

TITLE 9. HEALTH SERVICES
CHAPTER 10. HEALTH CARE INSTITUTIONS: LICENSING
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ARTICLE 12. HOME HEALTH AGENCIES

R9-10-1201. Definitions

In this Article, unless the context otherwise requires:

- #. "Branch office" means a location other than a home health agency's main administrative office that:
 - a. Operates under the license of the home health agency, and
 - b. Is under the control of the home health agency's administrator.
- #. "Home health aide services" means those tasks that are provided to a patient by a home health aide under the direction of a registered nurse or therapist.
- #. "Home health services director" means an individual who provides direction for the home health services provided by or through a home health agency.
- #. "Medical social services" means activities that assist a patient to cope with concerns about the patient's illness and may include:
 - a. Counseling, and
 - b. Helping to find resources to address the patient's concerns.

R9-10-1202. Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a home health agency shall:

- 1. Include on the application:
 - a. The name and address of each proposed branch office, if applicable; and
 - b. The geographic region to be served by:
 - i. The proposed home health agency administrative office, and
 - ii. Each proposed branch office; and
- 2. Submit to the Department a copy of a valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1 for:
 - a. If the applicant is an individual, the applicant; or
 - b. If the applicant is a business organization, each individual with a 10% or greater ownership of the business organization.

R9-10-1203. Administration

- A. A governing authority shall:
 - 1. Consist of one or more individuals responsible for the organization, operation, and administration of the home health agency;
 - 2. Designate, in writing:
 - a. A home health agency's scope of services, and

- b. Qualifications for an administrator;
 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
 4. Approve policies and procedures;
 5. Adopt a quality management program according to R9-10-1204;
 6. Review and evaluation the effectiveness of the quality management program at least once every 12 months;
 7. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present in a home health agency's administrative office for more than 30 calendar days, or
 - b. Not present in a home health agency's administrative office for more than 30 calendar days;
 8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and provide the name and qualifications of the new administrator;
 9. Appoint, according to A.R.S. § 36-151(5)(b) an advisory group that consists of four or more members that include:
 - a. A physician;
 - b. A registered nurse who has at least one year of experience as a registered nurse providing home health services; and
 - c. Two or more individuals who represent a medical, nursing, or health-related profession; and
 10. Ensure that the advisory group appointed according to subsection (A)(9):
 - a. Meets at least once every 12 months,
 - b. Documents meetings, and
 - c. Assists in establishing and evaluating policies and procedures for the home health agency.
- B. An administrator:
1. Is directly accountable to the governing authority of a home health agency for services provided by the home health agency;
 2. Has the authority and responsibility to manage the home health agency;
 3. Except as provided in subsection (A)(7), designates in writing, an individual who is present at the home health agency's administrative office and available and accountable

for services provided by the home health agency when the administrative is not present at the home health agency's administrative offices; and

4. Ensures compliance with A.R.S. § 36-411.

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 and knowledge for personnel members, employees, and volunteers;
- b. Cover orientation and in-service education for personnel members, employees, and volunteers;
- c. Cover how a personnel member may submit a complaint relating to patient care;
- d. Include a method to identify a patient to ensure the patient receives the appropriate services;
- e. Cover patient rights including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
- f. Cover health care directives;
- g. Cover medical records including electronic medical records; and
- h. Cover quality management including incident documentation;

2. Policies and procedures for services provided by a home health agency are established, documented, and implemented that:

- a. Cover patient admission, discharge instructions, and discharge;
- b. Cover the provision of home health services and, if applicable, supportive services;
- c. Include when general consent and informed consent are required;
- d. Cover the receipt of and process for resolving a complaint from a patient;
- e. Cover medication procurement, if applicable, and administration; and
- f. Cover infection control;

3. Ensure that policies and procedures are:

- a. Available to personnel members, and
- b. Reviewed at least once every 24 months and updated as needed;

4. Ensure that records of advisory group meetings are maintained for at least two years after the date of the meeting;

5. Designated in writing, a home health services director who is:

- a. A physician with at least two years of experience working for or with a home health agency, or

