this notification to the Department prior to patient notification, which would be acceptable. Refer to Rule111-8-37-.06(5) regarding the implementation of the requirement to report such discharges.
1426 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(c)3.	The hospice must notify the Department of the pending involuntary discharge of a terminally ill patient at the time of patient notification.	
1427 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(d)	No terminally ill patient receiving hospice care may be discharged due to inability to pay for the hospice services.	

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1428 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(e)	No hospice is permitted to discontinue hospice care for a terminally ill patient, nor discharge or transfer the patient, during a period of coordinated or approved appropriate hospital admission for the treatment of conditions related to the patient's terminal illness or any other condition.	
1429 ADMISSIONS, DISCHARGES, AND TRANSFERS. 111-8-37-.14(6)(f)	Hospices must assist in coordinating continued care should any hospice patient be transferred or discharged from the hospice. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Admissions, Discharges, and Transfers" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
1501 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(1)	The hospice must designate a hospice care team for each patient admitted by the hospice. The hospice care team must be composed of individuals who provide or supervise the care and services offered by the hospice.	
1502 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(2)	The hospice care team must include at least the following individuals: (a) A physician; (b) A registered nurse; (c) A social worker; (d) A member of the clergy or other counselors; and (e) Volunteers.	Counselors could include licensed professional counselors, nutritional counselors and dietitians, and grief and spiritual counselors. Volunteers would be included on the patient's hospice care team if needs for the volunteer services are identified. There should be documentation that these services were offered and the need for them truly assessed.
1507 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(3)	The appropriate members of the hospice care team must provide a comprehensive assessment, as dictated by the identified needs of the patient, no later than five days after admission that includes at least medical, nursing, psychosocial, and spiritual evaluations of the patient, as well as the capability of the family unit in meeting the care needs of the patient and the need for bereavement services.	The identified needs of the patient shall be based in part on the initial assessment as required by Rule 290-9-43-.14(1)(a)2. The Department recognizes that the appropriate members of the hospice care team may not be able to provide input for patients who die within seven days of admission.

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1508 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(3)(a)	The assessment must be designed to trigger identification of any referral needed by the patient for additional services, including at a minimum: 1. Professional counseling; 2. Spiritual counseling by a member of the clergy or other counselor; 3. Bereavement services; 4. Dietitian services; and 5. Other therapeutic services, as needed.	Spiritual counseling may be provided for the purpose of helping the patient and the patient's family unit to adjust to the patient's approaching death.
1513 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(3)(b)	If additional services are identified for a terminally ill patient, the hospice must ensure that those services are provided by qualified individuals who must be added to the patient's hospice care team. Such qualified individuals include, but not limited to: 1. Other appropriately licensed counselors, as applicable to the patient's needs; and 2. Volunteers who provide services for the patient.	
1515 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(4)	Based on the results of the assessment of the patient, the hospice care team must: (a) Establish the plan of care; and (b) Provide and supervise hospice care and services in accordance with accepted standards of care and the plan of care.	The plan of care must be adequate to meet patient needs in order to be considered to be in accordance with accepted standards of care.
1517 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(5)	The hospice care team must establish and maintain a written plan of care for each patient prior to providing care.	
1518 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(5)(a)	The plan of care must be developed with the input of the patient, the patient's family unit if designated by the patient, the patient's caregivers where the patient resides in a licensed facility, and the patient's representative, if any.	
1519 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(5)(b)	The plan of care must detail the scope and frequency of services to be provided to meet the needs of the patient and the patient's family unit.	

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1520 ASSESSMENT AND PLAN OF CARE 111-8-37-.15(5)(c)	The hospice care team must meet as a group to review each terminally ill patient's plan of care. The plan of care must be reviewed and updated as the patient's condition changes and as additional service needs are identified. The plan of care for terminally ill patients must be reviewed and updated at intervals of no more than 15 days. All reviews and updates shall be documented in the patient's medical record. Plans of care for patients receiving palliative care who have not been determined to be terminally ill will be reviewed and updated as the patient's condition changes or the patient requests additional services.	
1521 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(5)(d)	Documentation of plan of care review for the terminally ill patient must include a record of those participating and must also include evidence of the attending physician's opportunity to review and approve of any revised plans of care. In the absence of the attending physician's written approval of the revised plan of care, the revised plan of care must have the written approval of the medical director.	
1522 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)	The hospice care team must ensure that the patient receives treatment free from restraints, unless use of such restraints has been determined by a physician to be necessary for a temporary period to protect the patient from injury.	
1523 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(a)	Prior to using any restraint with a patient, the hospice care team must attempt less restrictive measures to accomplish the patient's treatment while affording the patient the maximum amount of personal freedom possible. The hospice must document the attempts at use of such less restrictive measures in the patient's medical record.	
1524 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(b)1.	If it is determined that restraints are necessary to prevent patient injury: 1. The hospice must obtain and document consent, specific to the type of restraint proposed, from the patient and/or the patient's representative for use of the restraint and such consent shall be obtained prior to the use of the restraint; ...	

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<p>1525 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(b)2.</p>	<p>If it is determined that restraints are necessary to prevent patient injury: 2. There must be a physician's order for the restraint, specifying the type of restraint to be used and the circumstances under which the restraint is to be applied, which is subject to the following conditions: (i) The physicians order must be time limited; and (ii) The order for the restraint must be re-evaluated prior to subsequent orders for the restraint; ...</p>	
<p>1527 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(b)3.</p>	<p>If it is determined that restraints are necessary to prevent patient injury: 3. The plan of care for the patient must include the plan and standard of care for use of the restraint, including the type and frequency of monitoring of the patient when the restraint is used. The plan must include maximum duration for each restraint application, with mandatory release at least every two hours, and a requirement that time, date, and duration of each restraint application are recorded and documented; ...</p>	
<p>1530 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(b)4.</p>	<p>If it is determined that restraints are necessary to prevent patient injury: 4. The plan of care must include procedures to ensure that the patient's comfort and safety needs are addressed during any period of restraint use; ...</p>	
<p>1531 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(b)5.</p>	<p>If it is determined that restraints are necessary to prevent patient injury: 5. The hospice must ensure safe and proper application and monitoring of the use of the restraint by adequately training staff and evaluating competency of each staff member treating patients in the use of the restraint and by directly observing staff performance with patients; ...</p>	
<p>1532 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(b)6.</p>	<p>If it is determined that restraints are necessary to prevent patient injury: ... 6. The hospice staff must provide training to other patient caregivers in safe and proper use and monitoring of the restraint. Such training must be documented in the patient's medical record.</p>	

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<p>1533 ASSESSMENT AND PLAN OF CARE. 111-8-37-.15(6)(c)</p>	<p>A positioning or securing device utilized during medical treatment procedures to temporarily maintain the patient's position or immobilize the patient will not be considered a restraint, provided such necessity is documented in the patient's plan of care and the physician orders it. Such devices must only be applied by trained nursing or medical personnel and the plan of care must require monitoring sufficient to ensure the patient's safety. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Assessment and Plan of Care" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	
<p>1601 HOME CARE. 111-8-37-.16(1)</p>	<p>Home Care. The hospice must provide home care services to patients primarily in the patient's home. At least 51 percent of the total of all hospice care days, delivered by the hospice in the fiscal year to terminally ill patients must be delivered in the homes of the terminally ill patients.</p>	<p>Home care may be provided in personal homes, personal care homes, nursing homes, or residential hospice facilities.</p>
<p>1603 HOME CARE. 111-8-37-.16(2)</p>	<p>During home care visits, the hospice employee must provide continuing education for the patient and the patient's primary caregiver regarding the progression of the patient's illness and the patient's care needs.</p>	
<p>1604 HOME CARE. 111-8-37-.16(3)</p>	<p>If, during the home care visit, there are observed or communicated significant changes in the patient's condition or needs, or if the hospice employee or volunteer observes that the patient's primary caregiver cannot provide the continuing support and care the patient requires, such findings must be communicated to the patient's hospice care team in a sufficiently timely manner to ensure that the patient's care and safety needs are addressed.</p>	<p>It is imperative that the hospice staff and volunteers providing patient care be sensitive to the changing needs of the patient or changes in the caregiver's ability to provide care. Failure to report such changes and to address them promptly could be considered neglect on the part of the provider.</p>
<p>1605 HOME CARE. 111-8-37-.16(4)</p>	<p>When hospice services are provided to a patient who is a resident of a licensed nursing home, licensed intermediate care home, licensed personal care home or licensed assisted living community, or another licensed hospice operating an inpatient unit, there must be written communication evidencing an understanding between the hospice and the licensed facility that makes clear that the hospice takes full responsibility for professional management of the patient's hospice care and that the licensed nursing home, licensed intermediate care home, licensed personal care home licensed or assisted living community takes responsibility for the other services the patient needs or receives that the licensed facility is authorized to provide.</p>	<p>The plan of care can suffice as the written communication if it is clear that the licensed facility has participated and provided input.</p>

