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TITLE 216 – DEPARTMENT OF HEALTH

CHAPTER 40 – PROFESSIONAL LICENSING AND FACILITY REGULATION

SUBCHAPTER 10 – FACILITIES REGULATION

PART 11 – Licensing Hospice Care

11.1 Authority

These regulations are promulgated pursuant to the authority conferred under R.I. Gen. Laws §§ 23-17-2(7) and 23-17-10(a)(1), and are established for the purpose of adopting minimum standards for licensed hospice care in this state.

11.2 Incorporated Materials

A. These regulations hereby adopt and incorporate the American Institute of Architects Academy of Architecture for Health's "Guidelines for Design and Construction of Hospital and Health Care Facilities" (2006) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

B. These regulations hereby adopt and incorporate the National Research Council National Academy of Sciences' "Recommended Dietary Allowances" (1989), by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

C. These regulations hereby adopt and incorporate the National Tuberculosis Center's "Policy and Procedures for Tuberculosis Screening of Health-Care Workers" (2016) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

D. These regulations hereby adopt and incorporate "Recommendations for Preventing the Spread of Vancomycin Resistance: Recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC)" (1995) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

E. These regulations hereby adopt and incorporate "The American National Standard - Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped" (1961) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

F. These regulations hereby adopt and incorporate "The Americans with Disabilities Act" 42 U.S.C §§ 12101-12213; 47 U.S.C §§ 152, 221, 225, 611; 29 U.S.C § 706 (1990) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

G. These regulations hereby adopt and incorporate “Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)” (1997) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

H. These regulations hereby adopt and incorporate the U.S. Department of Health & Human Services, Public Health Services, Centers for Disease Control & Prevention’s “Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities” (1994) by reference, not including any further editions or amendments thereof and only to the extent that the provisions therein are not inconsistent with these regulations.

11.3 Definitions (Applies to All Facilities and Programs)

A. Wherever used in these rules and regulations the following terms shall be construed as follows:

1. "Attending practitioner" means a physician, as defined in R.I. Gen. Laws Chapter 5-37, or a certified nurse practitioner, as defined in R.I. Gen. Laws Chapter 5-34, (who may or may not be on the hospice staff) identified by the terminally ill patient/family as having a significant role in the determination and delivery of the patient’s medical care. Attending practitioner also means a physician assistant (who may or may not be on the hospice staff), as long as the physician assistant’s role is providing medical and surgical services in collaboration with physicians, as set forth in the provisions of R.I. Gen. Laws Chapter 5-54.

2. "Bereavement" means the extended period of grief preceding the death and following (usually for one year) the death of a loved one, during which individuals experience, respond, and adjust emotionally, physically, socially, and spiritually to the loss of a loved one.

3. "Branch office" means a fixed and established geographical location from which a licensed hospice program provides services within a portion of the total geographic area served by the licensed central office.

4. "Certified nurse practitioner” means an advanced practice nurse utilizing independent knowledge of physical assessment, diagnosis, and management of health care and illnesses. The practice includes prescriptive privileges. Certified nurse practitioners are members of the health care delivery system practicing in areas including, but not limited to family practice, pediatrics, adult health care, geriatrics, and women’s health care in primary, acute, long-term, and critical care settings in health care facilities and the community. Certified nurse practitioners may be recognized as the primary care provider or acute-care provider of record.

5. "Change in operator" means a transfer by the governing body or operator of a hospice program to any other person (excluding delegations of authority to the medical or administrative staff of the facility) of the governing body's authority to:

a. Hire or fire the chief executive officer of the hospice program;

b. Maintain and control the books and records of the hospice program;

c. Dispose of assets and incur liabilities on behalf of the hospice program; or

d. Adopt and enforce policies regarding operation of the hospice program.

e. This definition is not applicable to circumstances wherein the governing body of a hospice program retains the immediate authority and jurisdiction over the activities enumerated in §§ 11.3(A)(6)(a) through (d) of this Part.

6. "Change in owner" means:

a. In the case of a hospice program that is a partnership, the removal, addition, or substitution of a partner which results in a new partner acquiring a controlling interest in such partnership;

b. In the case of a hospice program that is an unincorporated sole proprietorship, the transfer of the title and property to another person;

c. In the case of a hospice program that is a corporation:

(1) A sale, lease, exchange, or other disposition of all, or substantially all of the property and assets of the corporation; or

(2) A merger of the corporation into another corporation; or

(3) The consolidation of two or more corporations, resulting in the creation of a new corporation; or

(4) In the case of a hospice program that is a business corporation, any transfer of corporate stock that results in a new person acquiring a controlling interest in such corporation; or

(5) In the case of a hospice program that is a non-business corporation, any change in membership that results in a new person acquiring a controlling vote in such corporation.

7. “Collaboration” means the physician assistant shall, as indicated by the patient’s condition, the education, competencies, and experience of the physician assistant, and the standards of care, consult with or refer to an appropriate physician or other healthcare professional. The degree of collaboration shall be determined by the practice and includes decisions made by a physician employer, physician group practice, and the credentialing and privileging systems of a licensed hospital, health center, or ambulatory care center. A physician must be accessible at all times for consultation by the physician assistant.

8. “Department” means the Rhode Island Department of Health.

9. "Director" means the Director of the Rhode Island Department of Health.

10. “Disqualifying information” means that information produced by a criminal record check, pertaining to conviction, for the following crimes will result in a letter to the

employee and employer disqualifying the applicant from said employment: murder, voluntary manslaughter, involuntary manslaughter, first degree sexual assault, second degree sexual assault, third degree sexual assault, assault on persons sixty (60) years of age or older, child abuse, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the abominable and detestable crime against nature), felony assault, patient abuse, neglect or mistreatment of patients, burglary, first degree arson, robbery, felony drug offenses, larceny or felony banking law violations.

11. “Equity” means non-debt funds contributed toward the capital costs related to a change in owner or change in operator of a hospice facility which funds are free and clear of any repayment or liens against the assets of the proposed owner and/or licensee and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged.

12. "General inpatient care" means hospice care provided to terminally ill patients in an inpatient setting.

13. "Hospice care" (hereinafter referred to as “hospice program”) means a program of palliative care that provides for the physical, psychological, social and spiritual needs of a terminally ill patient and his/her family, both in the home and in an inpatient setting.

14. “Hospice inpatient facility” means a health care facility that cares for hospice and palliative care patients requiring short-term, general inpatient, respite care, or routine home care and is operated directly by a hospice program under a license issued by the Department.

15. "Inpatient respite care" means short-term inpatient care provided to terminally ill patients to provide relief to family members or others caring for the patient.

16. "Licensing agency" means the Rhode Island Department of Health.

17. “Medication aide”, as used herein, means selected unlicensed personnel who have satisfactorily completed a state-approved course in drug administration who may administer oral or topical drugs (with the exception of Schedule II drugs) in accordance with the requirements of § 11.5.8(J) of this Part.

18. "Nurse" means an individual licensed to practice as a professional (registered) (RN) or licensed practical nurse (LPN) in this state under the provisions of R.I. Gen. Laws Chapter 5-34.

19. "Nursing assistant" means a nurse's aide, orderly, or home health aide who is a paraprofessional, and who holds a Rhode Island certificate of registration pursuant to the provisions of R.I. Gen. Laws Chapter 23-17.9, and the rules and regulations promulgated thereunder, who is trained to give personal care and related health care and assistance based on his/her level of preparation to individuals who are sick, disabled, dependent, or infirm, and who are patients of or who are receiving services from health care facilities.

20. "Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice.

21. "Person" means an individual, trust or estate, partnership, corporation (including associations, joint stock companies), limited liability company, state or political subdivision or instrumentality of a state.

22. "Physician" means any individual licensed to practice medicine in this state under the provisions of R.I. Gen. Laws Chapter 5-37.

23. “Physician assistant” means a person who is qualified by academic and practical training to provide medical and surgical services in collaboration with physicians, as set forth in the provisions of R.I. Gen. Laws Chapter 5-54.

24. “Residential area” means a distinct living environment within an inpatient hospice facility that includes no more than sixty (60) beds.

25. “Social worker” means a person licensed under R.I. Gen. Laws Chapter 5-38.1 and the Rules and Regulations Pertaining to Licensing Clinical Social Workers and Independent Clinical Social Workers.

26. “Spiritual counselor” means clergy (individual ordained for religious service), pastoral or another similar counselor.

27. "Terminally ill" means that an individual has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

11.4 Licensure Procedures

11.4.1 General Requirements for Licensure

A. No person acting alone or jointly with any other person, shall establish, conduct, or maintain a hospice program in this state without a license in accordance with the requirements of R.I. Gen. Laws § 23-17-4 and in accordance with the rules and regulations of this Part.

1. However, pursuant to R.I. Gen. Laws § 23-17-2(7), any provider of hospice care who provides hospice care without charge shall be exempt from the licensing provisions above, but shall meet applicable standards of the National Hospice and Palliative Care Organization.

B. A certificate of need is required as a precondition to licensure of any hospice program, unless exempt under R.I. Gen. Laws § 23-15-2(4)(ii), in accordance with the Rules and Regulations Pertaining to Determination of Need for New Health Care Equipment and New Institutional Health Care Services.

C. Any change in owner, operator, or lessee of a licensed hospice program shall require prior review by the Health Services Council and approval of the licensing agency as

provided in §§ 11.4.5(A) and (B) of this Part, as a condition precedent to the transfer, assignment or issuance of a new license.

D. No facility shall hold itself or represent itself as a hospice program or use the term "hospice" or other similar term in its advertising, publicity or any other form of communication, unless licensed as a hospice program in accordance with the provisions herein.

E. A hospice program shall organize, manage, and administer its hospice care services to attain and maintain the highest obtainable quality of life for each patient and address issues related to care at the end of life in a manner consistent with acceptable standards of practice.

F. Upon notification by the Department, any licensed hospice program that holds a nursing facility license shall be issued a new license as a hospice inpatient facility and shall surrender its nursing facility license to the Department.

