Title 15: Mississippi State Department of Health

Part 16: Health Facilities

Subpart 1: Health Facilities Licensure and Certification

CHAPTER 46 MINIMUM STANDARDS OF OPERATION FOR HOME HEALTH AGENCIES

Subchapter 3 DEFINITIONS. As used in these minimum standards, the words and terms hereinafter set forth, shall be defined as follows:

Rule 46.3.4 **Care Team** shall mean a group of individuals responsible for the development of each patient's care plan. The care team shall consist of, but not be limited to, the physician, podiatrist, nurse practitioners, physician assistants, clinical nurse specialists, and pertinent members of the agency staff, the patient and member of his/her family.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.11 **Deleted**

Rule 46.3.20 **Home Health Agency** shall mean a public or privately owned agency or organization or a subdivision of such an agency or organization, properly authorized to conduct business in Mississippi, which is primarily engaged in providing to individuals, at the written direction of a licensed physician, podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists in the individual's place of resident, skilled nursing services provided by or under the supervision of a registered nurse licensed to practice in Mississippi and one or more of the following part-time intermittent services or items:

1. Physical, occupational, or speech therapy;
2. Medical Social Services;
3. Home Health aide services;
4. Other services as approved by the licensing agency;
5. Medical supplies, other than drugs and biologicals, and the use of medical appliances;
6. Medical services provided by a resident in training at a hospital under a teaching program of such hospital.
7. Drugs and Biologicals as allowed by Mississippi Board of Pharmacy permit for home health. (Refer to Home Health and Hospice Permits - MS Board of Pharmacy.)

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.29 1. **Medical Social Worker** shall mean a person who has a master's degree or bachelor's degree from a school of social work accredited by the Council on Social Work Education or Southern Association of Colleges and Schools and is licensed by the State of Mississippi as such and who has one year of social work experience in a health care setting.

2. **Nurse Practitioner** shall mean an individual who is currently licensed as an Advanced Practice Registered Nurse in the State of Mississippi and is performing nurse practitioner duties in accordance with the Mississippi Nursing Practice Act.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.31 **Occupational Therapy Assistant** shall mean a person who is currently licensed as such by the State of Mississippi and is performing therapy duties in accordance with the Mississippi Occupational Therapy Practice Act.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.35 **Patient** shall mean any individual whose condition is of such severity that the individual should be confined to his/her place of residence because of acute or chronic illness or injury or individuals with disabilities, convalescent or infirm, or who is in need of rehabilitative, obstetrical, surgical, medical, nursing, or supervisory care in their place of residence and under the care of a physician, podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.43 **Deleted**

Rule 46.3.44 **Plan of Treatment** shall mean the written instructions, signed and reviewed at least every 60 days or more often if the patient's condition so warrants, by the physician, podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists for the provision of services.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.46 **Deleted**

Rule 46.3.48 **Deleted**

Subchapter 7 THE LICENSE

Rule 46.7.2 **Provisional License**. Within its discretion, the Mississippi State Department of Health may issue a provisional license when a temporary condition of non-compliance with these regulations exists. A provisional license may be issued if

the Department is satisfied that preparations are being made to qualify for a regular license and that the health and safety of patients will not be endangered. One condition on which a provisional license may be issued is as follows: A new home health agency may be issued a provisional license prior to opening and subsequent to meeting the required minimum staffing personnel. A provisional license issued under this condition shall be valid until the issuance of a regular license or June 30 following date of issuance whichever may be sooner. A provisional license may be reissued only if it is satisfactorily proven to the Department of Health that efforts are being made to fully comply with these regulations by a specified time.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 12 DENIAL, SUSPENSION, OR REVOCATION OF LICENSE

Rule 46.12.1 **Denial or Revocation of License**. Hearings and Review. The licensing agency after notice and opportunity for a hearing to the applicant or licensee is authorized to deny, suspend, or revoke a license in any case in which it finds that there has been a failure to comply with the requirements established under the law and these minimum standards. Also, the following may be grounds for denial or revocation of license:

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

2. Violations by the licensee of the minimum standards established by the Department of Health.

3. Publicly misrepresenting the agency and/or its services.

4. Conduct or practices detrimental to the health or safety of patients and employees of said agency provided that this provision shall not be construed to have any reference to healing practices authorized by law. Detrimental practices include but are not necessarily limited to:

    A. Cruelty to patients or indifference to their needs which are essential to their general well-being and health.

    B. Misappropriations of the money or property of a patient.

    C. Inadequate staff to provide safe care and supervision of any patient.

    D. Failure to call a physician, podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists when required by patient's condition.

5. Failure to comply with the requirements of the Mississippi Commission Act of 1979, amended.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 14 TERMINATION OF OPERATION

Rule 46.14.1 **General**. In the event that Home Health Agency ceases operation, voluntarily or otherwise, the agency shall:

1. Inform the attending physician, podiatrist, nurse practitioners, physician assistants, clinical nurse specialists, patient, and persons responsible for the patient's care in ample time to provide for alternate methods of care.

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

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

4. Ensure the safekeeping, confidentiality, and storage of all clinical records for a period of seven (7) years, following discharge.

5. Return the license to the licensing agency.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 19 REGULATED MEDICAL WASTE

Rule 46.19.1 **Infectious medical wastes** include solid or liquid wastes which may contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host has been proven to result in an infectious disease. For purposes of this Regulation, the following wastes shall be considered to be infectious medical wastes:

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

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

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

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

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

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

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

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.19.2 **Medical Waste Management Plan**. All generators of infectious medical waste and medical waste shall have a medical waste management plan in accordance with Adopted Standards for the Regulation for Medical Waste, as listed in the most current version on the Department's website .

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 20 GOVERNING BODY AND ADMINISTRATION: EMERGENCY OPERATIONS PLAN

Rule 46.20.1 The licensed entity shall develop and maintain a written preparedness plan utilizing the Emergency Operations Plan (EOP) Template developed by the MSDH Office of Emergency Planning and Response. "All Hazards" and "Whole Community" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any pandemic, act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency Planning and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Planning and Response Plan." Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by the Office of Emergency Planning and Response. The nine (9) critical areas of consideration are:

1. Communications - Facility status reports shall be submitted in a format and a frequency as required by the Office of Emergency Planning and Response

2. Resources and Assets

3. Safety and Security

4. Staffing

5. Utilities

6. Clinical Activities

7. Fire drills shall be conducted a minimum of (2) times per year

8. Smoke Detectors/Extinguishers (refer to NFPA 10 and NFPA 72) and

9. Continuity of Operations Planning (COOP) to include surge and alternate care sites.

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

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 21 GOVERNING BODY

Rule 46.21.1 **General**. The Home Health Agency shall have an organized governing body so functioning which is legally responsible for the conduct of the agency. The administrator and all personnel shall be directly or indirectly responsible to this governing body. The ownership of the home health agency shall be fully disclosed to the State licensure authority. The governing body shall ensure that the agency complies with all applicable local, state and federal laws and regulations and similar requirements. Staff of the Agency shall be currently licensed or registered in accordance with applicable laws of the State of Mississippi. The governing body shall be responsible for periodic administrative and professional evaluations of the agency. The governing body shall receive, review and take action on recommendations made by the evaluating groups and so document the governing body shall adopt and enforce bylaws, or an acceptable equivalent thereof, in accordance with legal requirements. The bylaws, shall be written, revised as needed, and made available to all members of the governing body, the State licensure authority, and the advisory group. The terms of the bylaws shall cover at least the following:

1. The basis upon which members of the governing body are selected, their terms of office, and their duties and responsibilities.

2. A provision specifying to whom responsibilities for administration and supervision of the program and evaluation of practices may be delegated and the methods established by the governing body for holding such individuals responsible.

3. A provision specifying the frequency of board meetings and requiring that minutes be taken at each meeting.

4. A provision requiring the establishment of personnel policies and an organizational chart, clearly establishing lines of authority and relationships.

