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ARTICLE 4. NURSING CARE INSTITUTIONS

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ARTICLE 4. NURSING CARE INSTITUTIONS

R9-10-401. Definitions

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following definitions apply in this Article unless otherwise specified:

2. “Behavioral care” means:
 - a. Assistance with a resident’s psychosocial interactions to manage the resident’s behavior that can be performed by an individual without professional skills that may include direction provided by a behavioral health professional and medication ordered by a medical practitioner or behavioral health professional; or
 - b. Behavioral health services provided by a behavioral health professional on an intermittent basis to address a resident’s significant psychological or behavioral response to an identifiable stressor or stressors.
- ~~2.3.~~ “Care plan” means a documented description of medical services, nursing services, health-related services, social services, and ancillary services expected to be provided to a resident, based on the resident's comprehensive assessment, that includes measurable objectives and the methods for meeting the objectives.
- ~~3.4.~~ “Direct care” means medical services, nursing services, or ~~medically-related~~ social services provided to a resident.
9. “Intermittent” means not on a regular basis.
- ~~10.11.~~ “Nursing care institution services” means medical services, nursing services, health-related services, ancillary services, ~~medically-related~~ social services, and environmental services provided to a resident.
- ~~9.17.~~ ~~Medically-related social~~ Social services” means assistance provided to or activities provided for a resident to maintain or improve the resident's physical, mental, and psychosocial capabilities.
institution.
20. “Ventilator” means a device designed to provide, to a resident who is physically unable to breathe or who is breathing insufficiently, the mechanism of breathing by mechanically moving breathable air into and out of the resident’s lungs.

R9-10-402. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a initial license as a nursing care institution shall include:

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1. On the application whether the nursing care institution:
 - a. Has:
 - i. A secured area for a resident with Alzheimer's disease or other dementia,
or
 - ii. An area for a resident on a ventilator;
 - b. Is requesting authorization to provide to a resident:
 - i. Behavioral health services,
 - ii. Clinical laboratory services,
 - iii. Dialysis services, or
 - iv. Radiology services and diagnostic imaging services,
 - ~~v. Respiratory care services, or~~
 - ~~vi. Rehabilitation services, and~~
 - c. Is requesting authorization to operate a nutrition and feeding assistant training program; and

R9-10-403. Administration

- C. An administrator shall ensure that:
 1. Policies and procedures are established, documented, and implemented that:
 - a. Include job descriptions, duties, and qualifications including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to resident care;
 - d. Cover cardiopulmonary resuscitation training including:
 - i. Which personnel members are required to obtain cardiopulmonary resuscitation training,
 - ii. The method and content of cardiopulmonary resuscitation training,
 - iii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
 - iv. The time-frame for renewal of cardiopulmonary resuscitation training,
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- v. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
 - e. Cover first aid training;
 - f. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
 - g. Cover resident rights including assisting a resident who does not speak English or who has a disability to become aware of resident rights;
 - h. Cover specific steps and deadlines for:
 - i. A resident to file a complaint;
 - ii. The nursing care institution to respond to ~~and resolve~~ a resident's complaint; and
 - iii. The nursing care institution to obtain documentation of fingerprint clearance, if applicable;
 - i. Cover health care directives;
 - j. Cover medical records, including electronic medical records;
 - k. Cover a quality management program, including incident reports and supporting documentation;
 - l. Cover contracted services;
 - m. Cover resident's personal accounts;
 - n. Cover petty cash funds;
 - o. Cover fees and refund policies;
 - p. Cover misappropriation of resident property; and
 - q. Cover when an individual may visit a resident in a nursing care institution;
- F. If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred on the premises or while the resident is receiving services from a nursing care institution's employee or personnel member, an administrator shall:
- 1. Take immediate action to stop the alleged or suspected abuse, neglect, or exploitation;
 - 2. Immediately report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
 - a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
 - 3. Document the action in subsection (F)(1) and the report in subsection (F)(2) and maintain the documentation for at least 12 months after the date of the report;