- b. A registered nurse with at least three years of nursing experience, including at least two years of experience as a registered nurse providing home health services;
6. Ensure that:
- a. Speech therapy or speech-language pathology services are provided by a speech-language pathologist licensed according to A.R.S. Title 36, Chapter 17, Article 4 or speech-language pathologist assistant licensed according to A.R.S. § 36-1940.04;
 - b. Nutritional services are provided by a registered dietitian;
 - c. Occupational therapy services are provided by an occupational therapist or occupational therapy assistant licensed according to A.R.S. Title 32, Chapter 34;
 - d. Physical therapy services are provided by a physical therapist licensed according to A.R.S. Title 32, Chapter 19, or a physical therapist assistant certified according to A.R.S. Title 32, Chapter 19;
 - e. Respiratory care services are provided by a respiratory therapist or respiratory therapy technician licensed according to A.R.S. Title 32, Chapter 35 or by a registered nurse;
 - f. Pharmacy services are provided by a pharmacist licensed according to A.R.S. Title 32, Chapter 18; and
 - g. Medical social services are provided:
 - i. For medical social services under the practice of social work as defined in A.R.S. § 32-3251, by a clinical social worker, licensed according to A.R.S. § 32-3293, or a licensed baccalaureate social worker according to A.R.S. § 32-3291; and
 - ii. For other medical social services, by an individual with a master's or higher degree in social work who has at least one year of social work experience in a health care setting or by a licensed baccalaureate social worker, according to A.R.S. § 32-3291;
7. Ensure that the services specified in subsection (B)(6) are provided to a patient only under an order by the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
8. Unless otherwise stated:
- a. Documentation required by this Article is provided to the Department within two hours after a Department request; and

- b. When documentation or information is required by this Chapter to be submitted on behalf of a hospital, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the hospital.

R9-10-1204. Quality Management

An administrator shall ensure that:

- 1. A plan for a quality management program for the home health agency is established, documented, and implemented that includes:
 - a. A method to identify, document, and evaluate incidents;
 - b. A method to collect data to evaluate the provision of services, including oversight of personnel members;
 - c. A method to evaluate the data collected to identify a concern about the provision of services;
 - d. A method to make changes or take action as a result of the identification of a concern about the provision of services;
 - e. A method to determine whether actions taken improved the provision of services; and
 - f. The frequency of submitting the documented report required in subsection (3);
- 2. A documented report is submitted to the governing authority that includes:
 - a. Each identified concern in subsection (1)(c), and
 - b. Any change made or action taken in subsection (1)(d); and
- 3. The report in subsection (2) and the supporting documentation is:
 - a. Maintained for 12 months from the date the report is submitted to the governing authority, and
 - b. Provided to the Department within two hours after the Department's request.

R9-10-1205. Contracted Services

An administrator shall ensure that:

- 1. Contract services are provided according to the requirements in this Article, and
- 2. A documented list of current contracted services is maintained that includes a description of the contracted services provided.

R9-10-1206. Personnel

A. An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:

- ii. Verification of the individual's skills and knowledge;
 - iii. A license, certification, registration, or education, as applicable;
 - iv. Evidence of freedom from infectious tuberculosis as required in subsection (B)(4);
 - v. Compliance with the requirements in A.R.S. § 36-411; and
 - vi. Orientation and in-service education; and
2. Is maintained:
- a. Throughout the individual's period of providing services in or for the home health agency; and
 - b. For at least two years after the last date the individual provided services in or for the home health agency.

R9-10-1207. Patient Rights

- A. An administrator shall ensure:
- 1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
 - 2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
 - 3. There are policies and procedures that include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
 - b. Where patient rights are posted as required in subsection (A)(1).
- B. An administrator shall ensure that a patient:
- 1. Is not subjected to:
 - a. The intentional infliction of physical, mental or emotional pain unrelated to the patient's condition;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse according to A.R.S. § 13-1404;
 - g. Sexual abuse according to A.R.S. § 13-1406;
 - h. Seclusion or restraint if not necessary to prevent harm to self or others;
 - i. Retaliation for submitting a complaint to the Department or another entity; and

