

related management company/central office. Salaries shall be limited to Civil Service maximums.

20. Nurse Assistant Training. There shall be a supplemental cost report for nurse aide training and these costs shall not be included in the regular cost report.

21. Owner's Compensation. All types of owners' compensation costs are allowable based on the following limitations.

a. The position filled by the owner is normal to the industry.

b. The salary paid to the owner is in line with employees' salaries for similar positions as shown in the paragraph entitled Salaries.

c. Facility records document shows that the owner does perform the service for which he/she is being compensated.

22. Depreciation. Only the straight-line method of depreciation shall be allowed.

NOTE: Depreciation of assets being used by a vendor at the time he enters the Medicaid program is allowed. This applies even though such assets be fully or partially depreciated on the vendor's books. As long as an asset is being used, its useful life is considered not to have ended. Consequently, the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by the Medicaid program.

23. Costs Not Allowable

a. Dues paid to more than one professional trade association or organization, bad debts, unreasonable costs, costs not related to resident care, fines and penalties, and related party costs in excess of actual costs are examples of unallowable costs.

b. Nursing facilities are not to show any cost relating to ventilator equipment in their cost reports to Bureau of Health Services Financing.

c. In cases where nursing service expense at the various levels of care is not kept separate, the following formula may be used for allocating these costs:

i. step one, multiply the number of resident days at each level of care by the weighted factor;

NOTE: The factor represents the number of nursing hours required per patient day at each level of care.

ii. step two, compute the weighted percentage of patient days for each level of care;

iii. step three, apply the percentage computed in step two to the total nursing service expense for the period;

iv. step four, the result obtained in step three is carried to the appropriate schedule of the cost report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10153. Audits, Inspections, Reviews

A. General. Facilities shall be subject to audits, inspections of the quality of care provided, and review of each applicant/recipient's need for SN-NRTP, SN-TDC, SN-ID, SN, IC I, or IC II services.

B. Audits. All nursing facility providers participating in the Medicaid Program shall be subject to audit. A sufficient representative sample of each type of Long Term Care provider shall be fully audited to ensure the fiscal integrity of the program and compliance with program regulations governing reimbursement. Limited scope and exception audits shall be conducted as needed. The facility shall retain such records or file as required by the Department of Health and Hospitals-Bureau of Health Services Financing and shall have them available for inspection for three years from the date of service or until all audit exceptions are resolved, whichever period is longer.

NOTE: If the department's limited scope audit of the residents' Personal funds account indicate a material number of transactions were not sufficiently supported or material non-compliance, the department shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments. (Refer to Subchapter L, Sanctions and Appeal Procedures.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter G. Levels of Care

§10154. Nursing Facility Level of Care Determinations

A. The purpose of the level of care (LOC) determination is to assure that individuals meet the functional and medical necessity requirements for admission to and continued stay in a nursing facility. In addition, the LOC determination process assists persons with long-term or chronic health care needs in making informed decisions and selecting options that meet their needs and reflect their preferences.

B. In order for an individual to meet nursing facility level of care, functional and medical eligibility must be met as set forth and determined by the Office of Aging and Adult Services (OAAS). The functional and medical eligibility process is frequently referred to as the "nursing facility level of care determination."

C. OAAS shall utilize prescribed screening and assessment tools to gather evaluation data for the purpose of determining whether an individual has met the nursing facility level of care requirements as set forth in this Subchapter.

D. Individuals who are approved by OAAS, or its designee, as having met nursing facility level of care must continue to meet medical and functional eligibility criteria on an ongoing basis.

E. A LOC screening conducted via telephone shall be superseded by a face-to-face minimum data set (MDS) assessment, minimum data set for home care (MDS-HC)

assessment, or audit review LOC determination as determined by OAAS or its designee.

F. If on an audit review or other subsequent face-to-face LOC assessment, the LOC findings are determined to be incorrect or it is found that the individual no longer meets level of care, the audit or subsequent face-to-face LOC assessment findings will prevail.

G. The department may require applicants to submit documentation necessary to support the nursing facility level of care determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:2083 (November 2006), amended by the Office of Aging and Adult Services, LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:341 (January 2011), LR 39:1471 (June 2013).

§10155. Standards for Levels of Care

A. Classifications of care are established to ensure placement of residents in Long Term Care Facilities with available and appropriate resources to meet their social psychological, psychological, and biophysical needs.

B. Classifications of care are established with consideration of the resident as a person with innate dignity and worth as a human being.

C. Classifications of care are defined and established so that a resident's total needs, the complexity of the services rendered, and the time required to render these services be assessed in determining placement.

D. Classifications of care are established to prevent placement of residents in facilities where they would present a danger to themselves or other residents.