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4. Investigate the alleged or suspected abuse, neglect, or exploitation and develop a written report of the investigation within ~~48 hours~~ 5 days after the report required in subsection (F)(2) that includes:
 - a. Dates, times, and description of the alleged or suspected abuse, neglect, or exploitation;
 - b. Description of any injury to the resident and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. Names of witnesses to the alleged or suspected abuse, neglect, or exploitation; and
 - d. Actions taken by the administrator to prevent the alleged or suspected abuse, neglect, or exploitation from occurring in the future;
5. Submit a copy of the investigation report required in subsection (F)(4) to the Department within 10 working days after submitting the report in subsection (F)(2);
6. Maintain a copy of the investigation report required in subsection (F)(4) for at least 12 months after the date of the report;.

G. An administrator shall:

- ~~7.1.~~ 1. Allow a resident advocate ~~assists to assist~~ assist a resident, the resident's representative, or a resident group with a request or recommendation, and respond in writing to any complaint submitted to the nursing care institution;
2. Ensure that a monthly schedule of recreational activities for residents is developed, documented and implemented; and
- ~~8.3.~~ 3. Ensure that the following are conspicuously posted on the premises:
 - a. The current nursing care institution license and quality rating issued by the Department;
 - b. The name, address, and telephone number of:
 - i. The Department's Office of Long Term Care,
 - ii. The State Long Term Care Ombudsman Program, and
 - iii. Adult Protective Services of the Department of Economic Security;
 - c. A notice that a resident may file a complaint with the Department concerning the nursing care institution;
 - d. The monthly schedule of recreational activities; and
 - ~~d.e.~~ e. One of the following:

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- i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect or
- ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.

R9-10-404. Quality Management

R9-10-405. Contracted Services

R9-10-406. Personnel

- C. An administrator shall ensure that an individual who is a licensed baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision as defined in 4 A.A.C. 6, Article 1.
- D. An administrator shall ensure that a personnel member or an employee or volunteer that has or is expected to have direct interaction with a resident for more than 8 hours a week provides evidence of freedom from infectious tuberculosis as specified in R9-10-112.
- H. An administrator shall ~~designate:~~
 1. ~~A qualified individual to provide:~~
 - a. ~~Medically related social services, and~~
 - b. ~~Recreational activities; and~~
 2. ~~Ensure that A full-time a social worker if the nursing care institution has a licensed capacity of 120 or more:~~
 - a. Reviews social services in a resident care plan to ensure that a resident's needs for social services are being met,
 - b. Documents the review of a resident's social services in the resident's medical record, and
 - c. Is available for consultation regarding social services provided to a resident; and
 2. If a social worker is not employed full-time, a designated individual consults with a social worker as often as necessary to ensure that the social services needs of a resident are met.

R9-10-407. Admissions

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An administrator shall ensure that:

1. A resident is admitted only on a physician's order;
2. The physician's admitting order includes the nursing care institution services required to meet the immediate needs of a resident such as medication and food services;
3. At the time of a resident's admission, a registered nurse conducts or coordinates an initial assessment on a resident to ensure the resident's immediate needs for nursing care institution services are met;
- ~~3.4.~~ A resident's needs do not exceed the medical services and nursing services available at the nursing care institution as established in the nursing care institution's scope of services;
- ~~4.5.~~ Before or at the time of admission, a resident or the resident's representative:
 - a. Signs a written agreement with the nursing care institution that includes rates and charges,
 - b. Is informed of third-party coverage for rates and charges,
 - c. Is informed of the nursing care institution's refund policy ~~and nursing care institution guidelines concerning resident conduct and responsibilities~~, and
 - d. Receives written information concerning the nursing care institution's policies and procedures related to a resident's health care directives;
- ~~5.6.~~ Within 30 calendar days before admission or 10 working days after admission, a medical history and physical examination is completed on a resident by:
 - a. A physician, or
 - b. A physician assistant or a registered nurse practitioner designated by the attending physician;

R9-10-408. Discharge

R9-10-409. Transport; Transfer

R9-10-410. Resident Rights

R9-10-411. Medical Records

A. An administrator shall ensure that:

1. A medical record is established and maintained for a resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a resident's medical record is:

