NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES –

HEALTH CARE INSTITUTIONS: LICENSING

PREAMBLE

1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039(B) by the governor on:

April 21, 2025

2. Article, Part, or Section Affected (as applicable)	**Rulemaking Action**
R9-10-101	Amend
R9-10-102	Amend
R9-10-106	Amend
R9-10-111	Amend
R9-10-121	Amend
R9-10-122	New Section
R9-10-123	New Section
R9-10-124	New Section
R9-10-125	New Section
R9-10-126	New Section
Table 1.2	New Table
R9-10-801	Amend
R9-10-803	Amend
R9-10-806	Amend
R9-10-808	Amend
R9-10-811	Amend
R9-10-815	Amend
R9-10-816	Repeal
R9-10-816	New Section
R9-10-817	New Section
R9-10-818	Renumber
R9-10-819	Renumber
R9-10-819	Amend
R9-10-820	Renumber
R9-10-821	Renumber

3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. §§ 36-132(A)(1) and (17), 36-136(G), 36-405 and 36-406

Implementing statute: A.R.S. §§ 36-405, 36-405.03, 36-411, 36-420.05, 36-425, and 36-431.01, as amended by Laws 2024, Chapter 100

4. The effective date of the rule:

This rule shall become effective June 30, 2025 pursuant to Laws 2024, Chapter 100.

a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Pursuant to Laws 2024, Chapter 100, the rules need to be effective June 30, 2025. In addition, the rulemaking should be in effect earlier than the general 60-day effective date pursuant to A.R.S. § 41-1032(A)(1) through (4).

b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:

Notice of Rulemaking Docket Opening: 30 A.A.R. 3066, October 18, 2024, Issue Number: 42, [R24-197]

Notice of Proposed Rulemaking: 31 A.A.R. 703, March 7, 2025, Issue Number: 10, [R25-23]

6. The agency's contact person who can answer questions about the rulemaking:

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7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Revised Statutes (A.R.S.) § 36-132(A)(1) and (17) requires the Arizona Department of Health Services (Department) to protect the health of the people in Arizona, and license and regulate health care institutions. In order to ensure public health, safety, and welfare, A.R.S. §§ 36-405 and 36-406 requires the Department to adopt rules establishing minimum standards and requirements for the construction, modification, and licensure of health care institutions. The Department has adopted rules to implement these statutes in Arizona Administrative Code (A.A.C.) Title 9, Chapter 10. The Department plans to amend the rules in 9 A.A.C. 10, Articles 1 and 8, to comply with new statutory changes imposed by Laws 2024, Chapter 100, which requires the new rules to take effect by June 30, 2025. These rules will establish memory care services standards in assisted living facilities, requiring eight hours of initial training and four hours of annual continuing education for staff and contractors, as well as specific training for managers. Rehired staff and contractors after a 12-month gap must complete the initial training within 30 days. Facilities must

document staff and contractor training for compliance inspections, and penalties apply for non-compliance. On-site monitoring, associated fees, and in-service training requests will be formalized. Additionally, civil money penalties will increase up to $1,000 per resident or patient impacted, per day, and take other considerations into account (i.e. repeats, etc.). The Department may pursue court, administrative, or enforcement action against a licensee, even if the health care institution is in the process of being sold or transferred or has closed. Health care institutions failing to pay penalties may have their licenses revoked, and applications may be denied if resident or patient safety is at risk. After receiving rulemaking approval pursuant to A.R.S. § 41-1039, the Department plans to conduct a rulemaking to adhere to the statutory changes identified above. The Department anticipates that the rules may increase the regulatory burden or cost on some affected persons. However, the Department believes that the benefits of the rules will far outweigh any potential cost due to increasing the health and safety for residents or patients. Any proposed changes will conform to the rulemaking format and style requirements of the Governor's Regulatory Review Council (GRRC) and the Office of the Secretary of State.

8. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study related to this rulemaking package.

9. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

10. A summary of the economic, small business, and consumer impact:

The Arizona Department of Health Services (Department) is required by A.R.S. § 36-132(A)(1) and (17) to protect public health and regulate health care institutions, including establishing minimum standards under A.R.S. §§ 36-405 and 36-406. To comply with Laws 2024, Chapter 100, the Department is amending the rules in 9 A.A.C. 10, Articles 1 and 8. In Article 1, changes that affected all licensed health care institutions include on-site monitoring inspections, in-service training requests, increased civil money penalties up to $1,000 per resident or patient impacted by a violation, and an enforcement matrix that outlines violation severities and remedies. The Department may pursue legal action against non-compliant licensees, even if a facility is being sold or closed, and health care institutions failing to pay penalties may have their licenses revoked. Furthermore, Laws 2024, Chapter 100, establishes memory care services for in assisted living facilities authorized to provide directed care services, requiring staff and contractor training, compliance documentation, and penalties for non-compliance. While the rules may increase regulatory costs for some affected persons, the Department believes the benefits—enhancing health and safety for residents—will outweigh any financial impact. The cost/benefit analysis categorizes financial impacts as minimal, moderate, or substantial based on the extent of costs or revenue changes. Directly affected parties include the Department, assisted living facilities, training providers, health care providers and institutions, patients, residents and their families, and the general public.

Laws 2024, Chapter 100 also mandates a memory care services training program, increasing the Department's administrative responsibilities in approving training providers and ensuring compliance with new standards. The proposed rulemaking for memory care services in assisted living facilities authorized to provide directed care services aims to enhance care quality for residents receiving memory care services. The rules establish clear staffing, training, service planning, and environmental adaptation requirements, including a minimum of eight hours of specialized memory care services training within 30 days of hire, a minimum of four hours of annual continuing education, semi-annual elopement drills, and resident-specific service plans. While assisted living facilities licensed to provide directed care services may face minimal costs related to training and environmental

modifications, these measures are expected to improve operational efficiency, reduce liability risks, and enhance resident safety. Additionally, expanding directed care services to include memory care services may offer facilities greater flexibility in their scope of care. Overall, the economic impact on assisted living facilities is anticipated to be minimal to moderate and is expected to provide a significant benefit from having new rules for memory care services.

The Department is introducing five new sections in Article 1 for rules regulating new memory care services training programs. Memory care services training programs must apply for approval by submitting detailed applications, including training course descriptions covering cognitive impairments, communication, behavioral management, emergency protocols, and palliative care. Approved memory care services training programs must renew annually and comply with the applicable rules and statutes, while non-compliance may result in denial or revocation. Additional requirements for providers ensure transparency, including mandatory notifications of significant changes and Department access to records. The eligibility criteria for memory care services trainers emphasize education, experience, and certification. The rules also specify the criteria to be included on a certificate of completion when a participant successfully completes the memory care services training. While these regulations may impose administrative costs, the Department expects the new rules will improve care quality by having well trained staff and contractors on current evidence-based information. The overall economic impact is expected to be minimal to moderate, balancing compliance costs with long-term benefits and improved memory care services in Arizona.

The proposed rule changes to A.A.C. Title 9, Chapter 10 aim to strengthen oversight, improve compliance, and enhance enforcement across all health care institutions. Key updates include granting the Department authority to conduct on-site monitoring inspections for facilities with repeated violations, imposing fees for monitoring and in-service training, and clarifying conditions under which a facility's license may be revoked for unpaid penalties or fees. These measures prioritize high-risk facilities, improve patient safety, and encourage compliance. While initial enforcement activity may increase as facilities adjust, the long-term impact is expected to be enhanced regulatory clarity, improved care quality, and fewer severe violations. Financially, the new rules introduce fees to offset regulatory costs, with on-site monitoring inspections fees of up to $1,000 per inspection and training fees of up to $500 per hour. Additionally, Laws 2024, Chapter 100 raises the cap on civil money penalties from $500 to $1,000, potentially increasing annual penalty collections for the state general fund. While these changes may introduce minimal-to-moderate financial and operational impacts, they are expected to significantly improve patient safety, compliance, and enforcement efficiency across health care institutions.