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1606 HOME CARE. 111-8-37-.16(4)(a)	The written communication must clearly specify the patient-care activities and responsibilities that will be performed by the hospice employees and volunteers and those patient care tasks that will be performed by employees of the facility where the hospice patient resides. Hospice employees and volunteers must provide those services for which they are assigned responsibility in the hospice's plan of care for the patient.	Staff of facilities where hospice patients reside can be included in the hospice plans of care only to the extent that the hospice would routinely utilize the services of a patient's primary caregiver if the services were provided in the patient's home.
1607 HOME CARE. 111-8-37-.16(4)(b)	The written communication must specify an individual from the hospice and an individual from the facility where the patient resides who shall be responsible for communication between services providers regarding each patient's treatment and condition and for addressing any care issues. Such communication must be ongoing throughout the period of hospice service provision and must be documented in the patient's hospice medical record.	This rule requires that it be clear in the arrangement who are the points of contact between the providers to assure that care issues are addressed. Although these individuals may be identified by title, each patient's care plan should reflect when/how often and with whom the ongoing communication takes place. For example: At each scheduled visit by the hospice nurse, there will be documented communication between the hospice nurse and the charge nurse at the nursing home to discuss any changes in the patient's condition or care.
1608 HOME CARE. 111-8-37-.16(4)(c)	The hospice must provide a copy of any self-determination documentation to the licensed nursing home, licensed intermediate care home, licensed personal care home or licensed assisted living community where the patient resides and must communicate with the facility as to the procedure for the appropriate implementation of any advance directive or physician's order for life sustaining treatment.	
1609 HOME CARE. 111-8-37-.16(5)	If the hospice does not offer inpatient services directly, the hospice must have a contractual agreement with a licensed hospital, a licensed skilled nursing facility, or a licensed inpatient hospice for the provision of short-term, acute inpatient care and respite care for hospice patients.	
1610 HOME CARE. 111-8-37-.16(6)	The hospice must arrange for transport services when necessary to transport hospice patients to and from inpatient hospice care. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Home Care" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	

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1701 MEDICAL SERVICES. 111-8-37-.17(1)	Medical services must be under the direction of the medical director. In addition to palliation and management of the terminal illness and related conditions, physicians of the hospice, including the physician members of the hospice care team, must also address the basic medical needs of the patients to the extent that such needs are not met by each patient's attending physician or other physician of the patient's choice.	Hospice physicians can address the basic medical needs of the patients through the plan of care, through a referral to another physician, or through other means that are not in conflict with their licenses, hospice policies, or these rules and regulations. The rule is not intended to imply that the hospice treat or pay for medical needs of the patient which are not related to the patient's terminal illness. However, the intent is that the hospice will make referrals or otherwise assure that these other medical needs are addressed.
1703 MEDICAL SERVICES. 111-8-37-.17(2)	Medical Director. The medical director for the hospice must be a physician licensed to practice in this state and must have at least one year of documented experience on a hospice care team or in another setting managing the care of terminally ill patients.	
1704 MEDICAL SERVICES. 111-8-37-.17(2)(a)	The medical director must: (a) Be either an employee of the hospice or work under a written agreement with the hospice; ...	
1705 MEDICAL SERVICES. 111-8-37-.17(2)(b)	The medical director must: (b) Have admission privileges at one or more hospitals commonly serving patients in the hospice's geographical area; ...	
1706 MEDICAL SERVICES. 111-8-37-.17(2)(c)	The medical director must: (c) Be responsible for the direction and quality of the medical component of the care provided to patients by the hospice care team, including designating a licensed physician, employed by the hospice or working under a written agreement, to act on his or her behalf in the medical director's absence; ...	
1707 MEDICAL SERVICES. 111-8-37-.17(2)(d)	The medical director shall: (d) Participate in the interdisciplinary plan of care reviews, patient case review conferences, comprehensive patient assessment and reassessment, and the quality improvement and utilization reviews; ...	'Participate' means make a regular, personal contribution to the reviews, conferences, assessments, and reassessments.

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1708 MEDICAL SERVICES. 111-8-37-.17(2)(e)	The medical director shall: (e) Review the clinical material of the patient's attending physician that documents basic disease process, prescribed medicines, assessment of patient's health at time of entry and the drug regimen; ...	
1709 MEDICAL SERVICES. 111-8-37-.17(2)(f)	The medical director shall: (f) Ensure that each terminally ill patient receives a face-to-face assessment, by either the medical director or the terminally ill patient's attending physician, or is measured by a generally accepted life-expectancy predictability scale for continued admission eligibility at least every six months, as documented by a written certification from the medical director or the terminally ill patient's attending physician that includes: 1. The statement that the terminally ill patient's medical prognosis is for a life expectancy of six months or less if the terminal illness runs its natural course; 2. The specific current clinical finding and other documentation supporting a life expectancy of six months or less if the illness takes its natural course for the terminally ill patient; and 3. The signature of the physician. ...	Such predictability scales include, but are not limited to, the Palliative Performance Scale and the criteria defined by the state's Medicare fiscal intermediary for the diagnosis.
1712 MEDICAL SERVICES. 111-8-37-.17(2)(g)	The medical director shall: (g) Communicate with each patient's attending physician and act as a consultant to attending physicians and other members of the hospice care team; ...	
1713 MEDICAL SERVICES. 111-8-37-.17(2)(h)	The medical director shall: (h) Help to develop and review policies and procedures for delivering care and services to the patients and their family units; ...	
1714 MEDICAL SERVICES. 111-8-37-.17(2)(i)	The medical director shall: (i) Serve on appropriate committees and report regularly to the hospice administrator regarding the quality and appropriateness of medical care; ...	Note the quality management provisions of Rule 290-9-43-.09(2). There must be participation from the medical staff in the quality management program and in review of appropriate quality indicators (for example, those related to medical supervision or treatment) when data indicates a need for improvement.

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1715 MEDICAL SERVICES. 111-8-37-.17(2)(j)	The medical director shall: (j) Ensure written protocols for symptom control and medication management are available; ...	
1716 MEDICAL SERVICES. 111-8-37-.17(2)(k)	The medical director shall: (k) Assist the administrator in developing, documenting and implementing a policy for discharge of patients from hospice care.	
1717 MEDICAL SERVICES. 111-8-37-.17(3)	In addition to the hospice medical director, the hospice may appoint additional hospice physicians who shall assist the medical director in the performance of his or her duties, as prescribed by the hospice.	
1718 MEDICAL SERVICES. 111-8-37-.17(4)	The medical director must assist the administrator in developing, documenting, and implementing effective policies and procedures for the delivery of physicians' services, for orientation of new hospice physicians, and for continuing training and support of hospice physicians.	
1719 MEDICAL SERVICES. 111-8-37-.17(4)(a)	These policies and procedures [physicians' services] must: (a) Ensure that a hospice physician is on-call 24 hours a day, seven days a week; ...	
1720 MEDICAL SERVICES. 111-8-37-.17(4)(b)	These policies and procedures [physicians' services] must: b) Provide for the review and evaluation of clinical practices within home care, residential, and inpatient hospices in coordination with the quality management, utilization, and peer review committee.	
1721 MEDICAL SERVICES. 111-8-37-.17(5)	Verbal orders for medications and controlled substances shall only be given to appropriately licensed staff members, acting within the scope of their licenses, and must be immediately recorded, signed, and dated by the licensed staff member receiving such order.	
1722 MEDICAL SERVICES. 111-8-37-.17(5)(a)	The individual receiving the order shall immediately repeat the order and the prescribing physician must verify that the repeated order is correct. The individual receiving the order must document in the patient's medical record that the order was "repeated and verified."	