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- a. Recorded only by ~~a personnel member~~ an individual authorized by nursing care institution policies and procedures to make entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:
- a. Dated when the order is entered in the resident's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature code is used to authenticate an order, the individual whose signature the stamp or electronic code represents is accountable for the use of the stamp or the electronic code;
5. A resident's medical record is available to personnel members, medical practitioners, and behavioral health professionals authorized by nursing care institution policies and procedures;
6. Information in a resident's medical record is disclosed to an individual not authorized under subsection (A)(5) only with the written consent of a resident or the resident's representative or as permitted by law; and
7. A resident's medical record is:
- a. ~~Protected~~ protected from loss, damage or unauthorized use; ~~and~~
 - b. ~~Maintained according to A.R.S. § 12-2297.~~
- C. An administrator shall ensure that a resident's medical record contains:
1. Resident information that includes:
 - a. The resident's name;
 - b. The resident's date of birth;
 - c. The name and contact information of the resident's representative, if applicable; and
 - d. Any known allergy including medication allergies;
 2. Admission date;
 3. Admitting diagnosis or presenting symptoms;
 4. Documentation of general consent and, if applicable, informed consent;
 5. The medical history and physical examination required in R9-10-407(5);

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6. Copy of the resident's living will, health care power of attorney, or other health care directive, if applicable;
7. The name and telephone number of the resident's attending physician;
8. Orders;
9. Care plans;
10. Behavioral care plans, if a resident is receiving behavioral care;
11. Documentation of nursing care institution services provided to a resident;
12. Progress notes;
13. Disposition of the resident after discharge;
14. Discharge plan;
15. Discharge summary;
16. Transfer documentation;
17. If applicable:
 - a. A laboratory report,
 - b. A radiologic report,
 - c. A diagnostic report,
 - d. Documentation of restraint or seclusion, and
 - e. A consultation report;
18. Documentation of freedom from infectious tuberculosis required in R9-10-407(6);
19. Documentation of a medication administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. The type of vaccine, if applicable;
 - d. For a medication administered for pain on a PRN basis:
 - i. An ~~assessment~~ evaluation of the resident's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - e. For a psychotropic medication administered on a PRN basis:
 - i. An ~~assessment~~ evaluation of the resident's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - f. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and
 - g. Any adverse reaction a resident has to the medication;

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20. If the resident has been assessed for receiving nutrition and feeding assistance, documentation of the assessment and the determination of eligibility; and
21. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

R9-10-412. Nursing Services

- A. An administrator shall ensure that:
 1. Nursing services are provided 24 hours a day in a nursing care institution;
 2. A director of nursing is appointed who:
 - a. Is a registered nurse,
 - b. Works full-time at the nursing care institution, and
 - c. Is responsible for the direction of nursing services;
 3. The director of nursing or an individual designated by the administrator participates in the quality management program; and
 4. If the daily census of the nursing care institution is not more than 60, the director of nursing may provide direct care to residents on a regular basis.
- B. A director of nursing shall ensure that:
 1. A method is established and documented that identifies the types and numbers of nursing personnel that are necessary to provide nursing services to residents based on the residents' comprehensive assessments, orders for physical health services and behavioral health services, and care plans and the nursing care institution's scope of services;
 2. Sufficient nursing personnel, as determined by the method in subsection (B)(1), are on the nursing care institution premises to meet the needs of a resident for nursing services;
 3. At least one nurse is present and responsible for providing direct care to not more than 64 residents;
 4. Documentation of nursing personnel on duty each day is maintained at the nursing care institution and includes:
 - a. The date,
 - b. The number of residents,
 - c. The name and license or certification title of each nursing personnel who worked that day, and
 - d. The actual number of hours each nursing personnel worked that day;
 5. The documentation of nursing personnel required in subsection (B)(4) is maintained for at least 12 months after the date of the documentation;