G. Each hospice program that maintains a branch office shall disclose to the licensing agency the location of agency records (i.e., central office or branch office). At a minimum, all clinical records shall be maintained at the branch office for those patients served by the branch office.

11.4.2 Application for License

A. Application for a license to conduct, maintain or operate a hospice program shall be made to the licensing agency upon forms provided by the licensing agency and shall contain such information as the licensing agency reasonably requires which may include affirmative evidence of ability to comply with the provisions of R.I. Gen. Laws Chapter 23-17 and the rules and regulations of this Part.

1. Each application shall be accompanied by an application fee as set forth in the Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory and Administrative Services Provided by the Department of Health (Part 10-05-2 of this Title).

B. A notarized listing of names and addresses of direct and indirect owners whether individual, partnership, or corporation with percentages of ownership designated shall be provided with the application for licensure and shall be updated annually. The list shall include each owner (in whole or in part) of any mortgage, deed or trust, note or other obligation secured (in whole or in part) by the hospice care program or any of the property or assets of the hospice program.

C. The list shall also include all officers, directors, and other persons of any subsidiary corporation owning stock, if the hospice program is organized as a corporation and all partners if organized as a partnership.

11.4.3 Issuance and Renewal of License

A. Upon receipt of an application for a license, the licensing agency shall issue a license for a period of no more than one (1) year, if the applicant meets the requirements of R.I. Gen. Laws Chapter 23-17 and the rules and regulations of this Part. The license issued,

unless sooner suspended or revoked, shall expire by limitation on the 31st day of December following its issuance and may be renewed from year to year subject to inspection and approval by the licensing agency.

1. All renewal applications shall be accompanied by a renewal fee as set forth in the Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory and Administrative Services Provided by the Department of Health (Part 10-05-2 of this Title).

2. In accordance with R.I. Gen. Laws § 23-17-38, nonprofit hospice programs with current home nursing care provider licenses shall be exempt from the annual licensure fee stated herein.

3. Each hospice program that maintains a branch office shall indicate on the application the location of the central office as well as the location(s) of the branch office(s).

B. Hospice programs operating under a single license may establish branch offices under that same single license and such license shall be maintained and posted in the central office.

C. A license issued shall not be transferable or assignable except with the written approval of the licensing agency.

11.4.4 Application for Changes in Owner, Operator, or Lessee

A. Application for review for changes in the owner, operator, or lessee of a hospice program shall be made on forms provided by the licensing agency and shall contain but not be limited to information pertinent to the statutory purpose expressed in R.I. Gen. Laws § 23-17-3 or to the considerations enumerated in § 11.4.5(B) of this Part. Three (3) paper copies and an electronic copy of such applications are required to be provided.

1. Each application filed pursuant the provisions of this section shall be accompanied by a non-refundable, non-returnable application fee, as set forth in the Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory and Administrative Services Provided by the Department of Health (Part 10-05-2 of this Title).

11.4.5 Change in Owner, Operator, or Lessee Review

A. Reviews of applications for changes in the owner, operator, or lessee of a licensed hospice program shall be conducted according to the procedures stated in R.I. Gen. Laws § 23-17-14.4. The licensing agency will notify and afford the public thirty (30) days to comment on such applications.

B. The limits on licensing criteria are stated in R.I. Gen. Laws § 23-17-14.3. In conducting reviews of such applications, the Health Services Council shall specifically consider and it shall be the applicant's burden of proof to demonstrate:

1. The character, commitment, competence, and standing in the community of the proposed owners, operators or directors of the hospice program as evidenced by:

    a. In cases where the proposed owners, operators, or directors of the health care facility currently own, operate, or direct a health care facility, or in the past five years owned, operated, or directed a health care facility, whether within or outside Rhode Island, the demonstrated commitment and record of that (those) person(s):

        (1) In providing safe and adequate treatment to the individuals receiving the health care facility's services;

        (2) In encouraging, promoting, and effecting quality improvement in all aspects of health care facility services; and

        (3) In providing appropriate access to health care facility services;

    b. A complete disclosure of all individuals and entities comprising the applicant; and

    c. The applicant’s proposed and demonstrated financial commitment to the health care facility.

2. The extent to which the program will provide or will continue, without material effect on its viability at the time of change of owner, operator, or lessee, to provide safe and adequate treatment for individuals receiving the hospice services as evidenced by:

    a. The immediate and long-term financial feasibility of the proposed financing plan;

        (1) The proposed amount and sources of owner's equity to be provided by the applicant;

        (2) The proposed financial plan for operating and capital expenses and income for the period immediately prior to, during and after the implementation of the change in owner, operator, or lessee of the health care facility,

        (3) The relative availability of funds for capital and operating needs,

        (4) The applicant's demonstrated financial capability, and

        (5) Such other financial indicators as may be requested by the state agency.

3. The extent to which the program will provide or will continue to provide safe and adequate treatment for individuals receiving the hospice services and the extent to which the facility will encourage quality improvement in all aspects of the operation of the health care facility as evidenced by:

a. The applicant's demonstrated record in providing safe and adequate treatment to individuals receiving services at facilities owned, operated, or directed by the applicant; and

b. The credibility and demonstrated or potential effectiveness of the applicant's proposed quality assurance programs.

4. The extent to which the program will provide or will continue to provide appropriate access with respect to traditionally underserved populations as evidenced by:

a. In cases where the proposed owners, operators, or directors of the health care facility currently own, operate, or direct a health care facility, or in the past five (5) years owned, operated, or directed a health care facility, both within and outside of Rhode Island, the demonstrated record of that person(s) with respect to access of traditionally underserved populations to its health care facilities; and

b. The proposed immediate and long-term plans of the applicant to ensure adequate and appropriate access to the programs and health care services to be provided by the health care facility.

5. In consideration of the proposed continuation or termination of health care services by the hospice program:

a. The effect(s) of such continuation or termination on access to safe and adequate treatment of individuals, including but not limited to traditionally underserved populations.

6. And, in cases where the application involves a merger, consolidation or otherwise legal affiliation of two or more health care facilities, the proposed immediate and long-term plans of such health care facilities with respect to the health care programs to be offered and health care services to be provided by such health care facilities as a result of the merger, consolidation or otherwise legal affiliation.

C. Subsequent to reviews conducted under §§ 11.4.5(A), (B), (E), and (F) of this Part, the issuance of a license by the licensing agency may be made subject to any consideration, provided that no condition may be made unless it directly relates to the statutory purpose expressed in R.I. Gen. Laws § 23-17-3 or to the review criteria set forth in § 11.4.5(B) of this Part. This shall not limit the authority of the licensing agency to require correction of conditions or defects which existed prior to the proposed change of owner, operator, or lessee and of which notice has been given to the hospice program by the licensing agency.

D. A license issued hereunder shall be the property of the state and loaned to such licensee, and it shall be kept posted in a conspicuous place.

11.4.6 Change of Ownership, Operation and/or Location

A. When a change of ownership or operation or location of a hospice program or when discontinuation or addition of a service(s) is contemplated, the licensing agency shall be notified in writing.

B. The Department shall be notified immediately when a licensee/owner determines to cease operations and close a hospice agency.

1. A meeting shall be conducted between the Department and the licensee/owner prior to issuance of any closure notification to patients and the public to ensure there is a formal and comprehensive plan for an orderly closure.

C. At least sixty (60) days prior to the proposed closure date the hospice agency shall provide the Department a plan for orderly closure. This Closure Plan must include, but is not limited to, the following:

1. Letter of intent and/or determining factors/justification for the closure (i.e., voluntary, financial), which must include:

a. Proposed closure date;

b. Contact information for the staff member(s) responsible for implementing the closure plan; and

c. Last day new patients will be accepted.

2. Detailed plan and proposed timeline for patient discharge or transition of care to another licensed agency, including:

a. List of patients, including patient name, address, phone number, insurer/ guarantor, and contact information for guardian and/ or emergency contact;

b. Appointment schedule and acuity/level of care of each patient receiving services; and

c. Staff scale-down process as appropriate, given planned transition/reduction of patients/residents.

3. Plan for the retention, storage, and access to medical records in accordance with R.I. Gen. Laws Chapter 5-37.3 and applicable federal laws, including:

a. Name and contact information of agency/company or legally authorized person who will be storing the records and address where records will be stored.

4. Detailed plan for providing notification and estimated implementation of notices to the following:

a. Patients, Staff/union, and Public

(1) Patients, their guardians, or relatives so appointed or elected to be their decision makers must be provided at least thirty (30) days' notice prior to closure;

b. Medicaid, Medicare, and other third-party insurers;

c. Accreditation entities (if applicable); and

d. Other agencies as required by law.

5. Plan for the removal and/or disposal of any controlled or non-controlled substances (if applicable).

6. Plan for removal, transfer, or disposal of clinical/medical equipment and/or oxygen tanks (if applicable).

7. Projected fiscal management plan covering payroll, benefits, and operations during the closure period, including but not limited to:

a. Employee retirement plans currently in effect or under the control of the agency.

D. No implementation of any discontinuation of the operation of a hospice program shall be in effect without prior approval of the Department.

E. A license shall immediately become void and shall be returned to the licensing agency when operation of a hospice program is discontinued or when any changes in ownership occur in accordance with the rules and regulations of this Part and R.I. Gen. Laws § 23-17-6.

1. When there is a change in ownership or in the operation or control of the hospice program, the licensing agency reserves the right to extend the expiration date of such license, allowing the program to operate under the same license which applied to the prior license for such time as shall be required for the processing of a new application or reassignment of patients, not to exceed six (6) weeks.

11.4.7 Inspections

A. The licensing agency shall make, or cause to be made, such inspections and investigations, as deemed necessary in accordance with R.I. Gen. Laws § 23-17-10 and the Rules and Regulations of this Part.