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1723 MEDICAL SERVICES. 111-8-37-.17(5)(b)	The hospice must provide a written copy of the order to the prescribing physician within 24 hours of such order or by the end of the next business day. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Medical Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
1801 NURSING SERVICES. 111-8-37-.18(1)	The hospice shall have a system to make available nursing services 24-hours a day, seven days a week to meet the needs of the patients.	For home care services, on-call nursing services are sufficient for the 24-hour requirement so long as the needs of the patients are met.
1802 NURSING SERVICES. 111-8-37-.18(1)(a)	A registered nurse must be available at all times to provide or supervise the provision of nursing care.	
1803 NURSING SERVICES. 111-8-37-.18(1)(b)	On-site nursing services must be made available within one hour of notification where the terminally ill patient and the patient with an advanced and progressive disease who has contracted for nursing services experiences a symptom-management crisis situation.	
1804 NURSING SERVICES. 111-8-37-.18(1)(c)	The hospice must maintain an on-call log for all calls received after normal business hours, the records of which shall be kept for a period of two years.	
1805 NURSING SERVICES. 111-8-37-.18(2)	The hospice must designate a director of nursing who must be a Georgia-licensed registered nurse and who must be responsible for implementing a system for delivery, supervision, and evaluation of nursing and personal care services.	
1806 NURSING SERVICES. 111-8-37-.18(2)(a)	The director of nursing must establish and implement effective policies and procedures for nursing and personal care services based on generally accepted standards of nursing practice.	
1807 NURSING SERVICES. 111-8-37-.18(2)(b)	The director of nursing must ensure that nursing personnel are oriented to nursing policies and procedures and are qualified and competent for their assigned duties.	
1808 NURSING SERVICES. 111-8-37-.18(2)(c)	The director of nursing must ensure the types and numbers of nursing personnel necessary to provide appropriate nursing care for each patient in the hospice.	

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1809 NURSING SERVICES. 111-8-37-.18(2)(d)	The director of nursing must ensure patient assignments are made that reflect a consideration of patient needs as well as nursing staff qualifications and competencies.	
1810 NURSING SERVICES. 111-8-37-.18(3)	Nursing staff must administer medications and other treatments in accordance with the physicians' orders, generally accepted standards of practice, and any federal and state laws pertaining to medication administration.	
1811 NURSING SERVICES. 111-8-37-.18(4)	A registered professional nurse licensed in this state and employed by the hospice may make the determination and pronouncement of the death of a patient who is terminally ill or whose death is anticipated and who is receiving hospice care from the licensed hospice at the time of apparent death of such hospice patient in the absence of an attending physician, of said patient; provided, however, that, when a hospice patient is a registered organ donor, only a physician may make the determination or pronouncement of death.	
1812 NURSING SERVICES. 111-8-37-.18(5)	Personal Care Services. Personal care services must be available and provided in all components of the hospice to meet the needs of patients. The hospice may utilize licensed nurses or qualified personal care aides for the provision of personal care services.	
1816 NURSING SERVICES. 111-8-37-.18(5)(a)	Personal care aides considered qualified by training and experience to provide services to patients include: 1. Georgia Certified Nursing Aides with current certification as such; or 2. Individuals who have completed and can provide validation or documentation of completion of a home health aide training and competency evaluation program conducted in a Medicare-certified home health agency; or 3. Individuals who have successfully completed a personal care aide-training program, provided by the hospice under the direction of a registered nurse[.]	Licensed nurses are considered qualified to provide personal care services by virtue of their education and training.
1820 NURSING SERVICES. 111-8-37-.18(3)(a)3.(i)	[The personal care aide-training program provided by the hospice meets the following requirements]: (i) The personal care aide-training program must be conducted through classroom and supervised practical training totaling at least 75 hours; ...	Knowledge of emergency procedures means basic first aid training, which includes training in dealing with bleeding, shock, choking/Heimlich Maneuver, burns, poisoning, heat exhaustion or heat stroke, broken bones and spinal injuries, and moving a patient

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		only when necessary.
1821 NURSING SERVICES. 111-8-37- .18(3)(a)3.(ii)	[The personal care aide-training program provided by the hospice meets the following requirements]: (ii) At least 16 of the 75 hours of training shall be devoted to supervised practical training;	
1822 NURSING SERVICES. 111-8-37- .18(3)(a)3.(iii)	[The personal care aide-training program provided by the hospice meets the following requirements]: (iii) The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training; ...	
1823 NURSING SERVICES. 111-8-37- .18(3)(a)3.(iv)	[The personal care aide-training program provided by the hospice meets the following requirements]: (iv) Supervised practical training shall must be provided either in a laboratory setting or in one of the components of the hospice in which the trainee demonstrates knowledge while performing tasks on an individual or patient under the direct supervision of a registered nurse or licensed practical nurse; ...	Licensed nurses are considered qualified to provide personal care services by virtue of their education and training.
1824 NURSING SERVICES. 111-8-37- .18(3)(a)3.(v)	[The personal care aide-training program provided by the hospice meets the following requirements]: (v) The personal care aide-training program shall must address each of the following subject areas: (I) Communications skills; (II) Observation, reporting, and documentation of patient status and the care or service furnished; (III) Reading and recording temperature, pulse, and respiration; (IV) Basic infection control procedures; (V) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor; (VI) Maintenance of a clean, safe, and healthy environment; (VII) Recognizing emergencies and knowledge of emergency procedures; (VIII) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, the patient's privacy, and the patient's property; (IX) Appropriate and safe techniques in personal hygiene and grooming that include: I. Bed bath; II. Sponge, tub, or shower bath; III. Shampooing in the sink, tub, or bed; IV. Nail and skin care; V. Oral hygiene; and	

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	VI. Toileting and elimination; (X) Safe transfer techniques and ambulation; (XI) Normal range of motion and positioning; (XII) Adequate nutrition and fluid intake, including preparing and assisting with eating; (XIII) Any other task that the hospice may choose to have the personal care aide perform, as authorized by law; and (XIV) Patient rights, including effectuating advance directives and abuse reporting requirements.	
1832 NURSING SERVICES. 111-8-37-.18(3)(b)	Prior to providing care independently to patients, a registered nurse must observe personal care aides actually delivering care to patients and complete an initial competency evaluation for all personal care tasks assigned to the aide.	
1833 NURSING SERVICES. 111-8-37-.18(3)(c)	Personal care aides must receive at least 12 hours of continuing education annually regarding applicable aspects of hospice care and services.	
1834 NURSING SERVICES. 111-8-37-.18(3)(d)	A registered nurse must prepare for each personal care aide written instructions for patient care that are consistent with the interdisciplinary plan of care and must make and document supervisory visits to the terminally ill patient's residence or living facility at least every two weeks to assess the performance of the personal care aide services.	
1835 NURSING SERVICES. 111-8-37-.18(3)(e)	At least annually, there must be written evidence for each personal care aide that reflects that the personal care aide's performance of required job tasks was directly observed by a registered nurse and such performance was determined to be competent for all job tasks required to be performed. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Nursing Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
1901 OTHER SERVICES. 111-8-37-.19	Other Services. Hospices must make supportive services available to both the patient and the patient's family unit, including, but not limited to, bereavement services provided both prior to and after the patient's death, as well as spiritual counseling and any other counseling services identified in the interdisciplinary plan of care for the patient and the patient's family unit.	