E. Classifications of care are established to maintain health care so residents achieve a reasonable recovery, maintain a current level of wellness, or experience minimal health status deterioration.

F. Facility Submission of Data. Evaluative data for medical certification for IC I, IC II, and SNF levels of care shall be submitted to the appropriate Bureau of Health Services Financing-Health Standards, Admission Review Unit. This includes data for the following situations:

1. initial applications and reapplication;
2. applications for residents already in long term care facilities;
3. transfers of residents from one level to another;
4. transfer of residents between facilities; and
5. applications for residents who are residents in a mental health facility.

a. All applicants for admission to a nursing facility must be screened for indications of mental illness or mental

retardation prior to admission to the nursing facility. This is done by submitting the information requested on Forms 90-L and PASARR-1.

G. Nursing Hours Required

1. The facility will staff for any residents on pass and/or bed hold for hospitalization.

2. Private pay residents must be staffed at the highest level of care unless the level of care is determined by the attending physician.

3. The facility shall provide a minimum nurse staffing pattern and ratio for each level of care as follows.

a. Skilled service shall provide a minimum nurse staffing pattern over a 24 hour period at a ratio of 2.6 hours per skilled resident.

b. Intermediate care services shall provide a minimum licensed nurse staffing pattern over a 24 hour period of 2.35 hours per resident medically certified at the intermediate level.

c. NRTP/Rehabilitation 5.5; NRTP/Complex 4.5.

d. TDC 4.5.

e. Skilled ID 4.0.

4. Intermediate Care I. *Intermediate Care I* is defined as follows:

a. This is a medium level of care provided to Medicaid recipients residing in nursing facilities. The conditions requiring this level of care are characterized by a need for monitoring of moderate intensity. Care shall be provided by qualified facility staff or by ancillary health care providers under the supervision of a registered nurse or licensed practical nurse in accordance with physician's orders. This care shall be available to residents on a 24 hour a day basis.

b. Intermediate Care I services is determined by the following:

i. The resident shall need services in order to attain and maintain a maximum level of wellness.

ii. Care usually considered IC II can become IC I if there are complicating circumstances.

iii. A resident may have multiple conditions, any one of which could require only IC II level of care, but the sum total of which would indicate the need for IC I level of care.

NOTE: Examples of IC I Services (not all inclusive):

Administration of oral medications and eye drops;
 Special appliance: Urethral catheter care;
 Colostomy care;
 Surgical dressings;
 Care of decubitus ulcers which are not extensive;
 Dependence on staff for a majority of personal care needs;
 Bed or chair bound;
 Frequent periods of agitation requiring physical or chemical restraints;
 Combined sensory defects (e.g. blindness, deafness, significant speech impairment);
 Care of limbs in cast, splints, and other appliances;

upgrades and downgrades in level of care. If submitted within the 20 working day time frame, the effective date of change in medical certification will be the date the physician signs the Form 149-B.

2. If the facility fails to timely submit the request, the effective date of the medical certification will be the date the Form 149-B is received in the HSS Regional Office.

3. The completion of the Form 149-B is also required when a resident transfers to Medicare skilled level.

4. The Medicaid Program will pay co-insurance beginning on the twenty-first day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), LR 23:970 (August 1997), 24:457 (March 1998), LR 29:911 (June 2003).

§10156. Level of Care Pathways

A. Several potential avenues of functional and medical eligibility shall be investigated by OAAS. These avenues are called pathways. The pathways are utilized to ensure consistency, uniformity, and reliability in making nursing facility level of care determinations. In order to meet the nursing facility level of care, an individual must meet eligibility requirements in only one pathway.

B. When specific eligibility criteria are met within a pathway, that pathway is said to have triggered. The Medicaid program defines nursing facility level of care for Medicaid eligible individuals as the care required by individuals who meet or trigger any one of the established level of care pathways described in this Subchapter. The pathways of eligibility focus on information used to determine if an individual has met or triggered a level of care pathway.

C. The level of care pathways elicit specific information, within a specified look-back period, regarding the individual's:

1. functional capabilities;
2. receipt of assistance with activities of daily living (ADL);
3. current medical treatments and conditions; and
4. other aspects of an individual's life.

D. Activities of Daily Living Pathway

1. The intent of this pathway is to determine the individual's self-care performance in activities of daily living during a specified look-back period (e.g., the last seven days, last three days, etc. from the date the LOC assessment was completed), as specified in prescribed screening and assessment tools.

2. The ADL Pathway identifies those individuals with a significant loss of independent function measured by the amount of assistance received from another person in the

period just prior to the day the LOC assessment was completed.