1. Such inspections and investigations may include on-site visits to patients, either in their homes, in the hospital, hospice inpatient facility, or nursing facilities, provided however, that a signed statement of approval for home visitation has been obtained by the licensing agency from the patient/family.

B. Refusal to permit inspections, other than in-home visits referred to in § 11.4.7(A)(1) of this Part, shall constitute a valid ground for license denial, suspension, or revocation.

C. Every hospice program shall be given notice by the licensing agency of all deficiencies reported as a result of an inspection or investigation.

11.4.8 Denial, Suspension, Revocation of License or Curtailment of Activities

A. The licensing agency is authorized to deny, suspend, or revoke the license or curtail activities of any hospice program which:

1. Has failed to comply with the Rules and Regulations Pertaining to the Licensing of Hospice Care Programs; or

2. Has failed to comply with the provisions of R.I. Gen. Laws Chapter 23-17.

3. Reports of deficiencies shall be maintained on file in the licensing agency and shall be considered by the licensing agency in rendering determinations to deny, suspend or revoke the license or to curtail activities of a hospice program.

B. Whenever an action shall be proposed to deny, suspend or revoke a license for any hospice program or to curtail its activities, the licensing agency shall notify the hospice program by certified mail, setting forth reasons for the proposed action, and the applicant or licensee shall be given an opportunity for a prompt and fair hearing in accordance with R.I. Gen. Laws §§ 23-17-8 and 42-35-9, and in accordance with the provisions of § 11.8.4 of this Part.

1. However, if the licensing agency finds that public health, safety or welfare of patients requires emergency action and incorporates a finding to that effect in its order, the licensing agency may order summary suspension of license or curtailment of activities pending proceedings for revocation or other action in accordance with R.I. Gen. Laws §§ 42-35-14(c) and 23-1-21.

C. The appropriate state and federal agencies shall be notified of any action taken by the licensing agency pertaining to either denial, suspension, or revocation of license, or curtailment of activities.

11.5 Organization and Management

11.5.1 Governing Body

A. There shall be an organized governing body or equivalent legal authority ultimately responsible for:

1. The management, fiscal affairs, and operation of the hospice program;

2. The assurance of quality care and services; and

3. The compliance with all federal, state and local laws and regulations pertaining to a hospice program and the rules and regulations of this Part.

B. The governing body or other legal authority shall furthermore be responsible to:

1. Make services available on a twenty-four (24) hour basis to meet the needs of patients/family as required under the provisions of §§ 11.5.5(F)(2) and 11.5.5(G)(1) of this Part;

2. Provide a sufficient number of appropriate personnel, physical resources and equipment to facilitate the delivery of prescribed services;

3. Ensure conformity of the facility with all Federal, State, and local Rules and Regulations Pertaining to Fire, Safety, Sanitation, Communicable and Reportable Diseases, other relevant health and safety requirements, and all Rules and Regulations of this Part; and

4. Implement a policy of non-discrimination in the provision of services to patients and the employment of persons without regard to race, color, creed, national origin, gender, religion, sexual orientation, age, gender identity or expression, handicapping condition or degree of handicap, in accordance with Title VI of the Civil Rights Act of 1964, U.S. Executive Order #11246 entitled "Equal Employment Opportunity," U.S. Department of Labor Regulations, Title V of the Rehabilitation Act of 1973, the Rhode Island Fair Employment Practices Act, R.I. Gen. Laws Chapter 28-5, the Americans with Disabilities Act, and any other applicable Federal or State laws relating to discriminatory practices.

C. The governing body or other legal authority shall designate:

1. An administrator who shall be responsible for the management and operation of the hospice program; and

2. A medical director who assumes overall responsibility for the medical component of patient care and to ensure achievement and maintenance of quality standards of professional practice.

D. The governing body or equivalent legal authority shall adopt and maintain bylaws or acceptable equivalent which defines responsibilities for the operation and performance of the organization, identifies purposes and means of fulfilling such. In addition, the governing body or equivalent legal authority shall establish administrative policies pertaining to no less than the following:

1. Responsibilities of the administrator and the medical director;

2. Conflict of interest on the part of the governing body, professional staff, and employees;

3. The services to be provided;

4. Criteria for the selection, admission and transfer of terminally ill patient/families;

5. Patient/family consent and involvement in the development of patient care plan;

6. Developing support network when relatives are not available and patient needs and wants that support;

7. Linkages and referrals with community and other health care facilities or agencies that shall include a mechanism for recording, transmitting, and receiving information essential to the continuity of patient/family care. Such information must contain no less than:

a. Patient identification data such as name, address, age, gender, name of next of kin, health insurance coverage,

b. Diagnosis and prognosis, medical status of patient, brief description of current illness, medical and nursing plans of care including such information as medications, treatments, dietary needs, baseline laboratory data,

c. Functional status,

d. Special services such as physical therapy, occupational therapy, speech therapy and similar services,

e. Psychosocial needs,

f. Such other information pertinent to ensure continuity of patient care,

g. Any additional information as cited in the "continuity of care" form available on the department's website: www.health.ri.gov. Designated licensed personnel shall complete the "continuity of care" form approved by the department for each patient who is discharged to another health care facility, such as a hospital, or who is discharged home with follow-up home care required. Said form shall be provided to the receiving facility or agency prior to or upon transfer of the patient,

8. Professional management responsibilities for contracted services,

9. Reports of patient's condition and transmission thereof to the patient's physician, and

10. Such other matters as may be relevant to the organization and operation of hospice care.

11.5.2 Organization of Services

A. The governing body or other legal authority shall organize hospice program services to provide an integrated continuum of care for terminally ill patients/families and to ensure that such care is rendered under the professional management responsibility of the hospice program.

1. An organizational chart with written description of the organization, authorities, responsibilities, accountabilities, and relationships shall be maintained, that shall include but not be limited to:

a. A description of each level of care and services;

b. Policies and procedures pertaining to hospice care and services that are consistent with professionally recognized standards of practice;

c. A description of the system for the maintenance of patient records; and

d. Such other related provisions as deemed appropriate.

11.5.3 Quality Improvement

A. Each hospice program shall establish a written quality improvement plan that shall be reviewed by the Department during the facility's annual survey and that includes:

1. Program objectives;

2. Oversight responsibility (e.g., reports to the governing body);

3. Hospice-wide scope;

4. Involvement of all patient care disciplines/services;

5. Provides criteria to monitor nursing care, including medication administration;

6. Prevention and treatment of decubitus ulcers;

7. Accidents and injuries, resulting in unexpected death;

8. Any other data necessary to monitor quality of care; and

9. Methods to identify, evaluate, and correct problems.

B. All patient care services, including services rendered by a contractor, shall be evaluated.

C. Each licensed hospice program administrator shall designate a qualified individual to coordinate and manage the hospice program's quality improvement program.

D. A quality improvement committee for a hospice program shall be established and shall annually review and approve the quality improvement plan for the hospice program. Said plan shall be available to the public upon request.

E. The hospice program's quality improvement committee shall include at least the following members:

1. The hospice program administrator;

2. The director of nursing;

3. The medical director; and

4. A social worker.

F. The quality improvement committee shall meet at least quarterly; shall maintain records of all quality improvement activities; and shall keep records of committee meetings that shall be available to the Department during any on-site visit.

G. The Director may not require the quality improvement committee to disclose the records and the reports prepared by the committee except as necessary to assure compliance with the requirements of this Part.

H. Good faith attempts by the quality improvement committee to identify and correct quality deficiencies will not be used as a basis for hospice licensure sanctions.

I. If the Department determines that a hospice program is not implementing its quality improvement program effectively and that quality improvement activities are inadequate, the Department may impose sanctions on the hospice program to improve quality of patient care.

J. The program shall take and document appropriate remedial action to address problems identified through the quality improvement program. The outcome(s) of the remedial action shall be documented and submitted to the governing body for their consideration.

11.5.4 Written Agreements

A. There shall be written agreements for the provision of those services required in § 11.5.5(B) of this Part, not provided directly by the hospice program. The agreements shall clearly delineate the responsibilities of the parties involved and shall include no less than the following provisions:

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

2. The responsibility of the licensed hospice program for the admission of patients/families to the hospice service;

3. Identification of services to be provided that must be within the scope and limitations set forth in the plan of care and that must not be altered in type, amount, frequency or duration (except in case of adverse reaction) by the individual, agency, or institution;

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

5. Assurance of compliance with the patient care policies of the licensed hospice program;

6. Establishment of procedures for, and frequency of, patient/family care assessment;

7. Furnishing the hospice plan of care to other health care facilities upon transfer of patient;

8. Assurance that personnel and services meet the requirements specified herein pertaining to personnel and services, including licensure, personnel qualifications, functions, supervision, hospice training and orientation, in-service training, and attendance at case conferences;

9. Reimbursement mechanism, charges, and terms for the renewal or termination of the agreement;

10. Such other provisions as may be mutually agreed upon or as may be relevant and deemed necessary;

11. Assurance that the inpatient provider has established policies consistent with those of the hospice program and that the inpatient care facility agrees to abide by the patient care plan and protocol established by the hospice program;

12. Assurance the medical record shall include a record of all inpatient services and events, and a copy of the discharge summary and, if requested, a copy of the medical record to be provided to the hospice program; and

13. The party responsible for the implementation of the provisions of the agreement.

B. The hospice program shall retain professional management responsibility for contracted services to ensure that they are furnished in a safe and effective manner by persons meeting the qualifications stated herein, in accordance with the patient's plan of care.

11.5.5 Minimum Services Required/Availability and Accessibility of Services

A. Any service available through a hospice program shall be provided to patients/families, with the consent of the terminally ill patient and family.

B. Services that are to be provided directly through staff personnel of a hospice program shall include the following core services:

1. Physician services (may include attending physicians' or certified nurse practitioners' services in accordance with § 11.5.8(A) of this Part);

2. Nursing services;

3. Social services;

4. Counseling services, including spiritual counseling, when required;

5. Pain assessment; and

6. Availability of drugs and biologicals on a twenty-four (24) hour basis.

C. A hospice program may use contracted staff if necessary to supplement hospice staff personnel in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice shall maintain professional management responsibility for the services and shall assure that the qualifications of staff and services provided meet the requirements herein.