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1902 OTHER SERVICES. 111-8-37-.19(a)	Bereavement Services. Hospices must have an organized program for the provision of bereavement services under the supervision of a licensed professional counselor or licensed social worker or other professional determined, in compliance with applicable laws, to be qualified by training and education to provide the required supportive services.	'Other professional counselor' can include qualified clergy.
1903 OTHER SERVICES. 111-8-37-.19(a)	Bereavement services must be a part of the interdisciplinary plan of care and shall address the needs of the patient and the patient's family unit, the services to be provided, and the frequency of services.	Any professional counseling performed as part of bereavement services shall be provided by qualified individuals who are licensed, as required, by Chapter 43-10A of the Official Code of Georgia Annotated, the "Professional Counselors, Social Workers, and Marriage and Family Therapists Licensing Law."
1904 OTHER SERVICES. 111-8-37-.19(a)	Bereavement services, including educational and spiritual materials and individual and group support services, must be available to the terminally ill patient's family unit for a period of at least one year following the terminally ill patient's death.	
1905 OTHER SERVICES. 111-8-37-.19(a)	Hospices must maintain documentation of all bereavement services.	
1906 OTHER SERVICES. 111-8-37-.19(b)	Spiritual Counseling. Hospices must make available spiritual counseling and must notify patients and patients' family units as to the availability of clergy. In the delivery of spiritual counseling services, hospices must not impose any value or belief system on the patient or the patient's family unit.	
1907 OTHER SERVICES. 111-8-37-.19(c)	Other Counseling. Additional counseling for the patient or the patient's family unit may be provided by other qualified members of the hospice care team as well as by other qualified professionals in accordance with state practice acts. Such counseling includes, but is not limited to, access to a licensed clinical social worker or professional counselor for the provision of counseling to the patient or the patient's family unit or primary caregiver on a short-term basis to resolve assessed clear or direct impediments to the treatment of the patient's medical condition.	The hospice shall not be required to provide long-term counseling for family units for general problems not clearly impeding the treatment but may provide recommendations for such services.

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1910 OTHER SERVICES. 111-8-37-.19(d)	Physical Therapy, Occupational Therapy, and Speech Language Pathology Services. Physical therapy services, occupational therapy services, and speech language pathology services must be available to the patient and, when provided, offered by qualified personnel, in accordance with state practice acts, in a manner consistent with accepted standards of practice.	
1911 OTHER SERVICES. 111-8-37-.19(e)	Dietary and Nutritional Services. Dietary and nutritional services, as required, must be available to all patients in all components of hospice care and provided or supervised by a licensed dietitian. Hospices must develop, document, and implement effective written policies and procedures for dietary and nutritional services. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Other Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
2001 VOLUNTEER SERVICES. 111-8-37-.20(1)	The hospice must establish a program that utilizes volunteers to provide services to terminally ill patients and family units in accordance with patients' plans of care and/or to provide administrative support services for the hospice.	
2002 VOLUNTEER SERVICES. 111-8-37-.20(2)	The hospice must designate a coordinator of volunteer services who assists the administrator in developing, documenting, and implementing a volunteer services program.	
2003 VOLUNTEER SERVICES. 111-8-37-.20(3)	The hospice volunteer coordinator must establish and implement effective written policies and procedures relating to volunteer services. These policies and procedures must address at a minimum: (a) Recruitment and retention; (b) Screening; (c) Orientation; (d) Scope of function; (e) Supervision; (f) Basic infection control; (g) Ongoing training and support; (h) Documentation of volunteer activities; and (i) Patient rights and reporting abuse and other serious incidents.	

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2012 VOLUNTEER SERVICES. 111-8-37-.20(4)	Volunteer services must be provided without compensation. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Volunteer Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
2101 PHARMACEUTICAL SERVICES. 111-8-37-.21(1)	The hospice must provide for the procurement, storage, administration, and destruction of drugs and biologicals utilized for hospice care in accordance with accepted professional principles and in compliance with all applicable state and federal laws.	'Biologicals' are products containing biological material of either animal, human, plant, or microbial origin and include diagnostic kits, reagents, and media used in research, medical, or associated fields.
2102 PHARMACEUTICAL SERVICES. 111-8-37-.21(2)(a)	The hospice must: (a) Ensure medication and pharmacy procedures are approved by a licensed pharmacist who is either employed directly or has a formal arrangement with the hospice; ...	
2103 PHARMACEUTICAL SERVICES. 111-8-37-.21(2)(b)	The hospice must: (b) Ensure the availability of a licensed pharmacist on a 24-hour per day basis to advise the hospice staff regarding medication issues and to dispense medications; ...	
2104 PHARMACEUTICAL SERVICES. 111-8-37-.21(2)(c)	The hospice must: (c) Ensure that any emergency drug kit placed in the hospice is in accordance with all applicable laws and rules and regulations: ...	Georgia Administrative Rules and Regulations 480-24-.07 relates to a pharmacy's use of an emergency drug kit in a hospice.
2105 PHARMACEUTICAL SERVICES. 111-8-37-.21(2)(d)	The hospice must: (d) Ensure that drugs and biologicals are labeled in accordance with current accepted standards of practice; ...	
2106 PHARMACEUTICAL SERVICES. 111-8-37-.21(2)(e)	The hospice must: (e) Ensure effective procedures for control and accountability of all drugs and biologicals throughout the hospice, including records of receipt, disposition, destruction, and reconciliation of all controlled substances and dangerous drugs; ...	
2107 PHARMACEUTICAL SERVICES. 111-8-37-.21(2)(f)	The hospice must: (f) Ensure that only licensed nurses or physicians, acting within the scope of their licenses, administer medications on behalf of the hospice. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Pharmaceutical Services" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	

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2201 MEDICAL SUPPLIES. 111-8-37-.22	Medical Supplies. The hospice must make available sufficient medical supplies and equipment for the palliative care and management of the illness or conditions directly attributable to the terminal diagnosis of terminally ill patients.	
2202 MEDICAL SUPPLIES. 111-8-37-.22(a)	If the hospice directly provides medical supplies and equipment, the hospice must: 1. Develop and implement effective policies and procedures to maintain the supplies and equipment in good working order per the manufacturers' recommendations; 2. Ensure the safe handling and storage of supplies and equipment to ensure function and cleanliness; 3. Instruct the caregiver on the use and maintenance of the equipment; and 4. Replace supplies and equipment as essential for the care of terminally ill patients.	Any donated supplies or equipment must also meet the standards of this subparagraph.
2206 MEDICAL SUPPLIES. 111-8-37-.22(b)	If the hospice contracts for medical supplies and equipment services, the hospice must ensure that contract agreements include requirements consistent with subparagraph (a) of this rule and must ensure that contractors adhere to such agreements. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Medical Supplies" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
2301 MEDICAL RECORDS. 111-8-37-.23(1)	Medical Records. In accordance with accepted standards of practice, the hospice must establish and maintain a medical record for every patient admitted for care and services. The medical record must be complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval and to support the provision of patient care.	
2303 MEDICAL RECORDS. 111-8-37-.23(2)	Entries must be made for all services provided and must be signed and dated on the day of delivery by the individual providing the services for inclusion in the patient's medical record within seven days. The record shall include all services whether furnished directly or under arrangements made by the hospice.	This rule shall not be interpreted to conflict with the provisions of Rule 290-9-43-.17(5) regarding the authentication of verbal orders.

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<p>2305 MEDICAL RECORDS. 111-8-37-.23(3)</p>	<p>Each patient's medical record must contain: (a) Identification data; (b) The initial and subsequent assessments; (c) Pertinent medical and psychosocial history; (d) Consent and authorization forms; (e) The interdisciplinary plan of care; (f) The name of the patient's attending physician; and (g) Complete documentation of all services and events, including evaluations, treatments, progress notes, transfers, discharges, etc.</p>	
<p>2312 MEDICAL RECORDS. 111-8-37-.23(4)</p>	<p>The hospice must have the patient's medical record readily accessible and must safeguard the medical record against loss, destruction, and unauthorized use.</p>	
<p>2313 MEDICAL RECORDS. 111-8-37-.23(5)</p>	<p>Medical records must be preserved as original records, microfilms, or other usable forms and must be such as to afford a basis for complete audit of professional information. Hospices must retain all medical records at least until the sixth anniversary of the patient's death or discharge, and as otherwise required by law. If the patient is a minor, medical records must be retained for at least five years past the age of majority or, in the event the minor patient dies, for at least five years past the year in which the patient would have reached the age of majority. In the event the hospice ceases operation, the hospice must provide prior notice to the local community, referring providers and the Department of the location of the medical records and how such records may be retrieved. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Medical Records" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	
<p>2401 HOSPICE CARE FACILITIES. 111-8-37-.24(1)</p>	<p>Hospice Care Facilities. Hospices providing home care services may establish, as optional services, small home-like residential facilities or units, in order to provide 24-hour non-acute palliative hospice care, and/or inpatient units, in order to provide short-term, 24-hour acute hospice care to terminally ill hospice patients. Residential hospices built, or undergoing major renovations after the effective date of these rules must meet the Facility Guidelines Institute, Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, including the provisions specifically applicable to hospices.</p>	