3. The ADLs for which the LOC assessment elicits information are:

- a. locomotion—moving around in the individual's home;
- b. dressing—how the individual dresses/undresses;
- c. eating—how food is consumed (does not include meal preparation);
- d. bed mobility—moving around while in bed;
- e. transferring—how the individual moves from one surface to another (excludes getting on and off the toilet and getting in and out of the tub/shower);
- f. toileting—includes getting on and off the toilet, wiping, arranging clothing, etc;
- g. personal hygiene (excludes baths/showers); and
- h. bathing (excludes washing of hair and back).

4. Since an individual can vary in ADL performance from day to day, OAAS trained assessors shall capture the total picture of ADL performance over the specified look-back period.

5. In order for an individual to be approved under the ADL Pathway, the individual must score at the:

- a. limited assistance level or greater on toilet use, transferring, or bed mobility; or
- b. extensive assistance level or greater on eating.

E. Cognitive Performance Pathway.

1. This pathway identifies individuals with the following cognitive difficulties:

- a. short term memory which determines the individual's functional capacity to remember recent events;
- b. cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or activities of daily living such as:
 - i. planning how to spend his/her day;
 - ii. choosing what to wear; or
 - iii. reliably using canes/walkers or other assistive devices/equipment, if needed;
- c. making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

2. In order for an individual to be approved under the Cognitive Performance Pathway, the individual must have any one of the conditions noted in a. through m. below:

a. be severely impaired in daily decision making (never or rarely makes decisions);

b. have a short term memory problem and daily decision making is moderately impaired (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times);

c. have a short term memory problem and daily decision making is severely impaired (e.g., never or rarely makes decisions);

d. have a memory problem and is sometimes understood (e.g., the individual's ability is limited to making concrete requests);

e. have a short term memory problem and is rarely or never understood;

f. be moderately impaired in daily decision making (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is usually understood, (e.g., the individual has difficulty finding words or finishing thoughts and prompting may be required);

g. be moderately impaired in daily decision making (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is sometimes understood (e.g., his/her ability is limited to making concrete requests);

h. be moderately impaired in daily decision making (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is rarely or never understood;

i. be severely impaired in daily decision making, never or rarely makes decisions. The individual has difficulty finding words or finishing thoughts and prompting may be required;

j. be severely impaired in daily decision making (e.g., never or rarely makes decisions) and the individual is sometimes understood (e.g., his/her ability is limited to making concrete requests);

k. be severely impaired in daily decision making, never or rarely makes decisions, and the individual is rarely or never understood;

l. be minimally impaired in daily decision making (e.g., the individual has some difficulty in new situations or his/her decisions are poor and requires cues and supervision in specific situations only) and the individual is sometimes understood (e.g., the individual's ability is limited to making concrete requests); or

m. be minimally impaired in daily decision making (e.g., the individual has some difficulty in new situations or his/her decisions are poor, cues and supervision are required in specific situations only) and the individual is rarely or never understood.

F. Physician Involvement Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

2. Physician visits and physician orders will be investigated for this pathway. Consideration will be given to the physician visits in the last 14 days, excluding emergency room exams, and physician orders in the last 14 days, excluding order renewals without change or hospital inpatient visits.

3. In order for an individual to be approved under the physician involvement pathway, the individual must have 1 day of doctor visits and at least 4 new order changes within the last 14 days or:

a. at least 2 days of doctor visits and at least 2 new order changes within the last 14 days; and

b. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:

i. a copy of the physician's orders;

ii. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or

iii. the appropriate form designated by OAAS to document the individual's medical status and condition.

4. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

G. Treatments and Conditions Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself. The following treatments and conditions shall be investigated for this pathway:

a. stage 3-4 pressure sores in the last 14 days;

b. intravenous feedings in the last 7 days;

c. intravenous medications in the last 14 days;

d. daily tracheostomy care and ventilator/respiratory suctioning in the last 14 days;

e. pneumonia in the last 14 days and the individual's associated IADL or ADL needs or restorative nursing care needs;

f. daily respiratory therapy provided by a qualified professional in the last 14 days;

g. daily insulin injections with two or more order changes in the last 14 days:

i. supporting documentation shall be required for the daily insulin usage and the required order changes; and

h. peritoneal or hemodialysis in the last 14 days.

2. In order for an individual to be approved under the treatments and conditions pathway, the individual must have:

- a. any one of the conditions listed in §10156.G.1.a-h; and
- b. supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:
 - i. a copy of the physician's orders;
 - ii. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or
 - iii. the appropriate form designated by OAAS to document the individual's medical status and condition.

3. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

H. Skilled Rehabilitation Therapies Pathway

1. The intent of this pathway is to identify individuals who have received, or are scheduled to receive, at least 45 minutes of physical therapy, occupational therapy, or speech therapy in the last seven days or within seven days from the date the LOC assessment is completed.