D. In addition to the minimum services listed in § 11.5.5(B) of this Part, a hospice program shall ensure that the following services are provided, as applicable, to patients/families directly by hospice staff personnel or under written arrangement as specified in § 11.5.4 of this Part.

1. Home health aide and homemaker services;

2. Short-term respite care, and general inpatient care;

3. Physical therapy, occupational therapy, and speech-language pathology services;

4. Medical supplies and appliances; and

5. Nutritional counseling.

E. Pain Assessment

1. All health care providers licensed by this state to provide health care services and all health care facilities licensed under R.I. Gen. Laws, shall assess patient pain in accordance with the requirements of the Rules and Regulations Pertaining to Pain Assessment promulgated by the Department.

F. Availability of Services

1. A hospice program shall make:

a. Nursing services, physician services, drugs and biologicals routinely available on a twenty-four (24) hour basis, seven (7) days a week, as may be required in accordance with the plan of care;

b. All other services available on a twenty-four (24) hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions in accordance with the plan of care; and

c. Patient visiting and assessment capability available on a twenty-four (24) hour basis, seven (7) days a week to respond to acute and urgent patient/family needs.

2. Additional health services or related services may be provided as may be deemed appropriate to meet patient/family needs and such services must be rendered in a manner consistent with acceptable standards of practice.

G. Accessibility to Hospice Care

1. Each hospice program shall establish a mechanism to enable patients/families to make telephone contact with responsible staff personnel on a twenty-four (24) hour basis, seven (7) days a week. Mechanical answering devices shall not be acceptable.

H. Accessibility to Pharmacy Services

1. Each hospice program shall provide on a twenty-four (24) hour basis, seven (7) days a week, accessibility to pharmacy services to enable patient/family to obtain prescription drugs and biologicals, for the palliative care and management of the terminally ill patient.

I. Continuity of Care. The hospice program shall assure the continuity of patient/family care in the home and inpatient settings through written policies, procedures, and criteria pertaining to no less than the following:

1. Admission criteria and initial assessment of the patient/family need and decision for care;

2. Signed informed consent;

3. Ongoing assessment of patient/family needs;

4. Development and review of the plan of care by the interdisciplinary team;

5. Transfer of patients to inpatient care facilities for inpatient respite care and general inpatient care;

6. The provision of appropriate patient/family information at the point of transfer between levels of care settings;

7. Community or other resources to insure continuity of care and meet patient/family needs;

8. Management of symptom control through palliative care and utilization of therapeutic services (see § 11.5.5(E)(1) of this Part);

9. Provision of continuing care for patients transferred to inpatient care facilities;

10. Constraints imposed by limitations of services, family conditions; and

11. Such other criteria as may be deemed appropriate.

11.5.6 Plan of Care

A. After an initial assessment of patient/family needs, a written plan of care shall be established by the medical director or physician designee, the attending physician and the interdisciplinary team for each patient/family admitted to the hospice program. Such plan of care shall be developed with the participation of the patient and family, and shall include only those services that are acceptable to the patient and family. Furthermore, the family shall be involved whenever possible in the implementation and continuous assessment of the plan of care. The hospice program shall ensure that each patient and family/primary caregiver(s) receive education and training provided by the hospice appropriate to the care and services identified in the plan of care.

B. The plan of care shall include, but not be limited to, provisions pertaining to:

1. Pertinent diagnosis and prognosis;

2. Interventions to facilitate the management of pain and symptoms;

3. Measurable targeted outcomes anticipated from implementing and coordinating the plan of care;

4. A detailed statement of the patient/family needs addressing the physical, psychological, social, and spiritual needs of the patient/family; the scope of services required; the frequency of visits; the need for inpatient care (respite and/or general inpatients); nutritional needs; medications; management of discomfort and symptom control; management of grief;

5. Drugs and treatments necessary to meet the needs of the patient;

6. Medical supplies and appliances necessary to meet the needs of the patient;

7. The interdisciplinary group's documentation of patient and family understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record;

8. Consent of patient/patient's designated agent/family; and

9. Such other relevant modalities of care and services as may be appropriate to meet patient/family care needs.

C. The plan of care shall be reviewed and updated at periodic intervals by the interdisciplinary team.

D. A revised plan of care shall include information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the plan of care.

11.5.7 Levels of Care

A. Home Care: Home care services shall be provided to hospice patients/families either as routine home care or continuous home care during periods of crisis, in order to maintain the terminally ill patient at home.

B. General Inpatient Care: Short-term general inpatient care for the control of pain or management of acute and severe clinical conditions that cannot be managed in the current setting shall be provided only in licensed hospitals, licensed nursing facilities, or hospice inpatient facilities that meet the requirements of §§ 11.6.1 through 11.7.15(A) of this Part. Hospice care provided in a nursing facility or hospital shall have a binding written agreement with a hospice program that includes the provisions of § 11.5.4 of this Part.

C. Inpatient Respite Care: Inpatient respite care may be provided for short periods of time to relieve family members or others caring for the terminally ill patient in the home. Such care shall be provided only in a licensed hospital, nursing facility or hospice inpatient facility that meets the requirements of §§ 11.6.1 through 11.7.15(A) of this Part, and with whom the hospice program has entered into a binding agreement as provided in § 11.5.4 of this Part.

11.5.8 Hospice Services

A. Attending Practitioner Services: Attending practitioner services shall be provided by a physician, as defined in R.I. Gen. Laws Chapter 5-37, or a certified nurse practitioner, as defined in R.I. Gen. Laws Chapter 5-34, to meet the general medical needs of patients for the management of the terminal illness and related conditions, through palliative and supportive care and in accordance with hospice policies. Attending practitioner services may also be provided by a physician assistant, as long as the physician assistant's role is providing medical and surgical services in collaboration with physicians, as set forth in the provisions of R.I. Gen. Laws Chapter 5-54.

1. Such policies shall include provisions governing the relationship of the attending physician or the certified nurse practitioner, or physician assistant, to the medical director, and the interdisciplinary team.

2. In addition to palliation and management of terminal illness and related conditions, staff physician(s) and/or certified nurse practitioner(s) of the hospice program, including the physician member(s), certified nurse practitioner member(s), and/or physician assistant member(s) of the interdisciplinary group shall also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician, certified nurse practitioner, and/or physician assistant.

B. Nursing Services: Nursing services shall be provided under the direction of a licensed professional (registered) nurse to meet the nursing care needs of patients/families as prescribed in the plan of care and in accordance with acceptable standards of practice and hospice policies.

C. Social Services: Social services shall be offered by a person licensed under R.I. Gen. Laws Chapter 5-39.1 and the Rules and Regulations Pertaining to Licensing Clinical Social Workers and Independent Clinical Social Workers. Such services shall be provided as prescribed in the plan of care and in accordance with acceptable standards of practice and hospice care policies.

D. Bereavement Counseling Services: Bereavement counseling services shall be offered to meet the needs of the members of families both before and after the death of the patient. Such services shall be provided by a professional person qualified by training and experience for the development, implementation, and assessment of a plan of care to meet the needs of the bereaved.

E. Spiritual Counseling Services: Spiritual counseling services shall be available. Patients/families shall be notified of the availability of such services.

F. Nutritional Counseling: Dietary counseling services for the patient/family shall be available as may be required, while the individual is in hospice care.

G. Home-Health Aide/Nursing Assistant Services: Each hospice program shall provide home-health aide/nursing assistant services pursuant to § 11.5.5(E)(1) of this Part and as prescribed by the patient/family plan of care and consistent with policies of the hospice program.

1. The home-health aide/nursing assistant shall provide personal care and other related support services under the supervision of a registered nurse from the licensed hospice program and/or a therapist when the aide carries out simple procedures as an extension of physical, speech, or occupational therapy or social services. Duties of home-health aides/nursing assistants shall include, but not be limited to:

   a. Performance of simple procedures as an extension of therapy services;

   b. Personal care;

c. Ambulation and exercise;

d. Assistance with medications that are ordinarily self-administered, in accordance with state and federal laws and regulations;

e. Preparing meals and assisting patients with eating;

f. Household services that are essential to the patient's health care at home;

g. Reporting changes in patient's condition and needs; and

h. Completing appropriate records.

H. Volunteer Services: The development and utilization of trained lay and professional volunteers shall be required of a hospice program. Direct patient care rendered by volunteers shall be provided under the supervision of a qualified and experienced staff member of the hospice program and shall be consistent with the established patient/family plan of care. Furthermore, direct patient care volunteers shall:

1. Have the necessary qualifications and skills to provide the prescribed service;

2. Have participated in an appropriate orientation and training program of hospice care; and

3. Be responsible to record patient care services rendered.

I. Medical Supplies: Medical supplies and appliances, including drugs and biologicals, as may be needed, shall be provided (either directly or by arrangement) for the palliation and management of the terminal illness and related conditions in accordance with § 11.5.5(E)(1) of this Part.

J. Administration of Drugs and Biologicals. Drugs and biologicals as prescribed by the physician or other practitioner working within the scope of his/her practice in the plan of care may be administered by the following individuals:

1. A licensed nurse, certified nurse practitioner, physician, and/or physician assistant;

2. Selected non-licensed personnel with demonstrated competence who have satisfactorily completed a State-Approved Program on Drug Administration may administer oral or topical drugs in accordance with the Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs if adequate medical and nursing supervision is provided in accordance with R.I. Gen. Laws Chapter 5-34, agency policies, and applicable federal laws and regulations.

3. The patient may self-administer drugs, or a member of the family/caregiver may also administer drugs to the patient in accordance with the plan of care, upon written approval of the attending physician, certified nurse practitioner, or, as appropriate, physician assistant.

