

ARTICLE 12. HOME HEALTH AGENCIES

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ARTICLE 12. HOME HEALTH AGENCIES

R9-10-1201. Definitions

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

1. "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.
2. "Home health services director" means an individual who provides direction for the home health services provided by or through a home health agency.
3. "Medical social services" means activities that assist a patient to cope with concerns about the patient's illness or injury, and may include helping to find resources to address the patient's concerns.

R9-10-1202. Supplemental 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's 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. The applicant, if the applicant is an individual; or
 - b. Each individual with a 10% or greater ownership of the business organization, if the applicant is a 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. Establish, 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. Adopt a quality management program according to R9-10-1204;
 5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
 6. 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;
 7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator;
 8. 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
 9. Ensure that the advisory group appointed according to subsection (A)(8):
 - 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 all 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)(6), designates, in writing, an individual who is present at the home health agency's administrative office and accountable for services provided by the home health agency when the administrator is not present at the home

- health agency's administrative office; and
 - 4. Ensures compliance with A.R.S. § 36-411.
- C. An administrator shall:
- 1. Ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience 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. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Include a method to identify a patient to ensure the patient receives the appropriate services;
 - f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
 - g. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The home health agency to respond to a patient complaint;
 - h. Cover health care directives;
 - i. Cover medical records, including electronic medical records;
 - j. Cover a quality management program, including incident reports and supporting documentation;
 - k. Cover contracted services; and
 - l. Cover and designate which personnel members or employees are required to have current certification in cardiopulmonary resuscitation and first aid training;
 - 2. Ensure that policies and procedures for services provided by a home health agency are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient admission, discharge planning, 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 how personnel members will respond to a patient's sudden, intense, or out-

- of-control behavior to prevent harm to the patient or another individual;
 - 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, employees, and volunteers, and
 - b. Reviewed at least once every three years and updated as needed;
 - 4. Ensure that records of advisory group meetings are maintained for at least 24 months after the date of the meeting;
 - 5. Designate, in writing, a home health services director who is:
 - a. A physician with at least 24 months 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 24 months 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 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;
 - d. Physical therapy services are provided by a physical therapist or a physical therapist assistant;
 - e. Respiratory care services are provided by a respiratory therapist, respiratory therapy technician licensed according to A.R.S. Title 32, Chapter 35, or registered nurse;
 - f. Pharmacy services are provided by a pharmacist; and
 - g. Medical social services are provided:
 - i. By a personnel member qualified according to policies and procedures that coordinates medical social services; and
 - ii. For medical social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, by a personnel member licensed under A.R.S. Title 32, Chapter 33, Article 5;
 - 7. Ensure that the services specified in subsection (C)(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, ensure that:
 - 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 home health agency, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the home health agency.

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 (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
 - a. Each identified concern about the delivery of services related to patient care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

R9-10-1205. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation 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:
 - i. The type of services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services, and
 - b. According to policies and procedures;
3. Sufficient personnel members are available with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the home health agency's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient; and
4. A personnel member, or an employee, a volunteer, or a student who has or is expected to

have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:

- a. On or before the date the individual begins providing services at or on behalf of the home health agency, and
- b. As specified in R9-10-113.

B. An administrator shall ensure that a personnel record for each personnel member, employee, or volunteer:

1. Includes:

- a. The individual's name, date of birth, and contact telephone number;
- b. The individual's starting date of employment or volunteer service, and if applicable, ending date; and
- c. Documentation of:
 - i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education as required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - v. The individual's compliance with the requirements in A.R.S. § 36-411;
 - vi. Cardiopulmonary resuscitation training, if required for the individual according to this Article and policies and procedures;
 - vii. First aid training, if required for the individual according to this Article and policies and procedures; and
 - viii. Evidence of freedom from infectious tuberculosis, if required according to subsection (A)(4);

2. Is maintained:

- a. Throughout the individual's period of providing services in or for the home health agency; and
- b. For at least 24 months after the last date the individual provided services in or for the home health agency; and

3. For a personnel member who has not provided services for the home health agency during the previous 12 months, provided to the Department within 72 hours after the Department's request.

R9-10-1207. Care Plan

- A. An administrator shall ensure that a care plan is developed for each patient:
 1. Based on an assessment of the patient as required in R9-10-1210(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. Surgery dates relevant to home health services, if applicable;
 - c. The patient's cognitive awareness of self, location, and time;
 - d. Functional abilities and limitations;
 - e. Goals for functional rehabilitation, if applicable;
 - f. The type, duration, and frequency of each service to be provided;
 - g. Treatments the patient is receiving from a source other than the home health agency;
 - h. Medications and herbal supplements reported by the patient or the 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;
 - i. Any known drug allergies;
 - j. Nutritional requirements and preferences;
 - k. Specific measures to improve the patient's safety and protect the patient against injury; and
 - l. 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 care plan;
 2. The patient's care plan 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 care plan; and
- c. At least every 60 calendar days; and
- 3. The patient's physician, registered nurse practitioner, or podiatrist, as applicable, authenticates the care plan with a signature within 30 calendar days after the care plan is initially developed and whenever the care plan is reviewed or updated.