- j. Misappropriation of personal and private property by a home health agency's personnel members, employees, or volunteers; and
2. A patient or the patient's representative:
- a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent to treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed alternatives to a psychotropic medication and the associated risks and possible complications of a psychotropic medication;
 - d. Is informed of the following:
 - i. The adult day health care facility's policy on health care directives;
 - ii. The patient complaint process;
 - iii. Home health services provided by or through the home health agency; and
 - iv. The rates and charges for services before the services are initiated and before a change in rates, charges, or services;
 - e. Consents to photographs of the patient before a patient is photographed; and
 - f. Except as otherwise permitted by law, provides written consent to the release of the patient's:
 - i. Medical records, and
 - ii. Financial records.
- C. A patient has the following rights:
- 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
 - 2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
 - 3. To receive privacy in treatment and care for personal needs;
 - 4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293; 12-2294, and 12-2294.01;
 - 5. To receive a referral to another health care institution if the home health agency is unable to provide physical health services or behavioral health services for the patient;
 - 6. To participate or have the patient's representative participate in the development of or decisions concerning treatment;
 - 7. To participate or refuse to participate in research or experimental treatment; and

8. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

R9-10-1208. Plan of Care

- A. An administrator shall ensure that a plan of care is developed for each patient:
 1. Based on an assessment of the patient as required in R9-10-1209(D)(1) or (F)(2)(e)(i);
 2. With participation from:
 - a. The patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
 - b. A registered nurse; and
 3. That includes:
 - a. The patient's diagnosis;
 - b. The patient's health care directives;
 - c. Surgery dates relevant to home health services, if applicable;
 - d. The patient's cognitive awareness of self, location, and time;
 - e. Functional abilities and limitations;
 - f. Goals for functional rehabilitation, if applicable;
 - g. The type, duration, and frequency of each service to be provided;
 - h. Treatments the patient is receiving from a source other than the home health agency;
 - i. Medications and herbal supplements reported by the patient or patient's representative as being used by the patient and the dose, route of administration, and schedule for administration of each medication or herbal supplement;
 - j. Any known drug allergies;
 - k. Nutritional requirements and preferences;
 - l. Specific measures to improve the patient's safety and protect the patient against injury; and
 - m. A discharge plan for the patient including, if applicable, a plan for assessing the accomplishment of treatment or therapy goals for the patient.
- B. An administrator shall ensure that:
 1. Home health services are provided to a patient by the home health agency according to the patient's plan of care,
 2. The patient's plan of care is reviewed and updated:
 - a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of the services being provided;

- b. If the patient's physician, registered nurse practitioner, or podiatrist, as applicable, orders a change in the plan of care; and
 - c. At least every 60 days; and
3. The patient's physician, registered nurse practitioner, or podiatrist, as applicable, authenticates the plan of care with a signature within 30 days after the plan of care is initially developed and whenever the plan of care is reviewed or updated.

R9-10-1209. Home Health Services

- A. An administrator shall ensure that an individual admitted to the home health agency has an order from a physician, registered nurse practitioner, or podiatrist for home health services.
- B. An administrator shall ensure that the home health services director provides direction for home health services provided by or through the home health agency.
- C. A home health services director shall ensure that nursing services are provided by a registered nurse or practical nurse, according to policies and procedures.
- D. A home health services director shall ensure that a registered nurse:
 - 1. Unless a patient's physician or registered nurse practitioner orders only speech therapy, occupational therapy, or physical therapy for the patient, within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts an initial assessment of the patient to determine:
 - a. The needs of the patient;
 - b. Resources available to address the patient's needs;
 - c. The patient's home and family environment;
 - d. Goals for patient care;
 - e. Medications used by the patient, including non-compliance, drug interactions, side effects, and contraindications; and
 - f. Medical supplies or equipment needed by the patient;
 - 2. Reviews a patient's health care directives at the time of the initial assessment;
 - 3. Implements a patient's plan of care, developed as specified in R9-10-1208;
 - 4. Coordinates patient care with other individuals providing home health services or other services to the patient;
 - 5. Immediately informs the patient's physician or registered nurse practitioner of a change in a patient's condition that requires medical services; and
 - 6. At least every 60 calendar days until a patient is discharged:
 - a. Reassesses the patient based on the patient's plan of care, needs, and medical condition; and