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6. At the time of a resident's admission, an initial assessment is performed on the resident to ensure the resident's immediate needs, such as medication and food services, are met;
7. A comprehensive assessment is performed by a registered nurse and coordinated by the registered nurse in collaboration with an interdisciplinary team;
8. The comprehensive assessment required in subsection (B)(7) is performed on a resident:
 - a. Within 14 calendar days after admission to a nursing care institution, and
 - b. No later than 12 months after the date of the last comprehensive assessment;
9. A comprehensive assessment includes the resident's:
 - a. Heart rate, respiratory rate, blood pressure, and body temperature;
 - b. Diagnosis;
 - c. Medical history;
 - d. Treatment;
 - e. Dental condition;
 - f. Nutritional condition and nutritional needs;
 - g. Medications;
 - h. Clinical laboratory reports;
 - i. Diagnostic reports;
 - j. Capability to perform activities of daily living;
 - k. Psychosocial condition;
 - l. Cognitive condition;
 - m. Impairments in physical and sensory functioning;
 - n. Potential for recreational activities;
 - o. Potential for rehabilitation; and
 - p. Potential for discharge;
10. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing care institution unless a physician, a physician's designee, or a registered nurse determines the resident has a significant change in condition;
11. A care plan is developed, documented, and implemented for a resident within seven calendar days after completing the comprehensive assessment required in subsection (B)(7);
12. The care plan required in subsection (B)(11):
 - a. Is reviewed and revised as necessary if a resident has had a significant change in condition, and

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- ~~b.~~ Ensures that a resident is provided nursing services to maintain the resident's highest practicable well-being according to the resident's comprehensive assessment;
- ~~13.~~ A resident's comprehensive assessment is reviewed by a registered nurse at least once every three months after the date of the current comprehensive assessment and revised if there is a significant change in the resident's condition;
- ~~14.~~6. As soon as possible but not more than 24 hours after one of the following events occur, a nurse notifies a resident's attending physician and, if applicable, the resident's representative, if the resident:
 - a. Is injured,
 - b. Is involved in an incident that may require medical services, or
 - c. Has a significant change in condition; and
- ~~15.~~7. An unnecessary drug is not administered to a resident.

R9-10-413. Medical Services

- A. An administrator shall appoint a medical director.
- B. A medical director shall ensure that:
 - 1. A resident has an attending physician;
 - 2. An attending physician or a physician designated by the attending physician is available 24 hours a day;
 - ~~3.~~ ~~An attending physician designates a physician who is available when the attending physician is not available;~~
 - ~~4.~~3. A physical examination is performed on a resident at least once every 12 months after the date of admission by an individual listed in R9-10-407(5);
 - ~~5.~~4. As required in A.R.S. § 36-406, vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:
 - a. The attending physician provides documentation that the vaccination is medically contraindicated;
 - b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical records that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or
 - c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the last five years or the

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current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention; and

- 6.5. If the any of the following services are not provided by the nursing care institution and needed by a resident, the resident is assisted in obtaining, at the resident's expense:
- a. Vision services;
 - b. Hearing services;
 - c. Dental services;
 - d. Clinical laboratory services from a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
 - e. Psychosocial services;
 - f. Physical therapy;
 - g. Speech therapy;
 - h. Occupational therapy;
 - i. Behavioral health services; and
 - j. Services for an individual who has a developmental disability, as defined in A.R.S. Title 36, Chapter 5.1, Article 1.

R9-10-414. Behavioral Care Comprehensive Assessment; Care Plan

An administrator shall ensure that, for a resident who requests or receives behavioral care from a nursing care institution:

1. A behavioral health professional or medical practitioner:
 - a. Evaluates the resident:
 - i. Within 30 calendar days before admitting the resident or before the resident begins receiving behavioral care, and
 - ii. At least once every six months throughout the duration of the resident's need for behavioral care;
 - b. Reviews the nursing care institution's scope of services;
 - c. Signs and dates a determination stating that the resident's need for behavioral care can be met by the nursing care institution within the nursing care institution's scope of services and, for retention of a resident, are being met by the nursing care institution; and
 - d. Reviews, signs, and dates a behavioral care plan required in subsection (2);