R9-10-1208. Patient Rights

- A. An administrator shall ensure that:
 - 1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted at the home health agency's administrative office;
 - 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. Policies and procedures 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:
 - 1. A patient is treated with dignity, respect, and consideration;
 - 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by a home health agency's personnel members, employees, or volunteers; and
 - 3. A patient or the patient's representative:

- a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for 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 home health agency'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 the patient is photographed, except that a patient may be photographed when admitted to a home health agency for identification and administrative purposes; and
 - f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - 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, or diagnosis;
 - 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 not authorized or not able to provide physical health services needed by the patient;
 - 6. To participate or have the patient's representative participate in the development of a care plan 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, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

R9-10-1209. 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 physician, registered nurse practitioner, or podiatrist according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the physician, registered nurse practitioner, or podiatrist issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 5. A patient's medical record is available to personnel members, physicians, registered nurse practitioners, or podiatrists authorized by policies and procedures to access the patient's medical record;
 - 6. Information in a patient's medical record is disclosed to an individual not authorized under subsection (A)(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 patients' 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; and
 - d. Any known allergies, including medication 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 physician 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. A copy of patient's health care directive, if applicable;
 8. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Is a legal guardian, a copy of the court order establishing guardianship; or
 - ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
9. Orders;
 10. Assessments;
 11. Care plan;
 12. Progress notes;
 13. If applicable, documentation of any actions taken to control the patient's sudden, intense or out-of-control behavior to prevent harm to the patient or another individual;
 14. Documentation of meetings with the patient to assess the home health services and supportive services provided to the patient;
 15. The disposition of the patient upon discharge;
 16. The discharge plan;
 17. Discharge instructions and discharge summary, if applicable;
 18. If applicable:

- a. Laboratory reports,
 - b. Radiologic reports,
 - c. Diagnostic reports, and
 - d. Consultation reports;
19. Documentation of a medication 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; and
 - f. Any adverse reaction a patient has to the medication;
20. Documentation of tasks assigned to a home health aide or other personnel member;
21. Documentation of coordination of patient care;
22. Copies of patient summary reports sent to the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
23. Documentation of contacts with the patient's physician, registered nurse practitioner, or podiatrist, as applicable, by a personnel member or the patient.

R9-10-1210. 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 care plan, developed as specified in R9-10-1207;
 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 care plan, needs, and medical condition; and
 - b. Summarizes the patient's condition and needs for the patient's physician, registered nurse practitioner, or podiatrist, as applicable.
- E. A home health services director shall ensure that:
1. A patient's condition and the services provided to the patient are documented in the patient's medical record after each patient contact; and
 2. Verbal orders from a patient's physician, registered nurse practitioner, or podiatrist, as applicable, are:
 - a. Except as specified in subsection (F)(2)(d), received by a registered nurse and documented by the registered nurse in the patient's medical record; and
 - b. Authenticated by the patient's physician, registered nurse practitioner, or podiatrist, as applicable, with a signature, within 30 calendar days.
- F. A home health services director shall ensure that:
1. A registered nurse:
 - a. Except as specified in subsection (F)(2)(b)(i) and (ii):
 - i. Assigns tasks in writing to a home health aide who is providing home

- health services to a patient; and
 - ii. Verifies the competency of the home health aide in performing assigned tasks;
 - b. Except as specified in subsection (F)(2)(b)(iii), provides direction for the home health aide services provided to a patient; and
 - c. Except as specified in subsection (F)(2)(e)(ii), meets with a patient who is receiving home health aide services to assess the home health services provided by the home health aide:
 - i. At least every two weeks when the patient is also receiving nursing services or therapy services, and
 - ii. At least every 60 calendar days when the patient is only receiving home health aide services;
- 2. When a patient's physician or registered nurse practitioner orders speech therapy, occupational therapy, or physical therapy for the patient, an individual specified in R9-10-1203(C)(6)(a), (c), or (d), as applicable:
 - a. Provides the applicable therapy service to the patient according to the patient's care plan;
 - b. If a home health aide is assigned to assist the patient in performing activities related to the therapy service:
 - 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).

R9-10-1211. 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 R9-10-1210(D)(6); and
 - c. Supportive services are documented in a patient's medical record.