TAGS	RULE	IG
2402 HOSPICE CARE FACILITIES. 111-8-37-.24(2)	The environment of the hospice care facility must be designed, equipped, and maintained in accordance with applicable life safety code requirements to provide for the comfort, privacy, and safety of no more than 25 patients and family members in any one self-contained, home-like unit. A hospice may operate multiple self-contained, home-like units of no more than 25 beds each, either at the same location or separate locations, provided that each unit is fully staffed to meet the needs of the hospice patients in that unit, the locations are within 35 miles of the principal location and the governing body does not have a history of poor compliance with licensure requirements.	
2403 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(a)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (a) An emergency power source capable of providing electrical service for communication systems, alarm systems, egress lighting, and patient care areas; ...	The 25-bed limit is in accordance with the guidelines established by the American Institute of Architects (AIA).
2404 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(b)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (b) Décor and room configuration that is homelike in design and function; ...	
2405 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(c)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (c) Space accommodations, other than patient rooms, for private patient/family visiting and grieving; ...	
2406 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(d)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (d) Accommodations for at least one family member to remain with the patient throughout the night; ...	
2407 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(e)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (e) Separate restrooms for staff and public use; ...	
2408 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(f)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (f) A program to inspect, monitor and maintain biomedical, electrical equipment in proper and safe working order; ...	

TAGS	RULE	IG
2409 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(g)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (g) Procedures that prevent infestations of insects, rodents, or other vermin or vectors; ...	
2410 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(h)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (h) Security procedures sufficient for the protection of patients; ...	
2411 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(i)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (i) Procedures for the safe management of medical gases; ...	
2412 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(j)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (j) Procedures for infection control, including isolation of patients, in accordance with accepted standards; ...	
2413 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(k)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (k) An environment that is clean, in good repair, and designed and equipped to minimize the spread of infection; ...	
2414 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(l)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (l) Adequate lighting, ventilation, and control of temperature and air humidity; ...	
2415 HOSPICE CARE FACILITIES. 111-8-37-.24(2)(m)	Hospice care facilities, whether residential, inpatient, or residential and inpatient facilities, must provide: (m) An alternative power source to support the needs of the patients.	
2416 HOSPICE CARE FACILITIES. 111-8-37-.24(3)	Patient rooms and bathrooms must be designed and equipped to allow for easy access to the patient and for the comfort and safety of patients.	
2417 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(a)	Each residential and/or inpatient hospice care facility must provide rooms that: (a) Measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi-patient room; ...	Square footage requirements reflect the guidelines from the AIA

TAGS	RULE	IG
2418 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(b)	Each residential and/or inpatient hospice care facility must provide rooms that: (b) Are private rooms, unless consent for a roommate is obtained and then only if the following requirements are met: 1. The hospice must provide an alternative temporary accommodation for a patient whose roommate is in a crisis situation; 2. In no case shall more than two patients share a room; ...	The two-patient maximum requirement reflects the guidelines from the AIA.
2419 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(c)	Each residential and/or inpatient hospice care facility must provide rooms that: (c) Are equipped with a bathroom with an adequate supply of hot water and with automatically regulated temperature control of the hot water; ...	
2420 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(d)	Each residential and/or inpatient hospice care facility must provide rooms that: (d) Are at or above grade level and have a window to the outside; ...	
2421 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(e)	Each residential and/or inpatient hospice care facility must provide rooms that: (e) Contain a suitable bed and mattress for each patient, suitable furniture that allows family to remain in the room overnight, chairs for seating, and closets or furniture for storage of personal belongings; ...	
2422 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(f)	Each residential and/or inpatient hospice care facility must provide rooms that: (f) Are equipped with a system for patients to summon for assistance when needed; ...	
2423 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(g)	Each residential and/or inpatient hospice care facility must provide rooms that: (g) Are equipped with a telephone in each room or telephones located in private areas convenient to bedrooms; ...	
2424 HOSPICE CARE FACILITIES. 111-8-37-.24(4)(h)	Each residential and/or inpatient hospice care facility must provide rooms that: (h) Have an adequate amount of clean bed linens, towels, and washcloths.	

TAGS	RULE	IG
2425 HOSPICE CARE FACILITIES. 111-8-37-.24(5)	In addition to complying with all other requirements of these rules and regulations, each facility that is newly constructed or expands its existing facility after the date these rules and regulations take effect shall also provide a tub or shower in each patient room.	
2426 HOSPICE CARE FACILITIES. 111-8-37-.24(6)	In addition to the hospice's applicable home-care policies and procedures, hospice care facilities must develop and implement additional policies and procedures for post-mortem care and for pronouncement of deaths, in accordance with applicable law.	
2427 HOSPICE CARE FACILITIES. 111-8-37-.24(7)	Hospice care facilities must have policies regarding smoking which apply to employees, volunteers, patients, and visitors.	
2428 HOSPICE CARE FACILITIES. 111-8-37-.24(8)	Hospice care facilities must ensure adequate staff are on duty at all times in order to meet the needs of patients, in accordance with patients' plans of care and in accordance with accepted standards of nursing and hospice care.	
2429 HOSPICE CARE FACILITIES. 111-8-37-.24(8)(a)	Residential and/or inpatient hospice care facilities must provide: (a) At least two staff members on duty 24 hours per day, seven days per week, with additional staff as needed to meet the needs of patients; ...	While the minimum requirement is for two staff members on duty at all times, hospices shall recognize that at any given time having only two staff members on duty for a fully occupied 25-bed facility at would not meet the requirements of having adequate staff on duty at all times to meet the patients' needs, as stipulated in paragraph (5) of this rule.
2430 HOSPICE CARE FACILITIES. 111-8-37-.24(8)(b)	Residential and/or inpatient hospice care facilities must provide: (b) A registered nurse that must direct and supervise all patient care in accordance with the needs of patients and the individual plans of care.	
2431 HOSPICE CARE FACILITIES. 111-8-37-.24(8)(b)1.	Residential hospice care facilities may utilize licensed practical nurses for patient care provided that a registered nurse supervises the care and is available on call at all times.	Either a registered nurse (RN) or a licensed practical nurse (LPN) must be on the premises and on duty in a residential hospice facility at all times. As long as none of the beds are in use for acute inpatient care, an LPN may be on duty without an RN present, with an RN available and on call.

TAGS	RULE	IG
2432 HOSPICE CARE FACILITIES. 111-8-37-.24(8)(b)2.	Inpatient hospice care facilities must have a registered nurse present during each shift who provides direct patient care.	An RN must be on duty for all shifts if any beds at the facility are being used for an acute inpatient hospice care.
2433 HOSPICE CARE FACILITIES. 111-8-37-.24(9)	Meals must be provided in accordance with established dietary practice and the dietary needs and wishes of patients.	
2434 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(a)	The hospice must: (a) Serve three meals a day with not more than 14 hours between a substantial evening meal and breakfast, unless medically contraindicated; ...	
2435 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(b)	The hospice must: (b) Have a system for providing meals for patients outside the normal meal service hours, when requested; ...	
2436 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(c)	The hospice must: (c) Have snacks available between meals and at night, as appropriate to each patient's needs and medical condition; ...	
2437 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(d)	The hospice must: (d) Purchase, store, prepare, and serve food in a manner that prevents food borne illness; ...	
2438 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(e)	The hospice must: (e) Ensure patient diets follow the orders of physicians; ...	
2439 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(f)	The hospice must: (f) Ensure that a qualified staff member plans and supervises meals to ensure meals meet patient's nutritional needs and to ensure meals follow recommended dietary allowances and menu plans; ...	
2440 HOSPICE CARE FACILITIES. 111-8-37-.24(9)(g)	The hospice must: ... (g) Ensure the services of a licensed dietitian to review meal plans and to consult in practical freedom of choice diets to ensure that patients' favorite foods are included in their diets whenever possible. Authority O.C.G.A. §§ 31-7-170 et seq. History. Original Rule entitled "Hospice Care Facilities" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	