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2. ~~A behavioral care plan is developed, documented, and implemented that includes any of the following that are necessary to provide assistance with the resident's psychosocial interactions to manage the resident's behavior:~~
 - a. ~~The psychosocial interactions or behaviors for which the resident requires assistance;~~
 - b. ~~Psychotropic medications ordered for the resident;~~
 - c. ~~Planned strategies and actions for changing the resident's psychosocial interactions or behaviors; and~~
 - d. ~~Goals for changes in the resident's psychosocial interactions or behaviors; and~~
3. ~~At least once every six months and when there is a significant change in the resident's psychosocial interactions, a medical practitioner or behavioral health professional:~~
 - a. ~~Reviews and documents the review of the resident's behavioral care plan;~~
 - b. ~~Updates the resident's behavioral care plan; and~~
 - c. ~~Signs and dates the review of and updates to the resident's behavioral care plan.~~

A. A director of nursing shall ensure that:

1. A comprehensive assessment of a resident:
 - a. Is conducted or coordinated by a registered nurse in collaboration with an interdisciplinary team;
 - b. Is completed for the resident within 14 calendar days after the resident's admission to a nursing care institution;
 - c. Is reviewed and updated:
 - i. No later than 12 months after the date of the resident's last comprehensive assessment, and
 - ii. When the resident experiences a significant change;
 - d. Includes the following information for the resident:
 - i. Identifying information;
 - ii. An evaluation of the resident's hearing, speech, and vision;
 - iii. An evaluation of the resident's ability to understand and recall information;
 - iv. An evaluation of the resident's mental status;
 - v. Whether the resident's mental status or behaviors:
 - (1) Put the resident at risk for physical illness or injury,
 - (2) Significantly interfere with the resident's care,

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- (3) Significantly interfere with the resident's ability to participate in activities or social interactions,
- (4) Put other residents or personnel members at significant risk for physical injury,
- (5) Intrude on another resident's privacy, and
- (6) Significantly disrupt care for another resident;
- vi. Preferences for customary routine and activities;
- vii. An evaluation of the resident's ability to perform activities of daily living;
- viii. Need for a mobility device;
- ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
- x. Any diagnosis that impacts nursing care institution services that the resident may require;
- xi. Any medical conditions that impact the resident's functional status, quality of life, and need for nursing care institution services;
- xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;
- xiii. An evaluation of the resident's oral and dental status;
- xiv. An evaluation of the condition of the resident's skin;
- xv. Identification of any medication or treatment administered to the resident during a seven day calendar period that includes the time the comprehensive assessment was conducted;
- xvi. Identification of any treatment or medication ordered for the resident;
- xvii. Whether any restraints have been used for the resident during a seven day calendar period that includes the time the comprehensive assessment was conducted;
- xviii. A description of the resident or resident's representative's participation in the comprehensive assessment;
- xix. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;
- xx. Potential for rehabilitation; and
- xxi. Potential for discharge; and

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- e. Is signed and dated by the registered nurse who conducts or coordinates the comprehensive assessment or review;
 2. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing care institution unless a physician, an individual designated by the physician, or a registered nurse determines the resident has a significant change in condition; and
 3. A resident's comprehensive assessment is reviewed by a registered nurse at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition.
- B.** An administrator shall ensure that a care plan for a resident:
1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1);
 2. Is reviewed and revised based on any change to the resident's comprehensive assessment; and
 3. Ensures that a resident is provided nursing care institution services that:
 - a. Address any medical condition or behavioral health issue identified in the resident's comprehensive assessment; and
 - b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.