5. The agency's statement of objectives.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 22 ADMINISTRATOR

Rule 46.22.1 **Administrator**. The governing body shall be legally responsible for the appointment of a qualified administrator and the delegation of responsibility and authority. The governing body shall assure that the administrator has sufficient freedom from other responsibilities to permit adequate attention to the overall direction and management of the agency. When there is a change of the administrator, the governing authority shall immediately notify the licensing agency in writing of the change. The duties and responsibilities of the agency administrator shall include at least the following:

1. Implementing the policies approved and/or developed by the governing body;

2. Organizing and coordinating the administrative functions of the services, including implementing adequate budgeting and accounting procedures;

3. Maintaining an ongoing liaison with the agency staff;

4. Coordinating service components to be provided by contractual agreement; and

5. Arranging employee orientation, continuing education, and in-service training programs.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 24 DELETED

Rule 46.24.1 **Deleted.**

Rule 46.24.2 **Deleted.**

Rule 46.24.3 **Deleted.**

Subchapter 25 POLICY AND PROCEDURE MANUAL

Rule 46.25.1 **Manual**.

1. The home health agency administrator with advice from the director of nursing/supervising nurse shall develop a policy and procedure manual.

2. Written policies and procedures shall include provisions covering at least the following:

   A. Definition of the scope of services offered;

   B. Admission and discharge policies;

   C. Medical direction and supervision;

   D. Plans of treatment;

   E. Staff qualifications, assignments and responsibilities;

   F. Medication administration;

   G. Medical records;

   H. Patient safety and emergency care;

   I. Administrative records;

   J. Agency evaluation;

   K. Provisions for after hours emergency care (on call);

   L. Patients rights policies and procedures; and

   M. Provisions for the proper collection, storage and submission of all referral laboratory samples collected on home health patients.

3. Patient admission and discharge policies shall include but not be limited to the following:

   A. Patient shall be accepted for health service on a part-time or intermittent basis upon a plan of treatment established by the patient's physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. Patients accepted for admission should be essentially home bound and in need of skilled services.

   B. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.

C. When services are to be terminated by the home health agency, the patient and the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, are to be notified in advance of the date of termination stating the reason and a plan shall be developed or a referral made for any continuing care.

D. Services shall not be terminated without an order by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists in consultation with the registered nurse and/or the appropriate therapist. Except in cases of non-payment, where the specific and approved plan of care has been documented as completed, where the patient refuses treatment, in the event of an unsafe environment, or should the patient require the services beyond the capability of the agency. In any event, the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists shall be notified of the termination of services. Arrangements shall be made for continuing care when deemed appropriate.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 27 PERSONNEL POLICIES

Rule 46.27.3 **Criminal History Record Checks**.

1. Employee. For the purpose of fingerprinting and criminal background history checks, employee shall mean any individual employed by a covered entity. The term employee", also includes any individual who by contract with the covered entity provides direct patient care in a patient's, resident's, or client's room or in treatment rooms. The term employee does not include healthcare professional/technical students, as defined in Section 37-29-232, performing clinical training in a licensed entity under contracts between their schools and the licensed entity, and does not include students at high schools who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied health course taught in the school if:

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

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

such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

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

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

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

4. Health Care Professional/Vocational Technical Academic Program. For the purpose of criminal history record checks, "health care professional/vocational technical academic program" means an academic program in medicine, nursing, dentistry, occupational therapy, physical therapy, social services, speech therapy, or other allied-health professional whose purpose is to prepare professionals to render patient care services.

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

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

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

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

A. Every employee of a covered entity must have initial criminal history check and then every two years.

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

C. B. Every Each employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer and then every two years.

9. 2. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted.

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

A. possession or sale of drugs

B. murder

C. manslaughter

D. armed robbery

E. rape

F. sexual battery

G. sex offense listed in Section 45-33-23(g), Mississippi Code of 1972

H. child abuse

I. arson

J. grand larceny

K. burglary

L. gratification of lust

M. aggravated assault

N. felonious abuse and/or battery of vulnerable adult

11. Documentation of verification of the employee's disciplinary status, if any, with the employee's professional licensing agency as applicable, and evidence of submission of the employee's fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee's disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual's suitability for such employment.

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

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

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

15. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (g) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5)

current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility.

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

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

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

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

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 31 PATIENTS' RIGHTS

Rule 46.31.1 **General**. The agency shall maintain written policies and procedures regarding the rights and responsibilities of patients. Written policies regarding patients' rights shall be made available to patients and/or their guardian, next of kin, sponsoring agency or agencies, or lawful representative and to the public. There shall be documented evidence that the staff of the agency is trained and involved in the implementation of these policies and procedures. In-service on patient's rights

and responsibilities shall be conducted annually. The patients' rights policies and procedures ensure that each patient admitted to the agency:

1. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission, of these rights and of all rules and regulations governing patient conduct and responsibilities;

2. Is fully informed prior to or at the time of admission and during the course of treatment of services available through the agency, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or any other third party.

3. Is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

4. Is transferred or discharged only for medical reasons, or for his welfare, or for non-payment (except as prohibited by Titles XVIII or XIX of the Social Security Act), or on the event of an unsafe environment, or should the patient refuse treatment, and is given advance notice to ensure orderly transfer to discharge, and such actions are documented in his clinical record;

5. May voice grievances and recommend changes in policies and services to agency staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. Is assured confidential treatment of his personal and clinical records, and may approve or refuse their release to any individual outside the agency, except, in case of his transfer to another health care institution or agency or as required by law or third-party payment contract;

7. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care of his personal needs;

8. No person shall be refused service because of age, race, religious preference, sex, marital status or national origin.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 32 PLANNING FOR PATIENT TREATMENT: PLAN OF TREATMENT

Rule 46.32.1 **Development of Plan of Treatmen**t. Each home health agency shall establish policies and procedures for assuring that services and items to be provided are specified under a plan of treatment established and regularly reviewed by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, who is responsible for the care of the patient. Other agency personnel

shall have input into the development of the plan of treatment as deemed appropriate by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. The original plan of treatment shall be signed by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, who is responsible for the care of the patient and incorporated in the record maintained by the agency for the patient. The total plan is reviewed by the attending physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists in consultation with agency professional personnel at such intervals as the severity of the patient's illness requires but, in any instance, at least once every two (2) months. The registered nurse, and other health professional shall bring to the attention of the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists changes in the patient's condition which indicate the need for altering the treatment plan or for terminating services. No medication, treatment or services shall be given except on signed order of a person lawfully authorized to give such an order.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.32.2 **Plan of Treatment Content**. The plan of treatment shall include:

1. Diagnoses relevant to the provision of home health services;

2. Functional limitations and rehabilitation potential;

3. Prognosis;

4. Services authorized by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists including frequency and duration;

5. Medications ordered by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists to include dosage, route of administration and frequency;

6. Treatment, if applicable, including modality, frequency and duration; drug and food allergies;

7. Activities permitted;

8. Diet;

9. Specific procedures deemed essential for the health and safety of the patient;

10. The attending physician’s, podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist’s signature;

11. Long term goals and discharge plans;

12. Mental status; and

13. Equipment required.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.32.3 **Periodic Review of the Plan of Treatment**. The professional person responsible for any specific treatment shall notify the attending physician, podiatrist, nurse practitioner, physician assistant, clinical nurse specialist, or other professional persons, and responsible agency staff of significant changes in the patient's condition. The plan shall be reviewed by the agency care team at least every sixty (60) days. The attending physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists shall be consulted to approve additions or modifications to the original plan. When a patient is transferred to a hospital and readmitted to the agency, the plan of treatment shall be reviewed by the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. If the diagnosis of the patient has not changed (as documented in the agency's discharge/transfer summary, the hospital's discharge summary and reassessment of the patient), a statement to continue previous orders will suffice. At the end of the sixty (60) day period, new orders shall be written.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 33 PATIENT PLAN

Rule 46.33.1 **General**. A patient care plan shall be written for each patient by the registered nurse or other disciplines as needed based upon an assessment of the patient's significant clinical findings, resources, and environment. The initial assessment for patients requiring skilled nursing services is to be made by a registered nurse. Assessments by other care team members shall be made on orders of the physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. The patient care plan shall be updated as often as the patient's condition indicates at least every sixty (60) days and shall be maintained as a permanent part of the patient's record.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 34 SERVICES PROVIDED: GENERAL

Rule 46.34.1 Each agency shall provide skilled nursing service and at least one other home health service on a part-time or intermittent basis. The skilled nursing service shall be provided directly by agency staff. Other home health services may be provided by agency staff directly or provided under arrangement through a contractual purchase of services. All services shall be provided in accordance with order of the patient's physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, and under a plan of treatment established by such physician, podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 35 SKILLED NURSING

Rule 46.35.2 **Duties of the Registered Nurse**. The duties of the Registered Nurse shall include, but not be limited to the performance and documentation of the following:

1. Evaluate and regularly reevaluate the nursing needs of the patient;

2. Develop and implement the nursing component of the patient care plan;

3. Provide nursing services, treatments, and diagnostic and preventive procedures requiring substantial specialized skill;

4. Initiate preventive and rehabilitative nursing procedures as appropriate for the patient's care and safety;

5. Observe and report to the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialists when appropriate, signs and symptoms, reaction to treatments and changes in the patient's physical or emotional condition;

6. Teach, supervise, and counsel the patient and family members regarding the nursing care needs and other related problems of the patient at home; check all medications to identify ineffective drug therapies, adverse reactions, significant side effects, drug allergies and/or contraindicated medications. Promptly report any problems to the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist.