TAGS	RULE	IG
2501 WAIVERS AND VARIANCES. 111-8-37-.25(1)	Waivers and Variances. A hospice may request a waiver or variance of a specific rule by application on forms provided by the Department.	
2502 WAIVERS AND VARIANCES. 111-8-37-.25(2)	The Department may grant or deny the request for waiver or variance at its discretion. If the waiver or variance is granted, the Department may establish conditions that must be met by the hospice in order to operate under the waiver or variance.	
2503 WAIVERS AND VARIANCES. 111-8-37-.25(2)(a)	Waivers or variances may be granted with consideration of the following: (a) Variance. A variance may be granted by the Department, at its discretion, upon a showing by the applicant that the particular rule or regulation that is the subject of the variance request should not be applied as written because strict application would cause undue hardship. The applicant must also show that adequate standards exist for affording protection for the health, safety, and care of patients, and these existing standards would be met in lieu of the exact requirements of the rule or regulation; ...	
2504 WAIVERS AND VARIANCES. 111-8-37-.25(2)(b)	Waivers or variances may be granted with consideration of the following: (b) Waiver. The Department may, at its discretion, dispense altogether with the enforcement of a rule or regulation by granting a waiver upon a showing by the applicant that the purpose of the rule or regulation is met through equivalent standards affording equivalent protection for the health, safety, and care of the patients; ...	
2506 WAIVERS AND VARIANCES. 111-8-37-.25(2)(c)	Waivers or variances may be granted with consideration of the following: (c) Experimental Waiver or Variance. The Department may grant a waiver or variance, at its discretion, to allow experimentation and demonstration of new and innovative approaches to delivery of services upon a showing by the applicant that the intended protections afforded by the rule or regulation in question are met and that the innovative approach has the potential to improve service delivery.	

TAGS	RULE	IG
2507 WAIVERS AND VARIANCES. 111-8-37-.25(3)	Waivers and variances granted by the Department must be for a time certain, as determined by the Department.	
2508 WAIVERS AND VARIANCES. 111-8-37-.25(4)	The hospice may request a final review of the initial waiver or variance decision made by program staff to the chief of the Division of Healthcare Facility Regulation by filing a written request for review of the initial decision and providing any additional information which supports the request for review. The chief of the Division will issue a final decision on behalf of the Department.	
2509 WAIVERS AND VARIANCES. 111-8-37-.25(5)	Where the Department has denied the application for a waiver or variance in writing, the Department will not consider a subsequent application for the same waiver or variance from the same hospice unless the applicant includes new evidence of a substantial change in the circumstances which formed the basis for the initial request. Authority O.C.G.A. §§ 31-2-47, and 31-7-170 et seq. History. Original Rule entitled "Waivers and Variances" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	
2601 ENFORCEMENT. 111-8-37-.26	A hospice that fails to comply with licensing requirements as contained in the Rules and Regulations for Hospices, Chapter 111-8-37 and the Rules and Regulations for General Licensing and Enforcement Requirements, Chapter 111-8-25, is subject to civil and administrative actions brought by the Department to enforce licensing requirements as provided by applicable laws and rules. Such actions will be initiated in compliance with the Georgia Administrative Procedures Act, O.C.G.A. §§50-13-1 et seq., 31-2-8 and the Rules and Regulations for General Licensing and Enforcement Requirements, Chapter 111-8-25. The Department may suspend any requirements of these rules and the enforcement of any rules when the Governor of the State of Georgia has declared a public health emergency. Authority O.C.G.A. §§ 31-2-8, 31-7-170 et seq. and 50-13-1 et seq. History. Original Rule entitled "Enforcement" adopted. F. July 27, 2005; eff. Aug. 16, 2005.	The hospice's notice should be substantially similar to the following: THE GEORGIA DEPARTMENT OF HUMAN RESOURCES IS TAKING ACTION TO REVOKE OR SEEK AN EMERGENCY SUSPENSION OF THE LICENSE OF THIS HOSPICE OR THE CURRENT REVOCATION OR SUSPENSION OF THE LICENSE IS UNDER APPEAL. FOR ADDITIONAL INFORMATION, PLEASE CONTACT THE HOSPICE'S ADMINISTRATOR OR THE DEPARTMENT OF HUMAN RESOURCES OR VISIT THE DEPARTMENT'S WEBSITE (http://dhr.georgia.gov).

TAGS	RULE	IG
2701 SEVERABILITY. 111-8-37-.27	<p>Severability. In the event that any rule, sentence, clause, or phrase of any of these rules and regulations may be construed by any court of competent jurisdiction to be invalid, illegal, unconstitutional, or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portion thereof. The remaining rules or portions of rules shall remain in full force and effect, as if such rule or portions thereof so determined, declared, or adjudged invalid or unconstitutional were not originally a part of these rules.</p> <p>Authority O.C.G.A. §§ 31-2-4 and 31-7-170 et seq.</p> <p>History. Original Rule entitled "Severability" adopted. F. July 27, 2005; eff. Aug. 16, 2005.</p>	
9999 FINAL OBSERVATIONS.		



**GEORGIA DEPARTMENT OF
COMMUNITY HEALTH**

Fcxlf 'COEqm Commissioner

Pcyj cp'Fgcñ Governor

2 Peachtree Street, NW
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Atlanta, GA 30303-3159
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HOSPICE INITIAL MEDICARE CERTIFICATION PACKET

This letter is in response to your request for information about the requirements and procedures through which an agency in Georgia may be approved to participate as a Medicare provider of hospice services. The Health Care Section of the Healthcare Facility Regulation Division (HFRD) is contracted by the Centers for Medicare/Medicaid Services (CMS) to perform initial and periodic surveys and to certify whether providers of services meet the hospice Medicare Conditions of Participation. Compliance with the hospice Conditions of Participation is a requirement to participate in Medicare. Such Medicare approval, when required, is a prerequisite to qualifying to participate in the State Medicaid program as well.

Application Process:

As a part of your request to participate in Medicare, you must enroll with the fiscal intermediary (FI). Provider enrollment applications (855 forms) are available for downloading at <http://www.cms.hhs.gov/forms> along with a user's guide providing instructions for downloading and completing the forms. The provider enrollment application must be submitted directly to Palmetto Government Benefits Administration, the FI assigned to Georgia hospice providers. The contact at the FI is Marlene Frierson, who can be reached at (803) 764-5506. If you require help or assistance in completing the CMS 855 form, contact the FI, not HFRD. The FI will notify HFRD of its recommendation for approval or denial of enrollment for your hospice. HFRD cannot conduct the initial Medicare survey until HFRD receives an approval for enrollment for your hospice from the FI.

Enclosed are other CMS forms which you must complete if you desire to participate in the Medicare program. Complete and return the forms promptly to HFRD at the address above in order to avoid unnecessarily delaying approval, since your agency cannot claim provider reimbursement for services furnished prior to approval. If the forms are not self-explanatory, you may contact Jennifer Oetzel, program director at 404-657-6929 for assistance.

Please complete two (2) Health Insurance Benefits Agreements (CMS -1561) with original signatures on both agreements. The Health Insurance Benefits Agreement is your contract with CMS. On the second line of the Health Insurance Benefits Agreement, after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as the W-9 or 941 forms. For example, the ABC Corporation, owner of the Community General Hospital, would enter on the agreement, "ABC Corporation d/b/a Community General Hospital." A

partnership of several persons might complete the agreement to read: "Robert Johnson, Louis Miller and Paul Allen, ptr. d/b/a "Easy Care Home Health Services." A sole proprietorship would complete the agreement to read: "John Smith d/b/a Mercy Hospital." The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the hospice to enter into this agreement.

CMS is required to obtain information from new providers related to their compliance with civil rights requirements. Included in this packet are two (2) HHS 690 forms, entitled Assurance of Compliance, along with attachments that need to be completed and returned to the HFRD along with the rest of the application package. ORS will forward the completed forms to the regional Office for Civil Rights (OCR) for review. In practice, CMS Regional Offices will approve a provider's initial certification pending clearance from OCR. On rare occasions, OCR informs CMS that clearance has been denied or that the required assurances have not been submitted.