R9-10-415. Behavioral Health Services

Except as provided in R9-10-414 for behavioral care, if a nursing care institution provides behavioral health services, an administrator shall ensure that:

1. The behavioral health services are provided:
 - a. Under the direction of a behavioral health professional, and
 - b. In compliance with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-114; and
 - ii. For an assessment, in R9-10-1011(B);
2. ~~A behavioral health technician or a behavioral health paraprofessional complies with the requirements in R9-10-114;~~
3. Except for a psychotropic drug used as a chemical restraint or administered according to an order from a court of competent jurisdiction, informed consent is obtained from a resident or the resident's representative for a psychotropic drug and documented in the

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resident's medical record before the psychotropic drug is administered to the resident;
and

- 4.3. If the nursing care institution provides assistance in the self-administration of medication to a resident receiving behavioral health services:
- a. The resident's interdisciplinary team determines that the resident is capable of self-administration and the attending physician documents authorization for medication self-administration in the resident's medical records;
 - b. A resident's medication is stored by the nursing care institution;
 - c. The following assistance is provided to a resident:
 - i. A reminder when it is time to take the medication;
 - ii. Opening the medication container for the resident;
 - iii. Observing the resident while the resident removes the medication from the container;
 - iv. Verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:
 - (1) The resident taking the medication is the individual stated on the medication container label,
 - (2) The dosage of the medication is the same as stated on the medication container label, and
 - (3) The medication is being taken by the resident at the time stated on the medication container label; or
 - v. Observing the resident while the resident takes the medication;
 - d. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or a registered nurse;
 - e. Training for a personnel member, other than a medical practitioner, nurse, or medication assistant, in the self-administration of medication:
 - i. Is provided by a medical practitioner or nurse or an individual trained by a medical practitioner or nurse; and
 - ii. Includes:
 - (1) A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,

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- (2) Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
- (3) Process for notifying the appropriate entities when an emergency medical intervention is needed;
- f. A personnel member, other than a medical practitioner or a registered nurse, completes the training in subsection (4)(e) before the personnel member provides assistance in the self-administration of medication; and
- g. Assistance with the self-administration of medication provided to a resident:
 - a. Is in compliance with an order, and
 - b. Is documented in the resident's medical record.

R9-10-416. Clinical Laboratory Services

If clinical laboratory services are provided on the premises of the nursing care institution, an administrator shall ensure that:

- 1. Clinical laboratory services and pathology services are provided through a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
- 2. A copy of the certificate of accreditation, certificate of compliance, or certificate of waiver in subsection (1) is provided to the Department for review upon the Department's request;
- 3. A nursing care institution:
 - a. Is able to provide the clinical laboratory services delineated in the nursing care institution's scope of services when needed by the residents,
 - b. Obtains specimens for the clinical laboratory services delineated in the nursing care institution's scope of services without transporting the residents from the nursing care institution's premises, and
 - c. Has the examination of the specimens performed by a clinical laboratory;
- 4. Clinical laboratory and pathology test results are:
 - a. Available to the ordering physician:
 - i. Within 24 hours after the test is complete with results if the test is performed at a laboratory on the nursing care institution's premises, or

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- ii. Within 24 hours after the test result is received if the test is performed at a laboratory outside of the nursing care institution's premises; and
 - b. Documented in a resident's medical record;
5. If a test result is obtained that indicates a resident may have an emergency medical condition, as defined in the nursing care institution's policies and procedures, ~~laboratory~~ personnel notify:
 - a. The ordering physician,
 - b. A registered nurse in the resident's assigned unit,
 - c. The nursing care institution's administrator, or
 - d. The director of nursing;
6. If a clinical laboratory report is completed on a resident, a copy of the report is included in the resident's medical record;
7. If the nursing care institution provides blood or blood products, policies and procedures are established, documented, and implemented for:
 - a. Procuring, storing, transfusing, and disposing of blood or blood products;
 - b. Blood typing, antibody detection, and blood compatibility testing; and
 - c. Investigating transfusion adverse reactions that specify a process for review through the quality management program; and
8. Expired laboratory supplies are discarded according to policies and procedures.