7. Provide supervision and training to other nursing service personnel;

8. Provide direct supervision of the Licensed Practical Nurse in the home of each patient seen by the LPN at least once a month. It is not a requirement for the licensed practical nurse to be present at the supervisory visit by the RN; however, it does not preclude the licensed practical nurse from being present. In addition, the supervising RN must be accessible by telecommunications to the LPN at all times while the LPN is treating patients.

9. Make supervisory visits to the patient's residence at least every other week with the aide alternately present and absent, to provide direct supervision and to assess relationships and determine whether goals are being met; and

10. Ensures that the patient's nursing care and progress is recorded in the clinical record.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 36 LICENSED PRACTICAL NURSING SERVICES

Rule 46.36.1 **General**. Licensed Practical Nursing Services shall be provided by a trained licensed practical nurse working under the supervision of a registered nurse. The duties of the Licensed Practical Nurse shall include, but not limited to the following:

1. Observe, record and report to supervisor on the general physical and mental conditions of the patient;

2. Administer prescribed medications and treatments in accordance with the plan of treatment;

3. Assist the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, and/or registered nurse in performing specialized procedures;

4. Assist the patient with activities of daily living and encourage appropriate self-care; and

5. Prepare progress notes and clinical notes.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 38 HOME HEALTH AIDE SERVICES

Rule 46.38.1 **General**. When an agency provides or arranges for home health aide services, the aides shall be assigned because the patient needs personal care. The services shall be given under a physician's, podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's order and shall be supervised by a registered nurse. When appropriate, supervision may be given by a physical, speech, or occupational therapist.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 39 PHYSICAL THERAPY SERVICE

Rule 46.39.1 **General**. Physical therapy services shall be given in accordance with the responsible physician's, podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's written order by a physical therapist or physical therapy assistant currently licensed in the State of Mississippi to practice as a physical therapist or physical therapist assistant. The physician's, podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's, order shall be specific as to modalities to be utilized and frequency of therapy.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.39.2 **Duties of the Physical Therapist**. The duties of the physical therapist shall include, but not be limited to the following:

1. Assisting the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, in the functional evaluation of the patient and development of the individual plan of treatment;

2. Developing and implementing a physical therapy component of the patient care plan;

3. Rendering treatments to relieve pain, develop or restore function, and maintain maximum performance; directing and aiding the patient in active and passive exercise, muscle reeducation, and engaging in functional training activities in daily living;

4. Observing and reporting to the responsible physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, the patient's reactions to treatments and any changes in the patient's conditions;

5. Instructing the patient and family on the patient's total physical therapy program and in which they may work with the patient;

6. Instructing the patient and family on the patient's total physical therapy program and in the care and use of appliances, prosthetic and other orthopedic devices;

7. Preparing clinical notes, progress notes, and discharge summaries;

8. Participating in agency in-service training programs;

9. Acting as a consultant to other agency personnel;

10. Developing written policies and procedures for the physical therapy services of the home health agency;

11. Make the initial visit for evaluation of the patient and establishment of a plan of care;

12. The supervising physical therapist must have a case conference with the physical therapy assistant to discuss the evaluation, review the established plan of care, and provide the physical therapy assistant with instructions needed for the safe and effective treatment of the patient before the physical therapy assistant begins providing services to the patient;

13. The supervising physical therapist must visit and personally render treatment and reassess each patient who is provided services by the physical therapist assistant no later than every sixth treatment day or thirtieth calendar day, whichever occurs first. It is not a requirement for the physical therapist assistant to be present at this visit; however, it does not preclude the physical therapist assistant from being present. In addition, the supervising physical therapist must be accessible by

telecommunications to the physical therapist assistant, at all times, while the physical therapist assistant is treating patients.

14. Make the final visit to terminate the plan of care; and

15. Provide supervision for no more than four (4) physical therapy assistants.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 41 OCCUPATIONAL THERAPY SERVICES

Rule 46.41.1 **General**. When an agency provides or arranges for occupational therapy, services shall be given in accordance with a physician's, podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's written order by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.41.2 **Duties of the Occupational Therapist**. Duties of the occupational therapist shall include, but not be limited to, the following:

1. Assisting the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, in the evaluation of patients by applying diagnostic and prognostic tests and by reporting the findings in terms of problems and abilities of the patient; identifying patients' therapy needs and development of the individual plan of treatment;

2. Developing and implementing an occupational therapy component of the patient care plan.

3. Treating patients for the purpose of attaining maximum functional performance through use of such procedures as:

   A. Task orientation therapeutic activities;

   B. Activities of daily living;

   C. Perceptual motor training and sensory integrative treatment;

   D. Orthotics and splinting;

   E. Use of adaptive equipment;

   F. Prosthetic training;

   G. Homemaking training.

4. Observing, recording, and reporting to the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, and agency

personnel the patient's reaction to treatment and any changes in the patient's condition;

5. Counseling with regard to levels of functional performance and the availability of community resources;

6. Instructing other health team personnel, patients, and family members;

7. Preparing clinical notes, progress notes, and discharge summaries;

8. Participating in staff in-service educational programs;

9. Developing written policies and procedures for the occupational therapy services of the home health agency;

10. Acting as a consultant to other agency personnel; and

11. Make supervisory visits to the patient's residence with the Occupational Therapy Assistant at least once every three (3) weeks or every five (5) to seven (7) treatment sessions to provide direct supervision and to assess the adherence to the plan of treatment and progress toward established goals.

12. Conduct all initial assessments and establish the goals and plans of treatment before the treatments are provided to the patient by an Occupational Therapy Assistant.

13. Prepare discharge summaries, interim assessments, and initiate any changes in the plan of care for patients treated by Occupational Therapy Assistants.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 42 MEDICAL SOCIAL SERVICES

Rule 46.42.1 **General**. Medical social services shall be provided by a social worker who has a master’s degree from a school of social work accredited by the Council on Social Work Education and is licensed as such by the State of Mississippi and has one year of social work experience in a health care setting or by a licensed social worker who has a bachelor's degree from a school of social work accredited by the Council of Social Work Education or Southern Association of Colleges and Schools and has one year of social work experience in a health care setting and who is supervised by a licensed social worker with a master’s degree. Medical social services shall be given in accordance with the responsible physician’s, podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist’s written order by a medical social worker. Master's degree social worker shall review and evaluate the performance of the bachelor's degree social worker on a monthly basis.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.42.2 **Duties of the Medical Social Worker**. The duties of the medical social worker include, but are not limited to the following:

1. Assisting the responsible physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, and other members of the agency team in understanding the significant social and emotional factors related to patient health problems;

2. Assessing the social and emotional factors in order to estimate the patient's capacity and potential to cope with problems of daily living; and assisting in the development of an individual plan of treatment;

3. Developing and implementing a social work component of the patient care plan;

4. Helping the patient and his/her family to understand, accept, and follow medical recommendations and provide services planned to restore the patient to optimum social and health adjustment within his/her capacity;

5. Assisting patients and their families with personal and environmental difficulties which predispose towards illness or interfere with obtaining maximum benefits from medical care;

6. Utilizing resources such as family and community agencies to assist the patient in resuming life in the community or to learn to live with his/her disability;

7. Preparing clinical notes, progress notes, and discharge summaries;

8. Participating in agency in-service training programs;

9. Acting as a consultant to other agency personnel;

10. Development of written policies and procedures for medical social services of the home health agency; and

11. Review and evaluate the work of a bachelor's degree licensed social worker on a monthly basis.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 43 NUTRITIONAL SERVICES

Rule 46.43.2 **Duties of the Dietitian**. The responsibilities of the Dietitian shall include but not be limited to, the following:

1. Assisting the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist in the evaluation of the patient's nutritional status and development of the individual plan of treatment;

2. Developing and implementing a nutritional component of the patient care plan;

3. Selecting, preparing and evaluating teaching materials and aids for patient counseling and education and furnishing direct nutritional counseling services to the patient;

4. Observing and reporting to the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist the patient's reaction and adherence to the diet and change in the patient's nutritional status;

5. Preparing clinical notes, progress, and discharge summaries;

6. Participating in agency in-service training programs;

7. Acting as a consultant to other agency personnel; and

8. Developing written policies and procedures for the nutritional services of the home health agency.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 46 APPLIANCE AND EQUIPMENT SERVICE

Rule 46.46.1 **General**. Appliance and equipment services may be provided to patients by the home health agency only upon the written order of a physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist. A home health agency may elect to provide the service directly or indirectly through a supplier. Policies and procedures shall be developed for the appliance and equipment services. All appliances and equipment provided for patients shall be maintained in good condition.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 48 CLINICAL RECORD

Rule 46.48.1 **Clinical Record Content**. A clinical record shall be established and maintained for every person admitted to home health services. The original or signed copy of clinical reports shall be filed in the clinical record. Clinical records shall contain:

1. Appropriate identifying information for the patient, household members and caretakers, pertinent diagnoses, medical history, and current findings;

2. A plan of treatment;

3. Initial and periodic patient assessments by the professional discipline responsible performed in the home;

4. Patient care plan;

5. Clinical notes signed and dated by all disciplines rendering service to the patient for each contact, written the day of service and incorporated into the patient's clinical record at least weekly;

6. Reports of case conferences including staff contacts with physicians, podiatrists, nurse practitioners, physician assistants, or clinical nurse specialists, and other members of the health care pertaining to the patients. Case conferences shall be conducted and documented at least every sixty (60) days or more often as required by the patient's condition;

7. Progress notes written at least every sixty (60) days or more frequently as warranted by the patient's conditions;

8. Documentation of supervisory visits by a registered nurse or other applicable supervisory personnel;

9. A discharge summary;

10. A copy of the patient transfer information sheet if patient is admitted to another health care facility;

11. Home health aide written instructions;

12. Verbal orders shall be taken only by registered nurses or health care professionals, and immediately recorded in the patient's clinical record with the date. These orders shall be countersigned by the physician, podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist; and

13. Duplicate copies of all laboratory results as reported by the referral laboratory.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 52 EVALUATION: GENERAL

Rule 46.52.1 **General**. The home health agency shall have written policies requiring an overall evaluation of the agency's total program at least once a year. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation shall be reported to and acted upon by those responsible for the operation of the agency and maintained separately as administrative records. The objectives of the evaluation shall be:

1. To assist the Home Health Agency in using its personnel and facilities to meet individual and community needs;

2. To identify and correct deficiencies which undermine quality care and lead to waste of facility and personnel resources;

3. To help the home health agency make critical judgments regarding the quality and quantity of its services through self-examination;

4. To provide opportunities to evaluate the effectiveness of agency policies and when necessary, make recommendations to the administration of what controls or changes are needed to assure high standards of patient care; and

5. To augment in-service staff education.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 54 CLINICAL RECORD REVIEW (54)

Rule 46.54.1 **Clinical Records.** Home health agency's quality assurance team shall at least quarterly review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct as well as those under arrangement). The clinical records of at least 10% of the total patient census are to be reviewed; however, at no time shall the review consist of less than ten (10) or more than fifty (50) records. The records reviewed shall be representative of the services rendered and include records of patients served by branch offices, if applicable. This review shall include, but not be limited to the following:

1. If the patient care plan was directly related to the stated diagnosis and plan of treatment;

2. If the frequency of visits was consistent with plan of treatment;

3. If the services could have been provided in a shorter span of time.

SOURCE: Miss. Code Ann. §41-71-13

Title 15: Mississippi State Department of Health

Part 16: Health Facilities

Subpart 1: Health Facilities Licensure and Certification

CHAPTER 46 MINIMUM STANDARDS OF OPERATION FOR HOME HEALTH AGENCIES

Subchapter 3 DEFINITIONS. As used in these minimum standards, the words and terms hereinafter set forth, shall be defined as follows:

Rule 46.3.4 **Care Team** shall mean a group of individuals responsible for the development of each patient's care plan. The care team shall consist of, but not be limited to, the physician, or podiatrist, nurse practitioners, physician assistants, clinical nurse specialists, and pertinent members of the agency staff, the patient and member of his/her family.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.11 **Deleted ~~Criminal History Record Checks~~.**

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

~~2. **Employee**. For the purpose of fingerprinting and criminal background history checks, employee shall mean any individual employed by a covered entity. The term employee", also includes any individual who by contract with the covered entity provides direct patient care in a patient's, resident's, or client's room or in treatment rooms. The term employee does not include healthcare professional/technical students, as defined in Section 37-29-232, performing clinical training in a licensed entity under contracts between their schools and the licensed entity, and does not include students at high schools who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied health course taught in the school if:~~

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

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

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

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

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

~~5. Health Care Professional/Vocational Technical Academic Program. For the purpose of criminal history record checks, "health care professional/vocational technical academic program" means an academic program in medicine, nursing, dentistry, occupational therapy, physical therapy, social services, speech therapy, or other allied-health professional whose purpose is to prepare professionals to render patient care services.~~

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

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

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

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Rule 46.3.20 **Home Health Agency** shall mean a public or privately owned agency or organization or a subdivision of such an agency or organization, properly authorized to conduct business in Mississippi, which is primarily engaged in providing to individuals, at the written direction of a licensed physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists in the individual's place of resident, skilled nursing services provided by or under the supervision of a registered nurse licensed to practice in Mississippi and one or more of the following part-time intermittent services or items:

1. Physical, occupational, or speech therapy;
2. Medical Social Services;
3. Home Health aide services;
4. Other services as approved by the licensing agency;

5. Medical supplies, other than drugs and biologicals, and the use of medical appliances;

6. Medical services provided by a resident in training at a hospital under a teaching program of such hospital.

7. Drugs and Biologicals as allowed by Mississippi Board of Pharmacy permit for home health. ~~Every home health agency, hospice organization or business/location in this state subject to regulation by the Mississippi Board of Pharmacy where certain prescription drugs as approved by the Board are bought, maintained, administered, or provided directly to consumers, without the services of a pharmacist being required, shall obtain a permit as a home health/hospice from the Mississippi Board of Pharmacy.~~ (Refer to ~~article XXXIII~~ Home Health and Hospice Permits ~~-~~ MS Board of Pharmacy.)

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.29 1. **Medical Social Worker** shall mean a person who has a master's degree or bachelor's degree from a school of social work accredited by the Council on Social Work Education or Southern Association of Colleges and Schools and is licensed by the State of Mississippi as such and who has one year of social work experience in a health care setting.

2. **Nurse Practitioner** shall mean an individual who is currently licensed as an Advanced Practice Registered Nurse in the State of Mississippi and is performing nurse practitioner duties in accordance with the Mississippi Nursing Practice Act.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.31 ~~1.~~ **Occupational Therapy Assistant** shall mean a person who is currently licensed as such by the State of Mississippi and is performing therapy duties in accordance with the Mississippi Occupational Therapy Practice Act.