LABORATORY SERVICES: If you anticipate that your facility will be performing any clinical laboratory testing or specimen collection, you need to contact the **Diagnostic Services Unit at (404) 657-5450**. This unit will assist you in determining whether there are additional Federal and State laboratory requirements that your facility will have to meet.

Medicare Survey Process:

Before HFRD surveyors can conduct an initial Medicare survey to determine whether Medicare Conditions of Participation are met, the hospice must have obtained a *state license* (see separate packet for licensure instructions), submitted all required *CMS forms to HFRD, obtained approval from the FI of their Medicare provider enrollment application, and be fully operational*. The hospice must have accepted and provided care to two or more patients (who are not required to be Medicare patients), provided all services needed by the patients, demonstrated the operational capability of all facets of the hospice's operations, and be able to demonstrate compliance with each of the hospice Conditions of Participation.

At the time your hospice is fully operational and ready for the initial Medicare survey, a request for an initial Medicare survey is required to be made in writing to HFRD (See enclosed survey request form). In accordance with CMS policy, all certification surveys will be **UNANNOUNCED**.

At the time of the Medicare survey, it will be determined whether or not your hospice meets the Conditions of Participation for the Medicare program. If you are found to be in full compliance with the Medicare Conditions of Participation, HFRD will *recommend* to CMS that you be certified in the Medicare program, effective the date of the survey.

If deficiencies below the condition level are identified during the course of the survey, you will be given an opportunity to submit an **acceptable plan of correction**. Upon receipt of the acceptable plan of correction, HFRD will *recommend* to CMS that your hospice be certified effective the date that you submitted your acceptable plan of correction.

If condition level deficiencies are identified during the course of the survey, HFRD will *recommend* to CMS that your application to participate in the Medicare program be **denied**. If CMS accepts this recommendation, CMS will send a notice giving the reasons for denial and informing you of your right to appeal the denial.

Issuance of Provider Number:

After a determination is made that all requirements for participation in the Medicare program are met, you will be assigned a Medicare provider number. HFRD will notify you and your FI, Palmetto Government Benefits Administration, of your assigned provider number. The FI will subsequently contact you with information about submitting reimbursement claims for Medicare services. Your Hospice **cannot claim provider reimbursement for services rendered to Medicare patients prior to the effective date of your provider number.**

The two (2) Health Benefit Agreements will be countersigned by CMS and HFRD will forward one signed agreement to you for your files and will keep one signed agreement in your HFRD facility file.

Change in Ownership:

If operation of the hospice is later transferred to another owner, ownership group, or a lessee, the Medicare agreement will usually be automatically assigned to the successor. (If the new owner does not wish to accept assignment of the Medicare number, the new owner must make a specific request for a new provider number to CMS in writing). You are required to notify CMS through the HFRD at the time you plan such a change of ownership. Please note that under state law and regulations, you must notify HFRD at least 30 days in advance of any change in ownership.

Enclosures:

- CMS 1561 – Health Insurance Benefit Agreement (2)
- CMS 417 – Hospice Request for Certification in the Medicare Program
- HHS 690 – Assurance of Compliance/Civil Rights (2) and questionnaires
- Request for Medicare Survey memo



**GEORGIA DEPARTMENT OF
COMMUNITY HEALTH**

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Pcyj cp'F gcn Governor

2 Peachtree Street, NW
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www.dch.georgia.gov

HOSPICE APPLICATION REVIEW CHECKLIST

Please use the following checklist to ensure you include all the documents required for HFRD to review your application for initial hospice license. Please use the Applicant Check column for your own review; to be sure all necessary documents are included. Under each document, you will see content which must be acceptable in order to pass review. **Be aware that your application packet may be considered incomplete and ineligible for review if all major documents are not included. It must be clear to the reviewer what each document is, so it is advisable to have them clearly marked.**

Be advised that these are the minimum documents necessary for review for your initial license, but it is not intended to be a complete list of all policies, procedures, forms, etc., that you will need to operate your hospice facility effectively.

<i>Applicant Use</i>		<i>J HTF Office Use Only</i>			<i>Review Date:</i> _____
		<i>Acceptable</i>	<i>Not Accept.</i>	<i>Notes</i>	XXXXXXXXXXXXXXXXXXXX
_____	<u>290-9-43-.04</u> 1. A <i>completed</i> Application for a License to Operate a Hospice, signed and dated.	_____	_____	_____	_____
_____	2. Notarized Personal Identification Affidavit.	_____	_____	_____	_____
_____	3. Copy of Business License, or, if not required, evidence of such communication with local government.	_____	_____	_____	_____
_____	4. Copy of Certificate of Incorporation, if incorporated; or if not incorporated, listing of IRS Tax ID number.	_____	_____	_____	_____

<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>290-9-43-.07</u></p> <p>5. Hospice budget plan for 1st year.</p> <p>6. Description of Services as developed by the Governing Body.</p> <p>7. Designation of the individual responsible to act for the administrator during any period the administrator is absent and the individual responsible for the Quality Management program.</p> <p>8. Staff list, indicating whether employed, contracted, or volunteer.</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>_____</p>	<p><u>290-9-43-.08</u></p> <p>9. Name, qualifications and job description (including copy of professional license if applicable) of administrator.</p> <p>Meets qualification requirements of either (check):</p> <ul style="list-style-type: none"> Licensed healthcare professional with 2 years supervisory or management exp. in a hospice setting; or Education, training, and experience in health service administration with two years supervisory or management Experience in a hospice setting. <p>Job duties include requirements include:</p> <ul style="list-style-type: none"> Ensures that policies are developed w/ the IDT team Ensure employment of qualified staff Ensures policies and procedures are implemented Ensures a qualified DON and sufficient staff Ensures there is an orientation, training, & supervision for every employee and that they complete these programs Ensures that there are effective communication mechanisms for staff, patients, and families. 	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>

<p>_____</p>	<p><u>290-9-43-.09</u></p> <p>10. Outline of the quality management, utilization, and peer review program.</p> <p>Includes QM review of at least the following elements: Appropriateness of admissions, stay, and discharge Appropriateness of professional services and level of care Effectiveness of pain control Patient injuries Errors in medication administration that compromise Patient safety Infection control practices and surveillance data Patient and family complaints and on-call logs Inpatient hospitalizations Adherence to plans of care Appropriateness of treatment</p>	<p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p>
<p>_____</p>	<p><u>290-9-43-10</u></p> <p>11. The explanation of patient rights as provided to patients.</p> <p>Describes all patient and family rights as required in .10(1): Participate in hospice voluntarily and stop at any time Receive only care to which have consented Receive care where dignity, safety, and privacy are preserved Be free from physical or emotional abuse or neglect Be free from unnecessary restraints Have complaints and grievances resolved promptly Able to refuse any specific treatment w/o being discharged Choose their own attending physician Exercise their own religious beliefs Have family present at any time Participate in development of own plan of care Have information be kept confidential Continue hospice care during hospital admissions</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>

	<p>Be provided with description of services and charges Review any hospice inspection report for last two years Respect of self-determination rights and desires Receive care regardless of ability to pay Have information provided by a method effective for them</p> <p>Includes information for reporting complaints to HFRD.</p>			
_____	<p><u>290-9-43-.11</u></p> <p>12. Copy of the hospice’s disaster preparedness plan and forms for documenting rehearsals.</p> <p>The plan addresses weather emergencies and natural disasters, interruption of utilities at the office and in patient homes, and coordination of care if evacuation of the area is necessary.</p> <p>Rehearsal documentation includes date, type, participants, summary of any problems and evaluation of effectiveness.</p> <p>There is evidence that there has been an attempt to include the local EMA in the planning</p>	_____	_____	_____
_____	<p><u>290-9-43-.12</u></p> <p>13 Copies of policy and procedures for infection control.</p> <p>Addresses at least the infection control issues concerning:</p> <ul style="list-style-type: none"> Hand hygiene Wound care Urinary tract care Respiratory therapy Enteral therapy Infusion therapy Cleaning patient care equipment 	_____	_____	_____