K. Pharmacy Services: Hospice programs shall have policies pertaining to the disposal of controlled substances and legend drugs that are consistent with the Rules and Regulations Pertaining to the Disposal of Legend Drugs.

L. Other Services: such as physical, occupational, speech, and hearing therapy services must be available and when provided, such services must be rendered in accordance with the plan of care and in a manner consistent with accepted standards of practice.

M. Clinical Records.

1. A clinical record shall be established for every patient receiving care and services. The record shall be completed promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

2. Each clinical record shall include a comprehensive compilation of information. Entries shall be made for all services provided, signed by the staff providing the services. The record shall include entries on all services rendered whether furnished directly or under arrangements with the hospice. Each patient's record shall contain no less than:

    a. the initial and subsequent assessment;

    b. the plan of care;

    c. identification data;

    d. consent form;

    e. any advance directives;

    f. pertinent medical history; and

    g. complete documentation of all services and events (including evaluations, treatment, progress notes).

3. Records shall be maintained by the agency for a period of at least five (5) years following the date of discharge and shall be safeguarded against loss or unauthorized use.

4. Each program shall establish policies and procedures to govern the use and removal of records and determine the conditions for release of information in accordance with statutory provisions pertaining to confidentiality.

11.5.9 Personnel

A. A registered nurse with training and experience in hospice care shall be designated to coordinate the overall plan of care for each patient/family.

B. Each hospice program shall designate a sufficient number of staff personnel (including volunteers) with training and experience in hospice care and whose qualifications are commensurate with their duties and responsibilities to provide care services to patients/families.

1. Staff personnel shall provide evidence of current registration, certification or licensure as may be required by law. For every person employed by the hospice program who is licensed, certified, or registered by the Department, a mechanism shall be in place to electronically verify such licensure via the Department's electronic licensure database.

C. A job description for each classification of position shall be established clearly delineating qualifications, duties, authority, and responsibilities inherent in each position.

D. An ongoing program for the training of all personnel shall be conducted by the hospice program, that shall include:

1. An orientation program for new staff personnel (including volunteers); and

2. A continuing program for the development and improvement of skills of staff to ensure the delivery of quality hospice care services.

E. Administrator

1. The governing body or other legal authority shall appoint an individual who possesses appropriate education and experience to serve as administrator of the hospice program, and who shall be responsible for:

a. The management and operation of the program;

b. The enforcement of policies, rules and regulations, and statutory provisions pertaining to the program;

c. Serving as liaison between the governing body and staff; and

d. The planning, organizing, and directing of such other activities as may be delegated by the governing body.

2. A hospice inpatient facility shall have a full-time administrator. Any change in administrators shall be reported in writing to the Department within fifteen (15) days. The administrator shall designate in writing the person to act in his/her absence in order to provide the hospice inpatient facility with administrative direction at all times.

F. Medical Director

1. The overall responsibility for the medical component of patient care shall be under the direction of a physician, qualified by training and experience in hospice care, who shall also be responsible for no less than the following:

a. Coordination of medical care provided by the hospice program;

b. Ensuring and maintaining quality standards of professional practice;

c. Implementation of patient care policies;

d. The achievement and maintenance of quality assurance of professional practices through a mechanism for the assessment of patient/family care outcomes;

e. Ensuring completion of health care worker screening and immunization requirements as contained in the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title);

f. The certification of terminally ill patients admitted to the hospice program;

g. Participation as a member of the interdisciplinary team, in the development, implementation, and assessment of patient/family plan of care; and

h. Consulting with attending physicians and/or certified nurse practitioners regarding patient care plans.

2. Upon appointment, the name of the medical director shall be submitted to the Department. Each time a new medical director is appointed, the name of said physician shall be reported promptly to the Department. The medical director's Rhode Island medical license number, medical office address, telephone number, emergency telephone number, hospital affiliation and other credentialing information shall be maintained on file by the hospice program and updated as needed.

G. Criminal Records Check

1. Criminal records checks shall be in accordance with R.I. Gen. Laws § 23-17-34.

2. If an applicant has undergone a national criminal records check within eighteen (18) months of an application for employment, then an employer may request from the bureau a letter indicating if any disqualifying information was discovered. The bureau will respond without disclosing the nature of the disqualifying information. This letter must be maintained on file to satisfy the requirements of R.I. Gen. Laws § 23-17-34.

H. Photo Identification

1. A hospice program shall require all persons, including students, who examine, observe, or treat a patient to wear a photo identification badge which states, in a reasonably legible manner, the first name, licensure/registration status, if any, and staff position of such person.

I. Hospice Inpatient Facilities

1. In additional to the personnel requirements contained above, each hospice inpatient facility shall have a registered nurse on the premises twenty-four (24) hours a day. In addition, the necessary nursing service personnel (licensed and non-licensed) shall be in sufficient numbers on a twenty-four (24) hour basis, to assess patients' needs, to develop and implement patient care plans, to provide

direct patient care services, and to perform other related activities to maintain the health, safety, and welfare of patients.

J. In-Service Education

1. An in-service educational program shall be conducted on an ongoing basis, that shall include an orientation program for new personnel and a program for the development and improvement of skills of all personnel. The in-service program shall be geared to the needs of the population and shall include annual programs on prevention and control of infection, food services and sanitation (as appropriate), fire prevention and safety, confidentiality of patient information, patient rights and any other areas related to hospice care.

    a. Provisions shall be made for written documentation of in-service educational programs, including attendance.

K. Health Screening

1. Upon hire and prior to delivering services, a pre-employment health screening shall be required for each individual who has or may have direct contact with a patient in the hospice. Such health screening shall be conducted in accordance with the Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (Part 20-15-7 of this Title) promulgated by the Department.

L. Latex

1. Any hospice program that utilizes latex gloves shall do so in accordance with the provisions of the Rules and Regulations Pertaining to the Use of Latex Gloves by Health Care Workers, in Licensed Health Care Facilities, and by Other Persons, Firms, or Corporations Licensed or Registered by the Department (Part 20-15-3 of this Title) promulgated by the Department.

11.5.10 Interdisciplinary Team

A. The governing body or other legal authority shall designate an interdisciplinary team composed of staff personnel that includes:

1. Attending practitioner;

2. Professional (registered) nurse;

3. Social worker;

4. Spiritual counselors; and

5. Such other staff and non-staff personnel as may be deemed appropriate.

B. The interdisciplinary team shall be responsible to develop, implement and assess patient/family plans of care, and in addition:

1. The supervision of care, personnel and services provided;

2. The provision of direct patient care as may be required and appropriate;

3. The development of a patient/family plan of care, and the revision of such plan of care as may be required;

4. The development of policies and procedures governing patient/family care and services; and

5. Such other duties as may be deemed appropriate by the governing body.

11.5.11 Rights of Patients

A. Each hospice program shall adopt applicable "rights of patients" pursuant to the provisions of R.I. Gen. Laws § 23-17-19.1 and shall make such available to patients/patient's designated agent/families.

B. In addition to the rights stated in R.I. Gen. Laws § 23-17-19.1, the patient shall be offered treatment without discrimination as to creed, gender, sexual orientation, age, gender identity or expression, handicapping condition or degree of handicap.

C. No charge shall be made for furnishing a health record or part of a health record to a patient, his or her attorney or authorized representative if the record or part of the record is necessary for the purpose of supporting an appeal under any provision of the Social Security Act, 42 U.S.C. § 301 et seq., and the request is accompanied by documentation of the appeal or a claim under the provisions of the Workers' Compensation Act, R.I. Gen. Laws Chapters 28-29 through 28-38. Additionally, charges shall not be made if the record is requested for immunization records required for school admission or by the applicant or beneficiary or individual representing an applicant or beneficiary for the purposes of supporting a claim or appeal under the provision of the Social Security Act or any federal or state needs-based benefit program such as Medical Assistance, RIte Care, Temporary Disability Insurance, or unemployment compensation.

D. The hospice program shall provide the patient/patient's designated agent/family with written information concerning its policies on advance directives, including a description of any applicable state law.

11.5.12 Reporting of Patient Abuse or Neglect, Accidents and Death

A. Any physician, nurse, or other employee of a hospice program who has reasonable cause to believe that a patient has been abused, exploited, mistreated, or neglected shall within twenty-four (24) hours of the receipt of said information, transfer such to the Director. Any person required to make a report pursuant to this section shall be deemed to have complied with these requirements if a report is made to a high managerial agent. Once notified, the administrator or the director of nursing services shall be required to meet the above reporting requirements.

B. The hospice program shall maintain evidence that all allegations of abuse, neglect, and/or mistreatment have been thoroughly investigated and that further potential abuse has been prevented while the investigation is in progress. The results of said

investigation shall be reported to the Department. Appropriate corrective action shall be taken, as necessary.

C. Accidents resulting in hospitalization or death of any patient shall be reported in writing to the licensing agency before the end of the next working day. A copy of each report shall be retained by the facility for review during subsequent surveys.

D. All patient deaths occurring within a hospice program or in a hospice inpatient facility that are under the following categories shall be reported to the program medical director and to the Office of the State Medical Examiners in accordance with R.I. Gen. Laws Chapter 23-4:

1. Suspicious or unnatural;

2. The result of trauma, remote or otherwise;

3. The decedent is less than eighteen (18) years of age;

4. As a result of a drug overdose or poisoning, remote or otherwise, and

5. As a result of an infectious disease with epidemic potential.

E. The death of any hospice patient occurring within twenty-four (24) hours of admission to a hospice program providing care in the home or a program at an inpatient hospice unit shall be reported to the Office of the State Medical Examiners, unless declared exempt by the Chief Medical Examiner.