R9-10-417. Dialysis Services

R9-10-418. Radiology Services and Diagnostic Imaging Services

R9-10-419. Respiratory Care Services

R9-10-420. Rehabilitation Services

R9-10-421. Medication Services

- A. If a nursing care institution provides medication administration ~~or assistance in the self-administration of medication~~, an administrator shall ensure that policies and procedures:
 1. Include:
 - a. A process for providing information to a resident about medication prescribed for the resident including:
 - i. The prescribed medication's anticipated results,
 - ii. The prescribed medication's potential adverse reactions,
 - iii. The prescribed medication's potential side effects, and

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- iv. Potential adverse reactions that could result from not taking the medication as prescribed;
 - b. Procedures for preventing, responding to, and reporting:
 - i. A medication error,
 - ii. An adverse response to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a pharmacist reviews a resident's medications at least every three months and provides documentation to the resident's attending physician and the director of nursing indicating potential medication problems such as incompatible or duplicative medications;
 - d. Procedures for documenting medication services and assistance in the self-administration of medication; and
 - e. Procedures for assisting a resident in obtaining medication; and
 - 2. Specify a process for review through the quality management program of:
 - a. A medication administration error, and
 - b. An adverse reaction to a medication.
- B. If a nursing care institution provides medication administration, an administrator shall ensure that:
 - 1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by the director of nursing;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. A resident's refusal to take prescribed medication is documented in the resident's medical record;
 - 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
 - 3. A medication administered to a resident:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the resident's medical record;
 - 4. ~~If pain medication is administered to a resident, documentation in the resident's medical record includes:~~
 - a. ~~An identification of the resident's pain before administering the medication, and~~

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- ~~b.~~ ~~The effect of the pain medication administered; and~~
- ~~5.~~ If a psychotropic medication is administered to a resident:
 - a. Is only administered to a resident for a diagnosed medical condition; and
 - b. Unless clinically contraindicated or otherwise ordered by an attending physician or the attending physician's designee, is gradually reduced in dosage while the resident is simultaneously provided with interventions such as behavior and environment modification in an effort to discontinue the psychotropic medication unless a dose reduction is attempted and the resident displays behavior justifying the need for the psychotropic medication, and the attending physician documents the necessity for the continued use and dosage; ~~and~~
 - ~~e.~~ ~~Is documented as required in the resident's medical record and includes the resident's response to the medication.~~
- C. An administrator shall ensure that:
 - 1. A current drug reference guide is available for use by personnel members;
 - 2. ~~A current toxicology reference guide is available for use by personnel members; and~~
 - ~~3.~~ If pharmaceutical services are provided:
 - a. The pharmaceutical services are provided under the direction of a pharmacist;
 - b. The pharmaceutical services comply with ARS Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
 - c. A copy of the pharmacy license is provided to the Department upon request;

R9-10-422. Infection Control

- A. An administrator shall ensure that:
 - 1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the nursing care institution;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the nursing care institution;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the nursing care institution; and
 - d. Documentation of infection control activities including:
 - i. The collection and analysis of infection control data,

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- ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least ~~two years~~ twelve months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:
 - a. Compliance with the requirements in 9 A.A.C. 6 for reporting and control measures for communicable diseases and infestations;
 - b. Handling and disposal of biohazardous medical waste;
 - c. Sterilization, disinfection, and storage of medical equipment and supplies;
 - d. Use of personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
 - e. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a resident;
 - f. Training of personnel members, employees, and volunteers in infection control practices; and
 - g. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
5. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas; and
6. A personnel member, an employee, or a volunteer washes hands or use a hand disinfection product after a resident contact and after handling soiled linen, soiled clothing, or potentially infectious material.

R9-10-423. Food Services

R9-10-424. Emergency and Safety Standards

- A. An administrator shall ensure that:

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1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where residents will be relocated, including:
 - i. Instructions for the evacuation, transport, or transfer of residents;
 - ii. Assigned responsibilities for each employee and personnel member; and
 - iii. A plan for continuing to provide services to meet a resident's needs;
 - b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
 - c. A plan for back-up power and water supply;
 - d. A plan to ensure a resident's medication will be available to administer to the resident during a disaster;
 - e. A plan to ensure a resident is provided nursing services and other services required by the resident during a disaster; and
 - f. A plan for obtaining food and water for individuals present in the nursing care institution or the nursing care institution's relocation site during a disaster;
2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
4. ~~An evacuation~~ A fire drill for employees is conducted on each shift at least once every three months;
5. ~~An evacuation~~ A disaster drill for employees and residents:
 - a. ~~Is~~ is conducted at least once every six months, ~~and~~
 - b. ~~Except for a resident whose care plan contains documentation that evacuation from the nursing care institution would cause harm to the resident, includes all individuals in the nursing care institution;~~
6. Documentation of each ~~evacuation~~ drill is created, is maintained for at least 12 months after the date of the ~~evacuation~~ drill, and includes:
 - a. The date and time of the ~~evacuation~~ drill;