	<p>Isolation precautions Handling of medical waste and lab specimens Requirements for initial and annual health screenings Use of personal protective equipment (cont.) Work restrictions during employee illness Evaluation of patients and their environments for risks Outbreak investigation procedures Dietary practices in the hospice care facilities Reporting of communicable diseases as req. by law</p>			
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>290-9-43-.13</u></p> <p>14. Names, qualifications/resumes and job descriptions for all staff members, including verification of licensure where applicable.</p> <p>15. Copy of orientation curriculum.</p> <p style="padding-left: 40px;">Hospice concepts and philosophy</p> <p style="padding-left: 40px;">Patient Rights</p> <p style="padding-left: 40px;">Hospice policies and procedures</p> <p style="padding-left: 80px;">Includes: Reporting of abuse and neglect; disaster preparedness, and fire safety and emergency evacuations.</p> <p>16. Evidence of initial health screening for each employee and volunteer, including TB screening.</p> <p>17. Copies of any contracts for professional services from independent contractors.</p> <p>18. Copy of procedure and requirement for employees/volunteers report abuse or neglect.</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

	<p><u>290-9-43-.14</u></p> <p>19. Written criteria and procedures for admission into home care hospice services.</p> <p>Requires referral from a physician with prognosis of less than six months of life.</p> <p>Requires initial assessment to assess whether the hospice can meet the patient’s needs.</p> <p>Requires that the patient has been given a description of the scope of services offered prior to admission, and has given consent for hospice care.</p> <p>Requires that the patient resides within the hospice service area.</p> <p>Requires a primary caregiver be identified, or a plan by the hospice to meet the daily care needs of the patient.</p> <p>20. Policy regarding development of initial plan of care, including the form used for the initial plan of care.</p> <p>Requires development within 24 hours of admission.</p> <p>Requires input from a physician or RN and consideration of initial assessment.</p> <p>21. Policy/procedures for discharging patients.</p> <p>Requires that involuntary discharge be based on documented safety issues, and that there be documentation of attempts to resolve those issues without discharge.</p> <p>Requires that patients be given at least 14 days notice of discharge except in special circumstances.</p>			
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	<p>Does not require discharge of patients during a period of hospital admission.</p> <p>Requires the hospice participate in coordinating continued care through a discharge or transfer.</p>			
<p>_____</p> <p>_____</p> <p>_____</p>	<p><u>290-9-43-.15</u></p> <p>22. Name and qualifications of social worker.</p> <p>23. Description of composition and responsibilities of a hospice care team (may be policy or procedure).</p> <p>Contains all minimally required members.</p> <p>Responsibilities include providing a comprehensive assessment, and development and periodic review and revision of plans of care.</p> <p>24. Form for a comprehensive assessment.</p> <p>Provides for documentation of assessment of medical, nursing, psychosocial, and spiritual needs of the patient, the ability of the family to meet care needs, and of the family's bereavement needs.</p> <p>Provides for identification of need for referrals for additional assessments.</p> <p>25. Procedure for development and review of plan of care, and sample form for a patient's plan of care.</p>			

	<p>Provides for inclusion of participation of the patient, their family and/or caregiver and/or representative, and documentation of such inclusion.</p> <p>Provides for detail of the scope and frequency of services needed.</p> <p>Provides for review of the plan as needed but no longer than 30 days, and documentation of who participates in the review.</p> <p>Provides for documentation of the physician’s review of any revisions to the plan.</p> <p>26. Policy for use and monitoring of any use of physical restraints as a part of the plan of care.</p> <p>Requires that the restraints are required for prevention of patient injury only.</p> <p>Requires physician order and documentation of consent from the patient or their representative.</p> <p>Requires that the plan of care specify:</p> <p>Type and frequency of monitoring of the restraint; and</p> <p>Maximum duration for restraint application.</p> <p>Requires documentation of each use of restraint.</p>			
	<p><u>290-9-43-.16</u></p> <p>27. Policy/procedures for reporting changes in a patient’s condition noted during a home care visit.</p>			

	<p>28. Policy/procedures for agreements with nursing homes and personal care homes when services are provided to patients in those settings.</p> <p>Includes that the hospice takes full responsibility for the patient's hospice care, and that the agreements must clearly delineate who does what, and specify who is the contact person for communication with the facility.</p> <p>Requires that the hospice will provide a copy of any self-determination documents for the patient.</p> <p>29. Copy of contract(s) for inpatient hospice care and respite care.</p>			
	<p><u>290-9-43-.17</u></p> <p>30. Name and evidence of current license and experience with hospice or terminally ill patients for the Medical Director, with listing of hospitals at which the Director has admission privileges.</p> <p>31. Copy of job description for the Medical Director.</p> <p>Includes participation in the interdisciplinary plan of care reviews, case review conferences, patient assessment and reassessment, quality improvement and utilization reviews, and development of policies, procedures, and protocols related to physician services and patient care.</p> <p>Includes review from patients' attending physicians the clinical documentation of each patient's disease process, drug regimen, and health at time of entry.</p>			

<p>_____</p> <p>_____</p>	<p>Includes responsibility for assuring the face-to-face medical assessment of each patient’s eligibility for continued admission at least every six months (or assessment by a predictability scale).</p> <p>32. Name of designated physician to act in the Medical Director’s behalf during any absence.</p> <p>33. Policy/procedure assuring at a minimum on-call physician services 24/7.</p>			
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>290-9-43-.18</u></p> <p>34. Name, qualifications/resume, job description, and evidence of current license for Director of Nursing.</p> <p>35. Policies and procedures for nursing services, including types and numbers of nursing personnel needed.</p> <p>Provision for availability of nursing care 24/7 and within one hour of request.</p> <p>Supervision of provision of nursing services by an RN.</p> <p>36. Copy of forms used for an on-call log.</p> <p>37. Policies and procedures for provision of personal care services.</p> <p>(cont.) Includes requirement for CNA certification, HHA training completion, or completion of a training program provided by the hospice.</p> <p>Requires competency evaluations for CNAs/PCAs before providing services to clients.</p>			

<p>_____</p> <p>_____</p>	<p>Requires written instructions for each PCA task.</p> <p>Requires supervisory visits by an RN every two weeks at the patient's place of residence to evaluate the PCA performance.</p> <p>38. If the hospice provides an in-house training program for PCAs, a copy of the curriculum for the training program.</p> <p>Contains all elements as described under .18(3)(a)3.</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>290-9-43-19</u></p> <p>39. Description of an organized program for provision of bereavement services.</p> <p>Describes supervision by a licensed counselor, licensed social worker, or other qualified professional.</p> <p>40. Name and qualifications of the individual supervising the bereavement services.</p> <p>41. Description of the provision for availability of clergy for spiritual counseling, and the process/requirement for notifying patients and families of this availability.</p> <p>42. Name and qualifications of clergy provided by the hospice to serve on the hospice care team.</p> <p>Has completed at least one unit of clinical pastoral education.</p> <p>43. Copies of policies and procedures for delivery of dietary and nutritional services.</p> <p>44. Description of arrangements for provision of PT, OT, or speech pathology services if needed by patients.</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

	<p><u>290-9-43-.20</u></p> <p>45. Copy of policies/procedures for provision of volunteer services.</p> <p>Addresses recruitment, screening, orientation, scope of function, supervision, basic infection control, ongoing training and support, and documentation of volunteer activities.</p> <p>46. Name of designated volunteer services coordinator.</p>			
	<p><u>290-9-43-.21</u></p> <p>47. Copy of policies and procedures for management of drugs and biologicals.</p> <p>Evidence of approval by a licensed pharmacist.</p> <p>Addresses availability of a licensed pharmacist 24/7 for advice.</p> <p>Addresses placement of emergency drug kit, and records of receipt, disposition, destruction, and reconciliation of all controlled drugs.</p> <p>Assures that only licensed nurses or doctors are allowed to administer medications.</p>			
	<p><u>290-9-43-22</u></p> <p>48. Description of system for creating and maintaining medical records. (cont.)</p> <p>Requires entries be signed and dated by the service provider and entered into the record within seven days.</p>			

	<p>Requires each record contain identification data, the initial and subsequent assessments, medical and psychosocial history, consent and authorization forms, the interdisciplinary plan of care, the name of the attending physician, and complete documentation of all services and events concerning the patient and their family and the hospice.</p> <p>Defines safeguards for storage and confidentiality of the records.</p>			
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Reviewed by: _____

Date: _____