F. Reporting requirements shall be posted, pursuant to R.I. Gen. Laws Chapter 23-17.8

11.6 General Requirements for Inpatient Hospice Settings

11.6.1 Hospice Inpatient Facilities

A. A licensed hospital, a licensed nursing facility, or a hospice inpatient facility with whom a hospice program enters into a written agreement for the provision of inpatient care (general inpatient, or respite care, as described above) for hospice patients shall be required to meet the following provisions pertaining to:

1. Staffing (see also §§ 11.5.9(I)(1) and 11.5.9(J)(1) of this Part); and

2. Patient areas pursuant to § 11.6.1(B) of this Part.

3. Additionally, said facilities providing general inpatient care or inpatient respite care shall be required to meet the provisions of §§ 11.6.2 through 11.7.15(A) of this Part.

B. Patient Areas

1. The patient areas must be designed and equipped for the comfort and privacy of each patient/family that includes:

a. Physical space for private patient/family visiting;

b. Accommodations for family members, including children, if they wish to remain with patient overnight;

c. Accommodation for family privacy after a patient's death; and

d. Home-like interior.

2. Patients shall be permitted to receive visitors, including small children and pets, at any hour, provided that a therapeutic environment is maintained for all patients.

11.6.2 Dietetic Services

A. Each facility shall maintain a dietetic service under the supervision of a full-time person who, as a minimum, is a graduate of a state approved course that provided instruction in food service supervision and nutrition and has experience in the organization and management of food service.

1. When the dietary manager is absent, a responsible person shall be assigned to supervise dietetic service personnel and food service operations.

B. The facility's food service operation shall comply with all appropriate standards of the Rhode Island Food Code (Part 50-10-1 of this Title).

1. Diet kitchens, nourishment stations, and any other related areas shall be the responsibility of the dietetic service.

C. There shall be a supply of staple foods for a minimum of seven (7) days and of perishable foods for a minimum of two (2) days in the facility.

11.6.3 Infection Control

A. Infection control provisions shall be established for the mutual protection of patients, employees, and the public.

B. The facility shall be responsible for no less than the following:

1. Establishing and maintaining a facility-wide infection surveillance program;

2. Developing and implementing written policies and procedures for the surveillance, prevention, and control of infections in all patient care departments/services;

3. Establishing policies governing the admission and isolation of patients with known or suspected infectious diseases;

4. Developing, evaluating, and revising on a continuing basis infection control policies, procedures, and techniques for all appropriate areas of facility operation and services;

5. Developing and implementing a system for evaluating and recording the occurrences of all infections relevant to employment (e.g., skin rash) among

personnel and infections among patients; such records shall be made available to the licensing agency upon request;

6. Consistent with “Policy and Procedures for Tuberculosis Screening of Health-Care Workers” incorporated above at § 11.2(C) of this Part, implementing a tuberculosis (TB) infection control program requiring risk assessment and development of a TB infection control plan; early identification, treatment and isolation of strongly suspected or confirmed infectious TB patients; effective engineering controls; an appropriate respiratory protection program; health care worker TB training, education, counseling and screening; and evaluation of the program's effectiveness, per guidelines in “Policy and Procedures for Tuberculosis Screening of Health-Care Workers” incorporated above at § 11.2(C) of this Part.

7. Developing and implementing an institution-specific strategic plan for the prevention and control of vancomycin resistance, with a special focus on vancomycin-resistant enterococci, per guidelines in “Guidelines for the Control of Vancomycin Resistant Enterococci (VRE) in Nursing Homes and Extended Care Facilities” (1996). (See also “Recommendations for Preventing the Spread of Vancomycin Resistance: Recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC)” incorporated above at § 11.2(D) of this Part for additional information on this issue).

8. Developing and implementing protocols for:

   a. Discharge planning that includes full instruction to the family or caregivers regarding necessary infection control measures, and

   b. Hospital transfer of patients with infectious diseases which may present the risk of continuing transmission. Examples of such diseases include, but are not limited to, TB, methicillin resistant staphylococcus aureus (MRSA), VRE, and clostridium difficile.

9. Assuring that all patient care staff are available in order to assist in the prevention and control of infectious diseases and are provided with adequate direction, training, staffing and facilities to perform all required infection surveillance, prevention and control functions.

C. A continuing education program on infection control shall be conducted periodically for all staff.

D. Reporting of Communicable Diseases

1. Each facility shall report promptly to the Department, cases of communicable diseases designated as "reportable diseases" when such cases are diagnosed in the facility in accordance with the Rules and Regulations Pertaining to the Reporting of Infectious, Environmental and Occupational Diseases (Part 30-05-1 of this Title).

2. When infectious diseases present a potential hazard to patients or personnel, these shall be reported to the Department, Center for Acute Infectious Diseases and Epidemiology even if not designated as "reportable diseases."

3. When outbreaks of food-borne illness are suspected, such occurrences shall be reported immediately to the Department, Center for Acute Infectious Diseases and Epidemiology or to the Center for Food Protection.

4. Facilities shall comply with the provisions of R.I. Gen. Laws § 23-28.36-3, which require notification of fire fighters, police officers, and emergency medical technicians after exposure to infectious diseases.

11.6.4 Pharmaceutical Services

A. Each facility shall provide pharmaceutical services either directly within the facility or per contractual arrangement. Such services shall be provided in accordance with the requirements of the Rules and Regulations Pertaining to Pharmacists, Pharmacies and Manufacturers, Wholesalers and Distributors.

1. In either instance, appropriate methods and procedures for the procurement and the dispensing of drugs and biologicals shall be established in accordance with appropriate federal and state laws and regulations.

B. There shall be written policies and procedures relating to the pharmaceutical service that shall require no less than:

1. The authority, responsibility, and duties of the registered pharmacist;

2. The selection, procurement, distribution, storage, dispensing or other disposition of drugs and biologicals in accordance with appropriate federal and state laws and regulations;

3. Maintenance of records of all transactions, including recording of receipt and dispensing or other disposition of all drugs and biologicals;

4. Inspection of all drug and biological storage and medication areas and documented evidence of findings;

5. Automatic stop orders for drugs or biologicals;

6. The use of only approved drugs and biologicals;

7. Control of medications from any source;

8. A requirement that when automated storage and distribution devices are utilized, all pertinent provisions of the Rules and Regulations Pertaining to Pharmacists, Pharmacies and Manufacturers, Wholesalers and Distributors shall be met;

9. A monitoring program to identify adverse drug reactions, interactions and incompatibilities and antibiotic antagonisms; and

10. Drugs and biological stored outside of an automated storage and distribution device shall be labeled with the name of the patient, name of the physician, drug dosage, cautionary instructions, and expiration date.

C. Adequate space, equipment, supplies and locked storage areas shall be provided for the storage of drugs and biologicals based on the scope of services provided.

D. Refrigerated food storage units shall not be utilized for storage of drugs and/or biologicals except in facilities of thirty (30) beds or less, provided they are locked in an appropriate container.

E. Drugs may be administered to patients from bulk inventories of non-legend and non-controlled substance items such as aspirin or milk of magnesia, as ordered by a licensed physician.

F. An emergency medication kit, approved by the pharmaceutical service committee or its equivalent, shall be kept at each nursing station.

G. There shall be adequate drug and biological preparation areas with provisions for locked storage in accordance with federal and state laws and regulations.

H. The pharmaceutical service committee or its equivalent, consisting of not less than a registered pharmacist, a registered nurse, a physician, and the administrator, shall:

1. Serve as an advisory body on all matters pertaining to pharmaceutical services;

2. Establish a program of accountability for all drugs and biologicals;

3. Develop and review periodically all policies and procedures for safe and effective drug therapy; and

4. Monitor the pharmaceutical service.

I. A registered pharmacist shall assist in developing, coordinating, and supervising all pharmaceutical services in conjunction with the pharmaceutical services committee. In addition, a registered pharmacist shall:

1. Review the drug and biological regimen of each patient at least monthly;

2. Report any irregularities to the attending physician and/or medical director. These reports shall show documentation of review and response; and

3. Document in writing the performance of such review, which documentation shall be kept on file by the facility and shall be made accessible to the Department upon request.

11.6.5 Laboratory and Radiologic Services

A. All facilities shall make provisions for laboratory, x-ray, and other services to be provided either directly by the facility or per contractual arrangements with an outside provider.

B. If the facility provides its own laboratory and x-ray services, these shall meet all applicable statutory and regulatory requirements.

C. All services shall be provided only per order of the attending physician who shall be promptly notified of the findings in accordance with a protocol established by the facility. Such a protocol shall describe which laboratory values mandate a call to the patient's attending physician.

D. Signed and dated reports of all findings shall become part of the patient's medical record.

11.6.6 Equipment

A. Each facility shall maintain sufficient and appropriate types of equipment consistent with patient needs and sufficient to meet emergency situations.

B. All equipment to meet the needs of the patients shall be maintained in safe and effective operational condition.

11.6.7 Housekeeping

A. An employee of the facility shall be designated responsible for housekeeping services, supervision, and training of housekeeping personnel.

B. Sufficient housekeeping and maintenance personnel shall be employed to maintain a comfortable, safe, clean, sanitary, and orderly environment in the facility.

C. Written housekeeping policies and procedures shall be established in accordance with § 11.6.3 of this Part on infection control, for the operation of housekeeping services throughout the facility. Copies shall be made available to all housekeeping personnel.

D. Housekeeping personnel may assist in food distribution but not food preparation. Careful hand washing should be done prior to assisting in food distribution.

E. All parts of the facility and its premises shall be kept clean, neat, and free of litter and rubbish and offensive odors.

F. Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition and shall be properly stored.

G. Hazardous cleaning solutions, compounds, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials.

H. Cleaning shall be performed in such a manner so as to minimize the development and spread of pathogenic organisms in the facility environment.

I. Exhaust ducts from kitchens and other cooking areas shall be equipped with proper filters and cleaned at regular intervals. The ducts shall be cleaned as often as necessary and inspected by the facility no less than twice per year.

J. Facilities contracting with outside resources for housekeeping services shall require conformity with the regulations contained herein.