The new regulations, mandated by Laws 2024, Chapter 100, clarify enforcement actions and introduce on-site monitoring inspections for institutions with significant deficiencies or repeated violations. This includes the possibility of charging up to $1,000 for monitoring inspections and implementing civil money penalties of up to $1,000 per violation per affected patient. While these measures may create financial burdens, particularly for smaller facilities, they are designed to enhance regulatory compliance and patient safety. The rules also introduce a fee structure for in-service training on regulatory compliance, allowing the Department to charge up to $500 per hour. Despite the potential costs, these changes are expected to provide long-term benefits by improving compliance, reducing the need for frequent enforcement actions, and ultimately enhancing the quality of care. The overall financial impact will largely depend on each institution's compliance level, with fully compliant facilities experiencing minimal effects while those with persistent violations may face more substantial costs. Therefore, the proposed rule changes regarding the enforcement measures that are applicable to all health care institutions are expected to have a minimal to moderate cost on health care institution depending on the amount of noncompliance at that health care institutions.

The new rules in Article 1 and Article 8 are expected to provide significant benefits to patients, residents, and their families. The enforcement standards, on-site monitoring, and in-service training requirements aim to improve compliance with Title 9, Chapter

10, enhancing overall health and safety in health care institutions. Stricter monitoring and enforcement are anticipated to reduce risks and create a safer environment, particularly for vulnerable populations. The new memory care service rules for assisted living facilities are designed to expand health care options and improve the quality of care for individuals receiving memory care services. These regulations require personalized service plans, behavior management strategies, and regular medical evaluations, as well as specialized staff and contractor training. While there may be potential for increased costs due to compliance measures, the Department expects the economic impact on patients, residents, and their families to be none-to-minimal. The enhanced safety, improved quality of care, and greater peace of mind for residents, patients, and their families are expected to significantly outweigh any possible incurred costs.

The proposed rule changes are expected to have a significant positive impact on the general public by enhancing safety and quality of care in health care institutions. The stricter oversight and enforcement measures outlined in Article 1 aim to reduce serious health and safety violations, improving trust in the health care system. Clear enforcement mechanisms and robust penalties are designed to reassure the public that regulatory authorities are actively protecting patient welfare. Additionally, the new memory care service rules for assisted living facilities expand care options for directed care services, establishing clear standards and ensuring well-trained staff and contractors for memory care services. These regulations are intended to reduce risks such as elopement and neglect, contributing to safer communities. Overall, the Department anticipates that these changes will provide a substantial benefit to the general public by improving the reliability, safety, and quality of health care services, particularly for vulnerable populations requiring specialized care.

The Department anticipates that the proposed rule changes will have a varied impact on small businesses in the health care sector. While increased compliance requirements may initially incur moderate costs, particularly for those with repeated violations, businesses that maintain compliance are expected to face minimal expenses. The introduction of memory care services presents an opportunity for revenue growth for training providers and assisted living facilities. Although there may be minimal-to-moderate operational costs associated with implementing these new services, the Department estimates that the long-term benefits will outweigh these initial investments. These benefits include improved care quality, enhanced safety standards, better regulatory compliance, and potentially reduced liability risks. The new regulations are also expected to boost the reputation and trustworthiness of compliant facilities, particularly those offering specialized memory care services. While the impact may vary based on compliance levels and enforcement frequency, the Department anticipates that the long-term advantages of improved health care quality and regulatory adherence will ultimately provide a significant benefit to small health care businesses, outweighing any upfront costs.