~~2. **Occupational Therapist** shall mean a person who is currently licensed as such in the State of Mississippi and is performing therapy duties in accordance with the Mississippi Occupational Therapy Practice Act.~~

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.35 **Patient** shall mean any individual whose condition is of such severity that the individual should be confined to his/her place of residence because of acute or chronic illness or injury or individuals with disabilities, convalescent or infirm, or who is in need of rehabilitative, obstetrical, surgical, medical, nursing, or supervisory care in their place of residence and under the care of a physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.43 **Deleted ~~Physician's or Podiatrist's Summary Report~~** ~~shall mean a concise statement reflecting the care, treatment, frequency of treatment, and response in accordance with the patient's plan of care as prescribed by the physician or podiatrist. The statement should include written notations of any unusual occurrences that have or have not been previously reported and submitted to the physician or podiatrist at least every 60 days.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Rule 46.3.44 **Plan of Treatment** shall mean the written instructions, signed and reviewed at least every 60 days or more often if the patient's condition so warrants, by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, and clinical nurse specialists for the provision of services.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.3.46 **Deleted ~~Professional Advisory Committee Bylaws~~** ~~shall mean a set of rules adopted by the advisory committee governing the committee's operation.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Rule 46.3.48 **Deleted ~~Professional Advisory Committee~~** ~~shall mean a group, which includes at least one physician, one registered nurse, agency staff, professional not associated with the agency, consumers, and preferably other health professionals representing at least the scope of the program, which will advise the agency on professional issues, evaluate the agency and serve as liaison with the community.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Subchapter 7 THE LICENSE

Rule 46.7.2 **Provisional License**. Within its discretion, the Mississippi State Department of Health may issue a provisional license when a temporary condition of non-compliance with these regulations exists ~~in one or more particulars~~. A provisional license ~~shall~~ may be issued ~~only~~ if the Department ~~of Health~~ is satisfied that preparations are being made to qualify for a regular license and that the health and safety of patients will not be endangered. One condition on which a provisional license may be issued is as follows: A new home health agency may be issued a provisional license prior to opening and subsequent to meeting the required minimum staffing personnel. ~~The~~ A provisional license issued under this condition shall be valid until the issuance of a regular license or June 30 following date of issuance whichever may be sooner. A provisional license may be reissued only if it is satisfactorily proven to the Department of Health that efforts are being made to fully comply with these regulations by a specified time.

~~Within its discretion, the Mississippi Department of Health may issue a provisional license when a temporary condition of non-compliance with these minimum standards exists in one particular. A provisional license shall be issued only if the Department of Health is satisfied that preparations are being made to qualify for a regular license and that the health and safety of patients will not be endangered meanwhile. A provisional license may be reissued only if it is satisfactorily proven to the Department of Health that efforts are been made to fully comply with these minimum standards by a specified time.~~

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 12 DENIAL, SUSPENSION, OR REVOCATION OF LICENSE

Rule 46.12.1 **Denial or Revocation of License**. Hearings and Review. The licensing agency after notice and opportunity for a hearing to the applicant or licensee is authorized to deny, suspend, or revoke a license in any case in which it finds that there has been a failure to comply with the requirements established under the law and these minimum standards. Also, the following may be grounds for denial or revocation of license:

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

2. Violations by the licensee of the minimum standards established by the Department of Health.

3. Publicly misrepresenting the agency and/or its services.

4. Conduct or practices detrimental to the health or safety of patients and employees of said agency provided that this provision shall not be construed to have any reference to healing practices authorized by law. Detrimental practices include but are not necessarily limited to:

   A. Cruelty to patients or indifference to their needs which are essential to their general well-being and health.

   B. Misappropriations of the money or property of a patient.

   C. Inadequate staff to provide safe care and supervision of any patient.

   D. Failure to call a physician<u>,</u> ~~or~~ podiatrist<u>, nurse practitioners, physician assistants, and clinical nurse specialists</u> when required by patient's condition.

5. Failure to comply with the requirements of the Mississippi Commission Act of 1979, amended.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 14 TERMINATION OF OPERATION

Rule 46.14.1 **General**. In the event that Home Health Agency ceases operation, voluntarily or otherwise, the agency shall:

6. Inform the attending physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, clinical nurse specialists, patient, and persons responsible for the patient's care in ample time to provide for alternate methods of care.

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

8. Inform the community through public announcement of the termination.

9. Ensure the safekeeping, confidentiality, and storage of all clinical records for a period of seven (7) years, following discharge.

10. Return the license to the licensing agency.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 19 REGULATED MEDICAL WASTE

Rule 46.19.1 **Infectious medical wastes** include solid or liquid wastes which may contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host has been proven to result in an infectious disease. For purposes of this Regulation, the following wastes shall be considered to be infectious medical wastes:

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

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

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

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

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

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

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

~~8. "Medical Waste" means all waste generated in direct patient care or in diagnostic or research areas that is non-infectious but aesthetically repugnant if found in the environment.~~

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.19.2 **Medical Waste Management Plan**. All generators of infectious medical waste and medical waste shall have a medical waste management plan in accordance with Adopted Standards for the Regulation for Medical Waste, as listed in the most current version on the Department's website . ~~All generators of infectious medical waste and medical waste shall have a medical waste management plan that shall include, but is not limited to, the following:~~

~~1. Storage and Containment of Infectious Medical Waste and Medical Waste~~

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

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

~~c.Unless approved by the Mississippi Department of Health or treated and rendered non-infectious, infectious medical waste (except for sharps in approved containers) shall not be stored at a waste producing facility for more than seven (7) days above a temperature of 6 C (38F). Containment of infectious medical waste at the producing facility is permitted at or below a temperature of 0 C (32F) for a period of not more than ninety (90) days without specific approval of the Department of Health.~~

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

~~e.Infectious medical waste, except for sharps capable of puncturing or cutting, shall be contained in double disposable plastic bags or single bags (1.5 mills thick) which are impervious to moisture and have a strength~~

~~sufficient to preclude ripping, tearing, or bursting under normal conditions of usage. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid wastes during storage, handling, or transport.~~

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

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

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

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

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

~~2. Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with one or more of the following procedures:~~

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

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

~~i. Hypochlorite solution (500 ppm available chlorine).~~

~~ii. Phenolic solution (500 ppm active agent).~~

~~iii. Iodoform solution (100 ppm available iodine).~~

~~iv. Quaternary ammonium solution (400 ppm active agent).~~

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

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

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

4. Treatment or disposal of infectious medical waste shall be by one of the following methods:

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

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

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

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

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

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

v. Maintenance of records of procedures specified in (1), (2), (3), and (4) above for period of not less than a year.

c. By discharge of the approved sewerage system if the waste is liquid or semiliquid, except as prohibited by the State Department of Health.

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

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

~~5. Treatment and disposal of medical waste which is not infectious shall be by one of the following methods:~~

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

~~b.By sanitary landfill, in an approved landfill which shall mean a disposal facility or part of a facility where medical waste is placed in or on land, and which is not a treatment facility.~~

~~c.All the requirements of these standards shall apply, without regard to the quantity of medical waste generated per month, to any generator of medical waste.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Subchapter 20 GOVERNING BODY AND ADMINISTRATION: EMERGENCY OPERATIONS PLAN

Rule 46.20.1 The licensed entity shall develop and maintain a written preparedness plan utilizing the Emergency Operations Plan (EOP) Template developed by the MSDH Office of Emergency Planning and Response. "All Hazards" and "Whole Community" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any pandemic, act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency ~~Preparedness~~ Planning and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Planning ~~Preparedness~~ and Response Plan." Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by the Office of Emergency Planning ~~Preparedness~~ and Response. The nine ~~six~~ (~~9~~6) critical areas of consideration are:

~~1.~~ 1. Communications - Facility status reports shall be submitted in a format and a frequency as required by the Office of Emergency Planning and Response ~~EOP~~

~~A.~~ 2. Resources and Assets

~~B.~~ 3. Safety and Security

~~C.~~ 4. Staffing

~~D.~~ 5. Utilities

~~E.~~ 6. Clinical Activities

~~F.~~ 7. ~~Outpatient~~ Fire drills shall be conducted a minimum of (2) times per year

~~G.~~ 8. Smoke Detectors/Extinguishers (refer to NFPA 10 and NFPA 72) and

~~H.~~ 9. Continuity of Operations Planning (COOP) to include surge and alternate care sites.

~~2.~~ Emergency Operations Plans (EOPs) must be exercised and reviewed annually or as directed by the Office of Emergency Planning ~~Preparedness~~ and Response. Written evidence of current verification ~~approval~~ or review of provider EOPs, by the Office of Emergency Planning ~~Preparedness~~ and Response, shall accompany all applications for facility license renewals.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 21 GOVERNING BODY

Rule 46.21.1 **General**. The Home Health Agency shall have an organized governing body so functioning which is legally responsible for the conduct of the agency. The administrator and all personnel shall be directly or indirectly responsible to this governing body. The ownership of the home health agency shall be fully disclosed to the State licensure authority. The governing body shall ensure that the agency complies with all applicable local, state and federal laws and regulations and similar requirements. Staff of the Agency shall be currently licensed or registered in accordance with applicable laws of the State of Mississippi. The governing body shall be responsible for periodic administrative and professional evaluations of the agency. The governing body shall receive, review and take action on recommendations made by the evaluating groups and so document the governing body shall adopt and enforce bylaws, or an acceptable equivalent thereof, in accordance with legal requirements. The bylaws, shall be written, revised as needed, and made available to all members of the governing body, the State licensure authority, and the advisory group. The terms of the bylaws shall cover at least the following:

1. The basis upon which members of the governing body are selected, their terms of office, and their duties and responsibilities.