K. Each facility shall be maintained free from insects and rodents through the operation of a pest control program.

11.6.8 Laundry Services

A. Each facility shall make provisions for the cleaning of all linens and other washable goods.

B. Facilities providing laundry service shall have adequate space and equipment for the safe and effective operation of laundry service and, in unsewered areas, shall obtain approval of the sewage system by the licensing agency to ensure its adequacy.

C. Written policies and procedures for the operation of the laundry service including special procedures for the handling and processing of contaminated linens, shall be established in accordance with § 11.6.3 of this Part on infection control.

D. There shall be distinct areas for the separate storage and handling of clean and soiled linens.

1. The soiled linen area and the washing area shall be negatively pressurized or otherwise protected to prevent introduction of airborne contaminants.

2. The clean linen area and the drying area shall be physically separated from the soiled linen area and the washing area.

E. All soiled linen shall be placed in closed containers prior to transportation.

F. To safeguard clean linens from cross-contamination they shall be transported in containers used exclusively for clean linens which shall be kept covered at all times while in transit and stored in areas designated exclusively for this purpose.

G. A quantity of linen equivalent to three (3) times the number of beds including the set of linen that is in use shall be available and in good repair at all times.

H. Facilities contracting for services with an outside resource in accordance with § 11.5.4 of this Part shall require conformity with these regulations as part of the contract.

11.6.9 Disaster Preparedness

A. Each facility shall develop and maintain a written disaster preparedness plan that shall include plans and procedures to be followed in case of fire or other emergencies. The plan and procedures shall be developed with the assistance of qualified safety, emergency management, and/or other appropriate experts and shall be coordinated with the local emergency management agency.

B. The plan shall include procedures to be followed pertaining to no less than the following:

1. Fire, explosion, severe weather, loss of power and/or water, flooding, failure of internal systems and/or equipment, and other calamities;

2. Transfer of casualties;

3. Transfer of records;

4. Location and use of alarm systems, signals, and firefighting equipment;

5. Containment of fire;

6. Notification of appropriate persons;

7. Relocations of patients and evacuation routes;

8. Feeding of patients;

9. Handling of drugs and biologicals;

10. Missing patients; and

11. Any other essentials as required by the local emergency management agency.

C. A copy of the plan shall be available to the staff and to the public.

D. Emergency steps of action shall be clearly outlined and posted in conspicuous locations throughout the facility.

E. In-service training related to the disaster preparedness plan shall be conducted for all shifts at least semi-annually. Written documentation of all drills shall be maintained by the facility.

F. All personnel shall receive training in disaster preparedness as part of their employment orientation.

11.7 Physical Plant

11.7.1 New Construction, Addition or Modification

A. All new construction, alterations, extensions or modifications of an existing facility, as defined in rules and regulations pursuant to R.I. Gen. Laws Chapter 23-15, shall be subject to the following provisions:

1. R.I. Gen. Laws Chapter 23-15 (Certificate of Need);

2. R.I. Gen. Laws Chapter 23-1 (Department of Health);

3. Rhode Island Food Code (Part 50-10-1 of this Title);

4. Guidelines for Design and Construction of Hospital and Health Care Facilities incorporated above at § 11.2(A) of this Part;

5. R.I. Gen. Laws Chapter 23-28.1 (State Fire Code);

6. Rhode Island Department of Environmental Management Rules and Regulations Establishing Minimum Standards Relating to Location, Design, Construction and Maintenance of Individual Sewage Disposal Systems (Sewage regulations);

7. The American National Standard - Specifications for Making Buildings and Facilities Accessible to and Usable by, the Physically Handicapped incorporated above at § 11.2(E) of this Part;

8. R.I. Gen. Laws Chapter 23-27.3 (State Building Code); and

9. The Americans with Disabilities Act incorporated above at § 11.2(F) of this Part.

B. In addition, any other applicable State and local laws, codes, and Regulations shall apply. Where there is a difference between codes, the code having the higher standard shall apply.

C. All plans for new construction or the renovation, alteration, extension, modification, or conversion of an existing facility that may affect compliance with §§ 11.7.4, 11.7.6, 11.7.7, 11.7.8, 11.7.9, and 11.7.14 of this Part, and "Guidelines for Design and Construction of Hospital and Health Care Facilities" incorporated above at § 11.2(A) of this Part shall be reviewed by a Rhode Island licensed architect. Said architect shall certify that the plans conform to the construction requirements of §§ 11.7.4, 11.7.6, 11.7.7, 11.7.8, 11.7.9, and 11.7.14 of this Part, and "Guidelines for Design and Construction of Hospital and Health Care Facilities" incorporated above at § 11.2(A) of this Part, prior to construction. The facility shall maintain a copy of the plans reviewed and the architect's signed certification, for review by the Department upon request.

1. In the event of non-conformance for which the facility seeks a variance, the general procedures outlined in § 11.8.1 of this Part shall be followed. Variance requests shall include a written description of the entire project, details of the non-conformance for which the variance is sought and alternate provisions made, as well as details explaining the basis upon which the request is made. The Department may request additional information while evaluating variance requests.

2. If variances are granted, a licensed architect shall certify that the plans conform to all construction requirements of §§ 11.7.4, 11.7.6, 11.7.7, 11.7.8, 11.7.9, and 11.7.14 of this Part, and "Guidelines for Design and Construction of Hospital and Health Care Facilities" incorporated above at § 11.2(A) of this Part, except those for which variances were granted, prior to construction. The facility shall maintain a copy of the plans reviewed, the variance(s) granted, and the architect's signed certification, for review by the Department upon request.

D. Upon completion of construction, the facility shall provide written notification to the Department describing the project, and a copy of the architect's certification. The facility shall obtain authorization from the Department prior to occupying/re-occupying the area. At the discretion of the Department, an on-site visit may be required.

11.7.2 General Provisions - Physical Environment

A. Each facility shall be constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public. All equipment and furnishings shall be maintained in good condition, properly functioning, and replaced when necessary.

B. All steps, stairs, and corridors shall be suitably lighted, both day and night. Stairs used by patients shall have banisters, handrails, or other types of support. All stair treads shall be well maintained to prevent hazards.

C. All rooms utilized by patients shall have proper ventilation and shall have outside openings with satisfactory screens. Shades or Venetian blinds and draperies shall be provided for each window.

D. Grounds surrounding the facility shall be accessible to and usable by patients/families and shall be maintained in an orderly and well-kept manner.

11.7.3 Fire Safety

A. Each facility shall meet the provisions of R.I. Gen. Laws Chapter 23-28.1.

B. Each facility shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations. Such a program shall include written procedures for the implementation of said rules and regulations and logs shall be maintained.

11.7.4 Emergency Power

A. The facility shall provide an emergency source of electrical power necessary to protect the health and safety of patients in the event the normal electrical supply is interrupted.

1. Such emergency power system shall supply power adequate at least for:

a. Lighting all means of egress;

b. Equipment to maintain detection, alarm, and extinguishing systems; and

c. Life support systems, where applicable.

2. Where life support systems are used, emergency electrical service shall be provided by an emergency generator located on the premises.

11.7.5 Facility Requirements for the Physically Handicapped

A. Each facility shall be accessible to, and functional for, patients, personnel, and the public. All necessary accommodations shall be made to meet the needs of persons with mobility disabilities, or sight, hearing, and coordination or perception disabilities in accordance with "The Americans with Disabilities Act" incorporated above at § 11.2(F) of this Part.

B. Blind, non-ambulatory, or physically handicapped patients or patients with mobility disabilities that limit self-preservation capability shall not be housed above the street-level floor unless the facility is equipped with an elevator and meets other requirements of R.I. Gen. Laws Chapter 23-28.1. Further, the facility must meet one of the following as defined in the National Fire Protection Association Standards No. 220:

1. Is of fire-resistive, one (1) hour-protected non-combustible construction;

2. Is fully-sprinklered, one (1) hour-protected, ordinary construction; or

3. Is fully-sprinklered, one (1) hour-protected, wood frame construction.

11.7.6 Residential area

A. Each residential area, as defined in § 11.3.24 of this Part, shall have at least the following:

1. Staff areas with adjacent hand-washing facility;

2. Storage rooms for walkers, wheelchairs, and other equipment;

3. Appropriate clean and soiled utility space; and

4. A telephone with an outside line.

B. In addition, each residential area shall be equipped with a communication system which, at a minimum, shall be:

1. Electrically activated;

2. Operated from the bedside of each occupant and from all areas used by occupants, including multipurpose rooms, toilet, and bathing facilities; and

3. Capable of alerting the responsible person or persons on duty twenty-four (24) hours a day, regardless of the location of the person on duty.

11.7.7 Patient Rooms and Toilet Facilities

A. Patient rooms shall be designed with a personalized, homelike environment, and equipped for adequate nursing care, comfort, and privacy of patients with no more than one (1) bed per room.

B. Bedrooms shall be no less than one hundred (100) square feet in area and no less than eight (8) feet wide exclusive of toilet rooms, closets, lockers, wardrobes, alcoves or vestibules. In new construction, single bedrooms shall be constructed in accordance with the American Institute of Architects Academy of Architecture for Health guidelines of “Guidelines for Design and Construction of Hospital and Health Care Facilities” incorporated above at § 11.2(A) of this Part.

C. Each room shall have a window that can be easily opened. The windowsill shall not be higher than three feet (3'0") above the floor and shall be above grade level.

D. The size of each window shall be no less than two feet, six inches (2'6") wide by four feet, five inches (4'5") high, double hung or an approved equivalent.

E. Each room shall have direct access to a corridor and outside exposure with the window at or above grade level.

F. Lavatories and bathing areas to be used by the handicapped shall be equipped with grab-bars for the safety of the patients and shall meet the requirements of “Guidelines

for Design and Construction of Hospital and Health Care Facilities" incorporated above at § 11.2(A) of this Part.

G. All facilities constructed after March 20, 1977 shall have at, a minimum, connecting toilet rooms between patients' rooms in accordance with the requirements of § 11.7.1 of this Part. In addition, in facilities constructed prior to March 20, 1977, there shall be no less than one (1) toilet per eight (8) beds or fraction thereof on each floor where patient rooms are located.