- i. Assigns tasks in writing to the home health aide who is assisting the patient;
 - ii. Verifies the competency of the home health aide in performing assigned tasks; and
 - iii. Provides direction to the home health aide in performing the assigned tasks related to the therapy service;
 - c. Coordinates the provision of the therapy service to the patient with the registered nurse providing direction for other home health services for the patient;
 - d. Documents in the patient's medical record any orders by the patient's physician or registered nurse practitioner received concerning the therapy service; and
 - e. If the only home health services ordered for the patient are speech therapy, occupational therapy, or physical therapy:
 - i. Within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts an initial assessment of the patient as specified in subsections (D)(1)(a) through(f); and
 - ii. Meets with a patient who is receiving home health services from a home health aide every two weeks to assess the home health services provided by the home health aide; and
- 3. A home health aide:
 - a. Is only assigned to provide services the home health aide can competently perform; and
 - b. Only performs tasks assigned to the home health aide in writing by a registered nurse or as specified in subsection (F)(2)(b)(i).

R9-10-1210. Supportive Services

- A. A governing authority may include supportive services, including personal care services, in the scope of services for a home health agency.
- B. An administrator:
 - 1. May allow:
 - a. Supportive services to be provided to a patient without an order from a physician, registered nurse practitioner, or podiatrist; and
 - b. A personnel member who is not a home health aide to perform personal care services; and

2. Shall ensure that:
 - a. Supportive services are provided to a patient according to policies and procedures;
 - b. A registered nurse:
 - i. Assesses a patient's need for supportive services,
 - ii. Assigns specific tasks in writing to a home health aide providing supportive services other than personal care services,
 - iii. Assigns specific tasks in writing to a personnel member providing personal care services,
 - iv. Provides direction for supportive services, and
 - v. Includes supportive services in the reassessment of a patient required in R9-10-1209(D)(6); and
 - c. Supportive services are documented in a patient's medical record.

R9-10-1211. Medical Records

- A. An administrator shall ensure that:
 1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
 2. An entry in a patient's medical record is:
 - a. Recorded only by an individual authorized by a policies and procedures to make the 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 patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner, behavioral health professional, or podiatrist according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner, behavioral health professional, or podiatrist 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 patient's medical record is available to personnel members, medical practitioners, behavioral health professionals, or podiatrist authorized by policies and procedures;

6. Information in a patient's medical record is disclosed to an individual not authorized under subsection (5) only with the written consent of a patient or the patient's representative or as permitted by law; and
 7. A patient's medical record is protected from loss, damage, or unauthorized use.
- B. If a home health agency maintains patient's medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C. An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
 - a. The patient's name;
 - b. The patient's address and telephone number;
 - c. The patient's date of birth;
 - d. The name and contact information of the patient's representative, if applicable; and
 - e. Any known allergies including medication or biological allergies;
 2. The date the patient began receiving services from the home health agency and, if applicable, the date the patient stopped receiving services from the home health agency;
 3. The name and telephone of the patient's medical practitioner or registered nurse practitioner;
 4. The name and telephone number of patient's podiatrist, if applicable;
 5. Documentation of general consent and, if applicable, informed consent;
 6. Documentation of medical history and current diagnoses;
 7. Copy of patient's health care directive, if applicable;
 8. Orders;
 9. Assessments;
 10. Care plan;
 11. Progress notes;
 12. Documentation of meetings with the patient to assess the home health services and supportive services provided to the patient;
 13. Disposition of the patient upon discharge;
 14. Discharge plan;
 15. A discharge instructions and discharge summary, if applicable;

16. If applicable:
 - a. Laboratory reports,
 - b. Radiologic report,
 - c. Diagnostic reports, and
 - d. Consultation reports;
17. Documentation of a medication or a biological administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication or biological; and
 - f. Any adverse reaction a patient has to the medication or biological;
18. Documentation of tasks assigned to a home health aide or other personnel member;
19. Documentation of coordination of patient care;
20. Copies of patient summary reports sent to the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
21. Documentation of contacts with the patient's physician, registered nurse practitioner, or podiatrist, as applicable, by a personnel member or the patient.