2. A provision specifying to whom responsibilities for administration and supervision of the program and evaluation of practices may be delegated and the methods established by the governing body for holding such individuals responsible.

3. A provision specifying the frequency of board meetings and requiring that minutes be taken at each meeting.

4. A provision requiring the establishment of personnel policies and an organizational chart, clearly establishing lines of authority and relationships.

5. The agency's statement of objectives.

~~6. Provisions for appointment of an advisory committee.~~

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 22 ADMINISTRATOR

Rule 46.22.1 **Administrator**. The governing body shall be legally responsible for the appointment of a qualified administrator and the delegation of responsibility and authority. The governing body shall assure that the administrator has sufficient freedom from other responsibilities to permit adequate attention to the overall direction and management of the agency. When there is a change of the administrator, the governing authority shall immediately notify the licensing agency in writing of the change. The duties and responsibilities of the agency administrator shall include at least the following:

1. Implementing the policies approved and/or developed by the governing body;

2. Organizing and coordinating the administrative functions of the services, including implementing adequate budgeting and accounting procedures;

3. Maintaining an ongoing liaison ~~with the professional advisory committee and~~ the agency staff;

4. Coordinating service components to be provided by contractual agreement; and

5. Arranging employee orientation, continuing education, and in-service training programs.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 24 DELETED ~~PROFESSIONAL ADVISORY COMMITTEE~~

Rule 46.24.1 **Deleted. ~~General~~**. ~~The governing body shall appoint a multidisciplinary advisory committee to perform a systematic professional and administrative review and program evaluation of the services. Licensed hospitals may establish a committee specifically for this purpose or they may assign the responsibility to an existing committee. Bylaws or the equivalent for this committee shall be initially adopted and annually reviewed. Membership on the professional advisory committee shall include but not be limited to the following:~~

~~1. A licensed practicing physician;~~

~~2. A registered nurse;~~

~~3. Preferably, an appropriate number of members from other professional disciplines, who are representative of the scope of services offered;~~

~~4. A consumer; and~~

~~5. A professional who is neither an owner nor employee of the agency.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Rule 46.24.2 **Deleted. ~~Meetings~~**. ~~The professional advisory committee shall meet at regular intervals, but not less than every six months.~~

~~1. Dated written minutes of each committee meeting shall be maintained and made available to the licensing agency upon request; and~~

~~2. The agency administrator or his designee shall attend all meetings of the committee.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Rule 46.24.3 **Deleted. ~~Duties~~**. ~~The duties and responsibilities of the professional advisory committee shall include but not be limited to the following:~~

~~1. Annual review and reevaluation for the program objectives as required;~~

~~2. Annual evaluation of the appropriateness of the scope of services offered;~~

~~3. Annual review of admission, discharge and patient care policies and procedures;~~

~~4. Annual review of the findings of a random sample of medical records (performed by in-house staff members of professional advisory committee) and written evaluation on quality of services provided;~~

~~5. Annual review of staffing qualifications, responsibilities and needs;~~

~~6. Annual review of survey findings;~~

~~7. Review of quarterly utilization statistics and findings of quarterly clinical record review, and~~

~~8. Written recommendations to the governing body and the agency administrator for any revisions in policies and procedures and changes in delivery of care; and written recommendations on items such as methods for and participation in a continuing public education program to acquaint the community, the health care professions and public and private community resources on the scope, availability and appropriate utilization of home health services.~~

~~*SOURCE: Miss. Code Ann. §41-71-13*~~

Subchapter 25 POLICY AND PROCEDURE MANUAL

Rule 46.25.1 **Manual**.

1. The home health agency administrator with advice from ~~the professional advisory committee and~~ the director of nursing/supervising nurse shall develop a policy and procedure manual.

2. Written policies and procedures shall include provisions covering at least the following:

   A. Definition of the scope of services offered;

   B. Admission and discharge policies;

   C. Medical direction and supervision;

   D. Plans of treatment;

   E. Staff qualifications, assignments and responsibilities;

   F. Medication administration;

   G. Medical records;

   H. Patient safety and emergency care;

   I. Administrative records;

J. Agency evaluation;

K. Provisions for after hours emergency care (on call);

L. Patients rights policies and procedures; and

M. Provisions for the proper collection, storage and submission of all referral laboratory samples collected on home health patients.

3. Patient admission and discharge policies shall include but not be limited to the following:

A. Patient shall be accepted for health service on a part-time or intermittent basis upon a plan of treatment established by the patient's physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. Patients accepted for admission should be essentially home bound and in need of skilled services.

B. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.

C. When services are to be terminated by the home health agency, the patient and the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, are to be notified in advance of the date of termination stating the reason and a plan shall be developed or a referral made for any continuing care.

D. Services shall not be terminated without an order by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists in consultation with the registered nurse and/or the appropriate therapist. Except in cases of non-payment, where the specific and approved plan of care has been documented as completed, where the patient refuses treatment, in the event of an unsafe environment, or should the patient require the services beyond the capability of the agency. In any event, the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists shall be notified of the termination of services. Arrangements shall be made for continuing care when deemed appropriate.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 27 PERSONNEL POLICIES

Rule 46.27.3 **Criminal History Record Checks**.

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

2. Employee. For the purpose of fingerprinting and criminal background history checks, employee shall mean any individual employed by a covered entity. The term employee", also includes any individual who by contract with the covered entity provides direct patient care in a patient's, resident's, or client's room or in treatment rooms. The term employee does not include healthcare professional/technical students, as defined in Section 37-29-232, performing clinical training in a licensed entity under contracts between their schools and the licensed entity, and does not include students at high schools who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied health course taught in the school if:

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

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

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

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

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

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

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

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

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

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

   A. Every employee of a covered entity must have initial criminal history check and then every two years.

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

   C. ~~B. Every~~ Each employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer and then every two years.

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

pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted.

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

A. possession or sale of drugs

B. murder

C. manslaughter

D. armed robbery

E. rape

F. sexual battery

G. sex offense listed in Section 45-33-23(g), Mississippi Code of 1972

H. child abuse

I. arson

J. grand larceny

K. burglary

L. gratification of lust

M. aggravated assault

N. felonious abuse and/or battery of vulnerable adult

12. ~~4.~~ Documentation of verification of the employee's disciplinary status, if any, with the employee's professional licensing agency as applicable, and evidence of submission of the employee's fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee's disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual's suitability for such employment.

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

14. ~~6~~. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed an affidavit as required by this section. The covered entity shall place the affidavit in the employee's personnel file as proof of compliance with this section.

15. ~~7~~. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or pleas has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility's policies and procedures.

16. ~~8.~~ The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (g) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility.

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

18. ~~10.~~ Should results of an employee applicant's criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi Department of Health without the necessity of an additional criminal record check.

Any covered entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history check as required in this subsection.

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

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

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 31 PATIENTS' RIGHTS

Rule 46.31.1 **General**. The agency shall maintain written policies and procedures regarding the rights and responsibilities of patients. ~~These written policies and procedures shall be established in consultation with the Professional Advisory Committee.~~ Written policies regarding patients' rights shall be made available to patients and/or their guardian, next of kin, sponsoring agency or agencies, or lawful representative and to the public. There shall be documented evidence that the staff of the agency is trained and involved in the implementation of these policies and procedures. In-service on patient's rights and responsibilities shall be conducted annually. The patients' rights policies and procedures ensure that each patient admitted to the agency:

1. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission, of these rights and of all rules and regulations governing patient conduct and responsibilities;

2. Is fully informed prior to or at the time of admission and during the course of treatment of services available through the agency, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or any other third party.