H. In all facilities constructed after August 1, 2001, patient toilet rooms shall be equipped with facilities for cleaning bedpans.

I. Separate lavatory and toilet facilities shall be provided for employees and the general public commensurate with the needs of the facility.

J. A minimum of one (1) bathtub or shower shall be provided for every twelve (12) patients, not otherwise served by bathing facilities in patient rooms. At least one (1) bathtub shall be provided in each residential area.

K. Each bathtub or shower shall be in an individual room or enclosure which provides space for the private use of the bathing fixture, for drying and dressing and for a wheelchair and an attendant.

L. Complete privacy shall be provided to each patient in semi-private rooms by the use of overhead type fire resistive screens and/or cubicle fire resistive curtains suspended by inset overhead tracks in accordance with R.I. Gen. Laws Chapter 23-28.1.

1. When overhead-type screens and/or cubicle curtains are not provided, each semi-private room shall be equipped with a fire-resistant, portable screen.

M. Each patient shall be provided with a bed of proper size and height for the convenience and comfort of the patient, box spring and clean, comfortable mattress, bedside stand, straight-back chair, comfortable chair, dresser, and individual closet space for clothing with clothes racks and shelves accessible to patients in each room, and a reading lamp equipped with bulb of adequate candlepower.

1. Bedding including bedspread, shall be seasonally appropriate.

11.7.8 Special Care Unit

A patient room shall be designated for isolation purposes. Such room shall be properly identified with precautionary signs, shall have outside ventilation, private toilet, and hand washing facilities, and shall conform to other requirements established for the control of infection in accordance with § 11.6.3 of this Part.

11.7.9 Dining and Patient Activity Rooms

A. The facility shall provide one or more clean, orderly, appropriately furnished and easily accessible room(s) of adequate size designed for patient and family dining, as applicable.

1. These areas shall be appropriately lighted and ventilated with non-smoking areas identified.

2. If a multipurpose room is used, there must be sufficient space to accommodate dining to prevent interference with each other.

11.7.10 Plumbing

A. All plumbing shall be installed in such a manner as to prevent back siphonage or cross connections between potable and non-potable water supplies in accordance with R.I. Gen. Laws Chapter 23-27.3.

B. Fixtures from which grease is discharged may be served by a line in which a grease trap is installed in accordance with standards of R.I. Gen. Laws Chapter 23-27.3. The grease trap shall be cleaned sufficiently often to sustain efficient operation.

11.7.11 Water Supply

A. Water shall be distributed to conveniently located taps and fixtures throughout the building and shall be adequate in volume and pressure for all purposes including firefighting.

1. In patient areas, hot water temperatures shall not be less than one hundred (100) degrees Fahrenheit nor exceed one hundred ten (110) degrees Fahrenheit (plus or minus two degrees). Thermometers (accuracy of which can be plus or minus two degrees) shall be provided in each residential area to check water temperature periodically on that unit and at each site where patients are immersed or showered.

2. Thermostatic or pressure balanced mixing valves are required at each site or fixture used for immersion or showering of patients. Thermometers and tactical (skin sense) method shall be used to verify the appropriateness of the water temperature prior to each use.

3. In addition to temperature-regulating devices controlling the generation of domestic hot water, hot water supplies to patient care areas shall be regulated by anti-scalding, water tempering or mixing valves (approved by the Director or his/her designee) in order to maintain the temperature standards of § 11.7.11(A)(1) of this Part.

11.7.12 Waste Disposal Systems

Any new facility shall be connected to a public sanitary sewer, if available, or otherwise shall be subject to the requirements of Rhode Island Department of Environmental Management Rules Establishing Minimum Standards Relating to Location, Design, Construction and Maintenance of Onsite Wastewater Treatment Systems.

11.7.13 Maintenance

All essential mechanical, electrical, and patient care equipment shall be maintained in safe operating condition and logs/records shall be maintained of periodic inspections.

11.7.14 Other Provisions

A. Facilities shall make provisions to ensure that the following are maintained:

1. Adequate and comfortable lighting levels in all areas in accordance with "Guidelines for Design and Construction of Hospital and Health Care Facilities" incorporated above at § 11.2(A) of this Part;

2. Limitation of sounds at comfort levels;

3. Comfortable temperature levels for the patients in all parts of patient occupied areas with a centralized heating system to maintain a minimum of seventy (70) degrees Fahrenheit during the coldest periods;

4. Adequate ventilation through windows or by mechanical means; and

5. Corridors equipped with firmly secured handrails on each side.

6. Heat relief: any hospice inpatient facility that does not provide air conditioning in every patient room shall provide an air-conditioned room or rooms in a residential section(s) of the facility to provide relief to patients when the outdoor temperature exceeds eighty (80) degrees Fahrenheit.

11.7.15 Waste Disposal

A. Medical waste:

1. Medical waste as defined in the Rhode Island Department of Environmental Management Medical Waste Regulations, 250-RICR-140-15-1, shall be managed in accordance with the provisions of the aforementioned regulations.

B. Other Waste:

1. Wastes which are not classified as infectious wastes, hazardous wastes, or which are not otherwise regulated by law or rule may be disposed in dumpsters or load packers provided the following precautions are maintained:

a. Dumpsters shall be tightly covered, leak-proof, inaccessible to rodents and animals, and placed on concrete slabs preferably graded to a drain. Water supply shall be available within easy accessibility for washing down of the area. In addition, the pick-up schedule shall be maintained with more frequent pick-ups when required. The dumping site of waste materials must be in sanitary landfills approved by the Rhode Island Department of Environmental Management.

b. Load packers must conform to the same restrictions required for dumpsters and, in addition, load packers shall be:

(1) High enough off the ground to facilitate the cleaning of the underneath areas of the stationary equipment; and

(2) The loading section shall be constructed and maintained to prevent rubbish from blowing from said area site.

c. Recyclable waste: Containers for recyclable waste, including paper and cardboard, shall be tightly covered, leak-proof, inaccessible to rodents and animals, and placed on concrete slabs preferably graded to a drain. In addition, the pick-up schedule shall be maintained with more frequent pick-ups when required.

11.8 Practices and Procedures, Confidentiality, and Severability

11.8.1 Variance Procedure

A. The licensing agency may grant a variance either upon its own motion or upon request of the applicant from the provisions of any rule or regulation in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the applicant and that such variance will not be contrary to the public interest.

B. A request for a variance shall be filed by an applicant in writing setting forth in detail the basis upon which the request is made.

1. Upon the filing of each request for variance with the licensing agency and within a reasonable time thereafter, the licensing agency shall notify the applicant by certified mail of its approval or in the case of a denial, a hearing date, time, and place may be scheduled if the hospice program appeals the denial.

11.8.2 Deficiencies and Plans of Correction

A. The licensing agency shall notify the governing body or other legal authority of a facility of violations of individual standards through a notice of deficiencies which shall be forwarded to the facility within fifteen (15) days of inspection of the facility unless the Director determines that immediate action is necessary to protect the health, welfare, or safety of the public or any member thereof through the issuance of an immediate compliance order in accordance with R.I. Gen. Laws § 23-1-21.

B. A facility that received a notice of deficiencies must submit a plan of correction to the licensing agency within fifteen (15) days of the date of the notice of deficiencies. The plan of correction shall detail any requests for variances as well as document the reasons therefor.

C. The licensing agency will be required to approve or reject the plan of correction submitted by a facility in accordance with § 11.8.2(B) of this Part within fifteen (15) days of receipt of the plan of correction.

D. If the licensing agency rejects the plan of correction, or if the facility does not provide a plan of correction within the fifteen (15) day period stipulated in § 11.8.2(B) of this Part, or if a facility whose plan of correction has been approved by the licensing agency fails to execute its plan within a reasonable time, the licensing agency may invoke the sanctions enumerated in § 11.4.8 of this Part. If the facility is aggrieved by the action of the licensing agency, the facility may appeal the decision and request a hearing in accordance with R.I. Gen. Laws Chapter 42-35. The notice of the hearing to be given by

the Department shall comply in all respects with the provisions of R.I. Gen. Laws Chapter 42-35. The hearing shall in all respects comply with the provisions therein.

11.8.3 Uniform Reporting System

A. Each hospice program shall establish and maintain records and data in such a manner as to make uniform a system of periodic reporting. The manner in which the requirements of this Part may be met shall be prescribed from time to time in directives promulgated by the Director.

B. Each hospice program shall report to the licensing agency detailed statistical data pertaining to its operation and services. Such reports and data shall be made at such intervals and by such dates as determined by the Director.

C. The licensing agency is authorized to make the reported data available to any state or federal agency concerned with or exercising jurisdiction over the hospice program.

D. The directives promulgated by the Director pursuant to these regulations shall be sent to each hospice program to which they apply. Such directives shall prescribe the form and manner in which the statistical data required shall be furnished to the licensing agency.

11.8.4 Rules Governing Practices and Procedures

All hearings and reviews required under the provisions of R.I. Gen. Laws Chapter 23-17 shall be held in accordance with the provisions of the Rules and Regulations Pertaining to Practices and Procedures Before the Rhode Island Department of Health and the Rules and Regulations Pertaining to Access to Public Records of the Rhode Island Department of Health.

11.8.5 Confidentiality

Disclosure of any health care information relating to individuals shall be subject to the provisions of R.I. Gen. Laws Chapter 5-37.3, the Confidentiality of Health Care Information Act, and other relevant state and federal statutory and regulatory requirements.

216-RICR-40-10-11

TITLE 216 - DEPARTMENT OF HEALTH

CHAPTER 40 - PROFESSIONAL LICENSING AND FACILITY REGULATION

SUBCHAPTER 10 - FACILITIES REGULATION

PART 11 - LICENSING HOSPICE CARE (216-RICR-40-10-11)

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