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- b. Whether the ~~evacuation~~ drill was for employees only or for both employees and residents;
 - c. ~~The amount of time taken for all employees and, if applicable, residents to evacuate the nursing care institution;~~
 - ~~d.~~ If applicable:
 - i. The amount of time taken for employees and residents to evacuate,
 - ii. An identification of residents needing assistance for evacuation, and
 - ~~iii.~~ An identification of residents who were not evacuated;
 - ~~e.d.~~ Any problems encountered in conducting the ~~evacuation~~ drill; and
 - ~~f.e.~~ Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the nursing care institution.

R9-10-425. Environmental Standards

- A. An administrator shall ensure that:
- 1. A nursing care institution's premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness and infection; and
 - b. Free from a condition or situation that may cause a resident or an individual to suffer physical injury;
 - 2. A pest control program is implemented and documented;
 - 3. Equipment used to provide direct care is:
 - a. Maintained in working order;
 - b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 - 4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 - 5. Garbage and refuse are:
 - a. In areas used for food storage, food preparation, or food service, ~~Stored~~ stored in covered containers lined with plastic bags, and
 - b. In areas not used for food storage, food preparation, or food service, stored:
 - i. According to the requirements in subsection (5)(a), or

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1. Smoking or the use of tobacco products is not permitted within a nursing care institution, and
 2. Smoking and the use of tobacco products may be permitted outside a nursing care institution if:
 - a. Signs designating smoking areas are conspicuously posted, and
 - b. Smoking is prohibited in areas where combustible materials are stored or in use.
- C. If a swimming pool is located on the premises, an administrator shall ensure that:
1. At least one personnel member with cardiopulmonary resuscitation training that meets the requirements in R9-10-403(C)(1)(d) is present in the pool area when a resident is in the pool area, and
 2. At least two personnel members are present in the pool area when two or more residents are in the pool area.

R9-10-426. Physical Plant Standards

R9-10-427. Quality Rating

- C. The quality rating is determined by the total number of points awarded based on the following criteria:
1. Nursing Services:
 - a. 15 points: The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.
 - b. 5 points: The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.
 - c. 5 points: The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.
 2. Resident Rights:
 - a. 10 points: The nursing care institution is implementing a system that ensures a resident's privacy needs are met.

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- b. 10 points: The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.
 - c. 5 points: The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.
3. Administration:
- a. 10 points. The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey.
 - b. 5 points. The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Department and as required by A.R.S. § 46-454.
 - c. 5 points. The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.
 - d. 1 point. The nursing care institution is implementing a system to provide ~~medically-related~~ social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.
 - e. 1 point. The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.
 - f. 2 points. The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.
 - g. 1 point. The nursing care institution is implementing a system to ensure a personnel member attends ~~12 hours of in-service education every 12 months after the starting date of employment~~ according to policies and procedures.
4. Environment and Infection Control:

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- a. 5 points. The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.
 - b. 1 point. The nursing care institution establishes and maintains a pest control program.
 - c. 1 point. The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.
 - d. 1 point. The nursing care institution ensures orientation to the disaster plan for each personnel member is completed within the first scheduled week of employment.
 - e. 1 point. The nursing care institution maintains a clean and sanitary environment.
 - f. 5 points. The nursing care institution is implementing a system to prevent and control infection.
 - g. 1 point. An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.
5. Food Services:
- a. 1 point. The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license.
 - b. 3 points. The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan.
 - c. 2 points. The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs.
 - d. 2 points. The nursing care institution provides assistance to a resident who needs help in eating so that the individual's nutritional, physical, and social needs are met.
 - e. 1 point. The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.

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- f. 1 point. The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.

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