3. Is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

4. Is transferred or discharged only for medical reasons, or for his welfare, or for non-payment (except as prohibited by Titles XVIII or XIX of the Social Security Act), or on the event of an unsafe environment, or should the patient refuse treatment, and is given advance notice to ensure orderly transfer to discharge, and such actions are documented in his clinical record;

5. May voice grievances and recommend changes in policies and services to agency staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. Is assured confidential treatment of his personal and clinical records, and may approve or refuse their release to any individual outside the agency, except, in case of his transfer to another health care institution or agency or as required by law or third-party payment contract;

7. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care of his personal needs;

8. No person shall be refused service because of age, race, religious preference, sex, marital status or national origin.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 32 PLANNING FOR PATIENT TREATMENT: PLAN OF TREATMENT

Rule 46.32.1 **Development of Plan of Treatmen**t. Each home health agency shall establish policies and procedures for assuring that services and items to be provided are specified under a plan of treatment established and regularly reviewed by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, who is responsible for the care of the patient. Other agency personnel shall have input into the development of the plan of treatment as deemed appropriate by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. The original plan of treatment shall be signed by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, who is responsible for the care of the patient and incorporated in the record maintained by the agency for the patient. The total plan is reviewed by the attending physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists in consultation with agency professional personnel at such intervals as the severity of the patient's illness requires but, in any instance, at least once every two (2) months. The registered nurse, and other health professional shall bring to the attention of the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists changes in the patient's condition which indicate the need for altering the treatment plan or for terminating services. No medication, treatment or services

shall be given except on signed order of a person lawfully authorized to give such an order.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.32.2 **Plan of Treatment Content**. The plan of treatment shall include:

1. Diagnoses relevant to the provision of home health services;

2. Functional limitations and rehabilitation potential;

3. Prognosis;

4. Services authorized by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists including frequency and duration;

5. Medications ordered by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists to include dosage, route of administration and frequency;

6. Treatment, if applicable, including modality, frequency and duration; drug and food allergies;

7. Activities permitted;

8. Diet;

9. Specific procedures deemed essential for the health and safety of the patient;

10. The attending physician's, ~~or~~ podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's signature;

11. Long term goals and discharge plans;

12. Mental status; and

13. Equipment required.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.32.3 **Periodic Review of the Plan of Treatment**. The professional person responsible for any specific treatment shall notify the attending physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, clinical nurse specialist, or other professional persons, and responsible agency staff of significant changes in the patient's condition. The plan shall be reviewed by the agency care team at least every sixty (60) days. ~~and a written summary report sent to the attending physician or podiatrist containing home health services provided, the patient status, recommendations for revision of the plan of treatment, and the need for~~

~~continuation or termination of services.~~ The attending physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists shall be consulted to approve additions or modifications to the original plan. When a patient is transferred to a hospital and readmitted to the agency, the plan of treatment shall be reviewed by the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. If the diagnosis of the patient has not changed (as documented in the agency's discharge/transfer summary, the hospital's discharge summary and reassessment of the patient), a statement to continue previous orders will suffice. At the end of the sixty (60) day period, new orders shall be written.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 33 PATIENT PLAN

Rule 46.33.1 **General**. A patient care plan shall be written for each patient by the registered nurse or other disciplines as needed based upon an assessment of the patient's significant clinical findings, resources, and environment. The initial assessment for patients requiring skilled nursing services is to be made by a registered nurse. Assessments by other care team members shall be made on orders of the physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists. The patient care plan shall be updated as often as the patient's condition indicates at least every sixty (60) days and shall be maintained as a permanent part of the patient's record.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 34 SERVICES PROVIDED: GENERAL

Rule 46.34.1 Each agency shall provide skilled nursing service and at least one other home health service on a part-time or intermittent basis. The skilled nursing service shall be provided directly by agency staff. Other home health services may be provided by agency staff directly or provided under arrangement through a contractual purchase of services. All services shall be provided in accordance with order of the patient's physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists, and under a plan of treatment established by such physician, ~~or~~ podiatrist, nurse practitioners, physician assistants, or clinical nurse specialists.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 35 SKILLED NURSING

Rule 46.35.2 **Duties of the Registered Nurse**. The duties of the Registered Nurse shall include, but not be limited to the performance and documentation of the following:

1. Evaluate and regularly reevaluate the nursing needs of the patient;

2. Develop and implement the nursing component of the patient care plan;

3. Provide nursing services, treatments, and diagnostic and preventive procedures requiring substantial specialized skill;

4. Initiate preventive and rehabilitative nursing procedures as appropriate for the patient's care and safety;

5. Observe and report to the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialists when appropriate, signs and symptoms, reaction to treatments and changes in the patient's physical or emotional condition;

6. Teach, supervise, and counsel the patient and family members regarding the nursing care needs and other related problems of the patient at home; check all medications to identify ineffective drug therapies, adverse reactions, significant side effects, drug allergies and/or contraindicated medications. Promptly report any problems to the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist.

7. Provide supervision and training to other nursing service personnel;

8. Provide direct supervision of the Licensed Practical Nurse in the home of each patient seen by the LPN at least once a month. It is not a requirement for the licensed practical nurse to be present at the supervisory visit by the RN; however, it does not preclude the licensed practical nurse from being present. In addition, the supervising RN must be accessible by telecommunications to the LPN at all times while the LPN is treating patients.

9. Make supervisory visits to the patient's residence at least every other week with the aide alternately present and absent, to provide direct supervision and to assess relationships and determine whether goals are being met; and

10. Ensures that the patient's nursing care and progress is recorded in the clinical record.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 36 LICENSED PRACTICAL NURSING SERVICES

Rule 46.36.1 **General**. Licensed Practical Nursing Services shall be provided by a trained licensed practical nurse working under the supervision of a registered nurse. The duties of the Licensed Practical Nurse shall include, but not limited to the following:

1. Observe, record and report to supervisor on the general physical and mental conditions of the patient;

2. Administer prescribed medications and treatments in accordance with the plan of treatment;

3. Assist the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, and/or registered nurse in performing specialized procedures;

4. Assist the patient with activities of daily living and encourage appropriate self-care; and

5. Prepare progress notes and clinical notes.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 38 HOME HEALTH AIDE SERVICES

Rule 46.38.1 **General**. When an agency provides or arranges for home health aide services, the aides shall be assigned because the patient needs personal care. The services shall be given under a physician's, ~~or~~ podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's order and shall be supervised by a registered nurse. When appropriate, supervision may be given by a physical, speech, or occupational therapist.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 39 PHYSICAL THERAPY SERVICE

Rule 46.39.1 **General**. Physical therapy services shall be given in accordance with the responsible physician's, ~~or~~ podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's written order by a physical therapist or physical therapy assistant currently licensed in the State of Mississippi to practice as a physical therapist or physical therapist assistant. The physician's, ~~or~~ podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's, order shall be specific as to modalities to be utilized and frequency of therapy.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.39.2 **Duties of the Physical Therapist**. The duties of the physical therapist shall include, but not be limited to the following:

1. Assisting the physician, or podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, in the functional evaluation of the patient and development of the individual plan of treatment;

2. Developing and implementing a physical therapy component of the patient care plan;

3. Rendering treatments to relieve pain, develop or restore function, and maintain maximum performance; directing and aiding the patient in active and passive exercise, muscle reeducation, and engaging in functional training activities in daily living;

4. Observing and reporting to the responsible physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, the patient's reactions to treatments and any changes in the patient's conditions;

5. Instructing the patient and family on the patient's total physical therapy program and in which they may work with the patient;

6. Instructing the patient and family on the patient's total physical therapy program and in the care and use of appliances, prosthetic and other orthopedic devices;

7. Preparing clinical notes, progress notes, and discharge summaries;

8. Participating in agency in-service training programs;

9. Acting as a consultant to other agency personnel;

10. Developing written policies and procedures for the physical therapy services of the home health agency;

11. Make the initial visit for evaluation of the patient and establishment of a plan of care;

12. The supervising physical therapist must have a case conference with the physical therapy assistant to discuss the evaluation, review the established plan of care, and provide the physical therapy assistant with instructions needed for the safe and effective treatment of the patient before the physical therapy assistant begins providing services to the patient;

13. The supervising physical therapist must visit and personally render treatment and reassess each patient who is provided services by the physical therapist assistant no later than every sixth treatment day or thirtieth calendar day, whichever occurs first. It is not a requirement for the physical therapist assistant to be present at this visit; however, it does not preclude the physical therapist assistant from being present. In addition, the supervising physical therapist must be accessible by telecommunications to the physical therapist assistant, at all times, while the physical therapist assistant is treating patients.