2. In order for an individual to be approved under the skilled rehabilitation therapies pathway, the individual must have:

- a. received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the last seven days; or
- b. at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled for the next seven days as specified in the applicable screening/assessment tool and supporting documentation for the specific condition(s) identified and deemed applicable by OAAS. Acceptable documentation may include:
 - i. a copy of the physician's orders for the scheduled therapy;
 - ii. the home health care plan notes indicating the therapy received during the required look-back period;
 - iii. progress notes indicating the physical, occupational, and/or speech therapy received or scheduled;
 - iv. nursing facility or hospital discharge plans indicating the therapy received for the required look-back period or therapy scheduled for the required look-forward period; or
 - v. the appropriate form designated by OAAS to document the individual's medical status and condition.

3. This pathway is approved for limited stay/length of service as deemed appropriate by OAAS.

I. Behavior Pathway

1. The intent of this pathway is to identify individuals who have experienced repetitive behavioral challenges which have impacted his/her ability to function in the community during the specified screening/assessment look-back period. The behavior challenges may include:

- a. wandering;
- b. verbally or physically abusive behavior;
- c. socially inappropriate behavior; or
- d. delusions or hallucinations.

2. In order for an individual to be approved under the behavior pathway, the individual must have:

a. exhibited any one of the following behaviors four to six days of the screening tool's seven-day look-back period, but less than daily:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive; or

b. exhibited any one of the following behaviors daily during the screening tool's seven-day look-back period:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive; or

c. experienced delusions or hallucinations within the screening tool's seven-day look-back period that impacted his/her ability to live independently in the community; or

d. exhibited any one of the following behaviors during the assessment tool's three-day look-back period and behavior(s) were not easily altered:

- i. wandering;
- ii. verbally abusive;
- iii. physically abusive;
- iv. socially inappropriate or disruptive; or

e. experienced delusions or hallucinations within the assessment tool's three-day look-back period that impacted his/her ability to live independently in the community.

J. Service Dependency Pathway

1. The intent of this pathway is to identify individuals who are currently in a nursing facility or receiving services through the adult day health care waiver, the community choices waiver, program of all inclusive care for the elderly (PACE) or receiving long-term personal care services.

2. In order for individuals to be approved under this pathway, the afore-mentioned services must have been approved prior to December 1, 2006 and ongoing services are required in order for the individual to maintain current functional status.

3. There must have been no break in services during this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 2013), LR 41:1289 (July 2015).

Subchapter H. Reserved

Subchapter I. Resident Rights

§10161. General Provisions

A. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.

B. Exercise of Rights

1. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

3. In the case of a resident adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

C. Civil Rights Act Of 1964 (Title VI)

1. Title VI of the Civil Rights Act of 1964 states No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or subjected to discrimination under any program or activity receiving federal financial assistance.

2. Nursing facilities shall meet the following criteria in regard to the above-mentioned Act.

a. **Compliance.** Facilities shall be in compliance with Title VI of the Civil Rights Act of 1964 and shall not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

b. **Written Policies.** Facilities shall has written policies and procedures that notify the community that admission to the facility, resident care services, and other activities are provided without regard to race, color, or national origin.

c. **Community Notification.** Facilities shall notify the community that admission to the facility, resident care

services, and other activities are provided without regard to race, color, or national origin. Notice to the community may be given by letters to and meeting with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity. Notices published in newspapers and signs posted in the facility may also be used to inform the public.

D. Section 504 Of The Rehabilitation Act Of 1973. Facilities shall comply with Section 504 of the Rehabilitation Act of 1973 which states the following: No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

E. Age Discrimination Act of 1975. This Act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All facilities must be in compliance with this Act.

F. Notice Of Rights and Services. All residents or legal representative shall sign a statement that they have been fully informed verbally and in writing in a language that the resident understands of the following information prior to or at the time of admission and when changes occur during their stay in the facility:

1. the facility's rules and regulations;

2. their rights;

3. their responsibilities to obey all reasonable rules and regulations and respect the personal rights and private property of other residents;

4. rules for conduct at the time of their admission and subsequent changes during their stay in the facility;

a. changes in resident rights policies shall be conveyed both verbally and in writing to each resident at the time of or prior to the change, and acknowledged in writing.

b. the resident or his/her legal representative has the right:

i. upon an oral or written request to access all records pertaining to himself or herself including clinical records within 24 hours; and

ii. after receipt of his/her records for inspection to purchase, at a cost as set forth in LA R.S. 40:1299.96, photocopies of the records or any portions of them upon request and two working days advance notice to the facility;

5. the resident has the right to be fully informed in a language that he/she can understand of his/her total health status including but not limited to his/her medical condition;

6. the resident has the right to:

a. refuse medication and medical treatment including a physician visit, other than to discover and prevent the spread of infection of contagious disease to protect environmental health and hygiene or otherwise