14. Make the final visit to terminate the plan of care; and

15. Provide supervision for no more than four (4) physical therapy assistants.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 41 OCCUPATIONAL THERAPY SERVICES

Rule 46.41.1 **General**. When an agency provides or arranges for occupational therapy, services shall be given in accordance with a physician's, ~~or~~ podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's written order by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.41.2 **Duties of the Occupational Therapist**. Duties of the occupational therapist shall include, but not be limited to, the following:

1. Assisting the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, in the evaluation of patients by applying diagnostic and prognostic tests and by reporting the findings in terms of problems and abilities of the patient; identifying patients' therapy needs and development of the individual plan of treatment;

2. Developing and implementing an occupational therapy component of the patient care plan.

3. Treating patients for the purpose of attaining maximum functional performance through use of such procedures as:

   H. Task orientation therapeutic activities;

   I. Activities of daily living;

   J. Perceptual motor training and sensory integrative treatment;

   K. Orthotics and splinting;

   L. Use of adaptive equipment;

   M. Prosthetic training;

   N. Homemaking training.

4. Observing, recording, and reporting to the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, and agency personnel the patient's reaction to treatment and any changes in the patient's condition;

5. Counseling with regard to levels of functional performance and the availability of community resources;

6. Instructing other health team personnel, patients, and family members;

7. Preparing clinical notes, progress notes, and discharge summaries;

8. Participating in staff in-service educational programs;

9. Developing written policies and procedures for the occupational therapy services of the home health agency;

10. Acting as a consultant to other agency personnel; and

11. Make supervisory visits to the patient's residence with the Occupational Therapy Assistant at least once every three (3) weeks or every five (5) to seven (7) treatment sessions to provide direct supervision and to assess the adherence to the plan of treatment and progress toward established goals.

12. Conduct all initial assessments and establish the goals and plans of treatment before the treatments are provided to the patient by an Occupational Therapy Assistant.

13. Prepare discharge summaries, interim assessments, and initiate any changes in the plan of care for patients treated by Occupational Therapy Assistants.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 42 MEDICAL SOCIAL SERVICES

Rule 46.42.1 **General**. Medical social services shall be provided by a social worker who has a master's degree from a school of social work accredited by the Council on Social Work Education and is licensed as such by the State of Mississippi and has one year of social work experience in a health care setting or by a licensed social worker who has a bachelor's degree from a school of social work accredited by the Council of Social Work Education or Southern Association of Colleges and Schools and has one year of social work experience in a health care setting and who is supervised by a licensed social worker with a master's degree. Medical social services shall be given in accordance with the responsible physician's, ~~or~~ podiatrist's, nurse practitioners, physician assistants, or clinical nurse specialist's written order by a medical social worker. Master's degree social worker shall review and evaluate the performance of the bachelor's degree social worker on a monthly basis.

SOURCE: Miss. Code Ann. §41-71-13

Rule 46.42.2 **Duties of the Medical Social Worker**. The duties of the medical social worker include, but are not limited to the following:

1. Assisting the responsible physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist, and other members of the agency team in understanding the significant social and emotional factors related to patient health problems;

2. Assessing the social and emotional factors in order to estimate the patient's capacity and potential to cope with problems of daily living; and assisting in the development of an individual plan of treatment;

3. Developing and implementing a social work component of the patient care plan;

4. Helping the patient and his/her family to understand, accept, and follow medical recommendations and provide services planned to restore the patient to optimum social and health adjustment within his/her capacity;

5. Assisting patients and their families with personal and environmental difficulties which predispose towards illness or interfere with obtaining maximum benefits from medical care;

6. Utilizing resources such as family and community agencies to assist the patient in resuming life in the community or to learn to live with his/her disability;

7. Preparing clinical notes, progress notes, and discharge summaries;

8. Participating in agency in-service training programs;

9. Acting as a consultant to other agency personnel;

10. Development of written policies and procedures for medical social services of the home health agency; and

11. Review and evaluate the work of a bachelor's degree licensed social worker on a monthly basis.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 43 NUTRITIONAL SERVICES

Rule 46.43.2 **Duties of the Dietitian**. The responsibilities of the Dietitian shall include but not be limited to, the following:

1. Assisting the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist in the evaluation of the patient's nutritional status and development of the individual plan of treatment;

2. Developing and implementing a nutritional component of the patient care plan;

3. Selecting, preparing and evaluating teaching materials and aids for patient counseling and education and furnishing direct nutritional counseling services to the patient;

4. Observing and reporting to the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist the patient's reaction and adherence to the diet and change in the patient's nutritional status;

5. Preparing clinical notes, progress, and discharge summaries;

6. Participating in agency in-service training programs;

7. Acting as a consultant to other agency personnel; and

8. Developing written policies and procedures for the nutritional services of the home health agency.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 46 APPLIANCE AND EQUIPMENT SERVICE

Rule 46.46.1 **General**. Appliance and equipment services may be provided to patients by the home health agency only upon the written order of a physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist. A home health agency may elect to provide the service directly or indirectly through a supplier. Policies and procedures shall be developed for the appliance and equipment services. All appliances and equipment provided for patients shall be maintained in good condition.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 48 CLINICAL RECORD

Rule 46.48.1 **Clinical Record Content**. A clinical record shall be established and maintained for every person admitted to home health services. The original or signed copy of clinical reports shall be filed in the clinical record. Clinical records shall contain:

1. Appropriate identifying information for the patient, household members and caretakers, pertinent diagnoses, medical history, and current findings;

2. A plan of treatment;

3. Initial and periodic patient assessments by the professional discipline responsible performed in the home;

4. Patient care plan;

5. Clinical notes signed and dated by all disciplines rendering service to the patient for each contact, written the day of service and incorporated into the patient's clinical record at least weekly;

6. Reports of case conferences including staff contacts with physicians, ~~or~~ podiatrists, nurse practitioners, physician assistants, or clinical nurse specialists, and other members of the health care pertaining to the patients.

Case conferences shall be conducted and documented at least every sixty (60) days or more often as required by the patient's condition;

~~7. Written summary reports to the physician or podiatrist every sixty (60) days;~~

~~8.~~ 7. Progress notes written at least every sixty (60) days or more frequently as warranted by the patient's conditions;

~~9.~~ 8. Documentation of supervisory visits by a registered nurse or other applicable supervisory personnel;

~~10.~~ 9. A discharge summary;

~~11.~~ 10. A copy of the patient transfer information sheet if patient is admitted to another health care facility;

~~12.~~ 11. Home health aide written instructions;

~~13.~~ 12. Verbal orders shall be taken only by registered nurses or health care professionals, and immediately recorded in the patient's clinical record with the date. These orders shall be countersigned by the physician, ~~or~~ podiatrist, nurse practitioner, physician assistant, or clinical nurse specialist; and

~~14.~~ 13. Duplicate copies of all laboratory results as reported by the referral laboratory.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 52 EVALUATION: GENERAL

Rule 46.52.1 **General**. The home health agency shall have written policies requiring an overall evaluation of the agency's total program at least once a year. ~~This evaluation shall be made by the Professional Advisory Group (or a committee of this group), home health agency staff, and consumers, or representation from professional disciplines outside the agency working in conjunction with consumers.~~ The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation shall be reported to and acted upon by those responsible for the operation of the agency and maintained separately as administrative records. The objectives of the evaluation shall be:

1. To assist the Home Health Agency in using its personnel and facilities to meet individual and community needs;

2. To identify and correct deficiencies which undermine quality care and lead to waste of facility and personnel resources;

3. To help the home health agency make critical judgments regarding the quality and quantity of its services through self-examination;

4. To provide opportunities to evaluate the effectiveness of agency policies and when necessary, make recommendations to the administration of what controls or changes are needed to assure high standards of patient care; and

5. To augment in-service staff education.

SOURCE: Miss. Code Ann. §41-71-13

Subchapter 54 CLINICAL RECORD REVIEW (54)

Rule 46.54.1 **Clinical Records.** ~~In addition to the annual clinical record review by the in-house staff members on the Professional Advisory Committee, members of professional disciplines representing at least the scope of the agency's programs.~~ Home health agency's quality assurance team shall at least quarterly review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct as well as those under arrangement). The clinical records of at least 10% of the total patient census are to be reviewed; however, at no time shall the review consist of less than ten (10) or more than fifty (50) records. The records reviewed shall be representative of the services rendered and include records of patients served by branch offices, if applicable. This review shall include, but not be limited to the following:

1. If the patient care plan was directly related to the stated diagnosis and plan of treatment;

2. If the frequency of visits was consistent with plan of treatment;

3. If the services could have been provided in a shorter span of time.

SOURCE: Miss. Code Ann. §41-71-13