In conclusion, the proposed rule changes to 9 A.A.C. 10, Articles 1 and 8 are designed to enhance the safety, quality, and regulatory oversight of health care institutions, particularly in memory care services within assisted living facilities. By establishing clear training, compliance, and enforcement standards, these amendments aim to improve resident and patient care while ensuring facilities meet rigorous health and safety requirements. Although some financial and operational impacts are expected, especially for facilities with repeated violations, the long-term benefits—including improved compliance, reduced enforcement actions, and enhanced public trust—outweigh potential costs. Strengthening monitoring, increasing civil money penalties, and formalizing memory care services training will ultimately lead to a more accountable and higher-quality health care system in Arizona, benefiting residents, families, and providers alike.

11. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

The Department is currently working on a separate rulemaking that amends some of the same Sections as in this rulemaking. The Department had planned to finalize that rulemaking before this rulemaking, in which case, the Department used those rules as "base rules" in the Notice of Proposed Rulemaking. Since this separate rulemaking has not been completed, the Department has amended the Notice of Final to reflect the current codified rules. Furthermore, the Department corrected the numbering in the subsection labels in R9-10-125(A) and (B) and R9-10-816(A)(1)(i) to follow the proper rulewriting format. The Department also changed the word "controls" to "monitors" in R9-10-815(F)(2)(a)(ii) and (b)(ii) and clarified that the facility is secured.

12. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

During the formal comment period, the Department received a total of 122 written comments.

There were 111 individuals who submitted similar comments as well as personal stories and expressed support of the proposed memory care service rules, highlighting their potential to significantly improve resident safety and quality of care for individuals receiving memory care services at an assisted living facility. The comments also thanked the Department for including person-centered care planning, timely incident reporting, specialized staff training, adequate staffing levels, supportive environmental features, meaningful activities, nutrition and hydration, safety measures, and evacuation emergency procedures. Furthermore, the comments thanked the Department for improving the state's enforcement matrix for infractions related to health care facilities and strongly urged the Department to finalize the rules as proposed. The Department responded to each individual who submitted comments and thanked them for their feedback and participation in the rulemaking.

The Department received a comment from Allan A. Anderson, MD, similar to the 111 comments received in support of the rulemaking. Anderson added further commentary and questions regarding how adequate staffing is assessed and how training programs will be evaluated. The Department clarified that adequate staffing is assessed according to the service plans of the residents as well as the staff's ability to meet their needs. For example, if multiple residents require more than one caregiver to assist, the facility will be required to increase staffing levels. If residents require the use of specific medical equipment, the staff on-site would need documented training on using the equipment. The training will be assessed during the application review. All memory care training applications will have an administrative review and substantive review. During the substantive review is when the Department will review the quality of the training program to ensure it meets the standards outlined in rule. The training program will be required to demonstrate that the program is evidenced- based before being approved by the Department.

Another similar comment was received from Jennifer Ladd Omo in support of the proposed memory care services rules, however, concerns were expressed about training being required twice a year and a registered nurse being part of the eligibility requirement to be a memory care services trainer. In response, the Department clarified that the required trainings are on an annual basis and the staff training and manager trainings are two different trainings pursuant to A.R.S. § 36-405.03. Furthermore, the Department explained that rules do not require memory care services trainers to be RNs—though that is one option. As specified in R9-10-125(A) and (B), there are multiple pathways for individuals to qualify as trainers. The Department's intent with the rule is to

maintain flexibility and allow individuals with appropriate experience and expertise, including those without RN credentials, to be a memory care services trainer.

The Department also received a similar comment from Adrienne Montgomery, an assisted living manager at Vi at Silverstone. The comment was in support of the rules but also included suggestions to allow for online training and for existing managers to be grandfathered in. The Department let Montgomery know that R9-10-122(B) clarifies that the memory care services training program must include in-person components and may incorporate online elements. The in-person component must include a demonstration of the individual's skills and knowledge necessary to provide memory care services. Furthermore, the manager training is required pursuant to A.R.S. § 36-405.03. Montgomery also asked the Department to consider allowing all licensed nurses to be memory care trainers, including LPNs. The Department thanked Montgomery for the comment and stated this would be discussed and considered in internal discussions.

The Department received a comment from Phyllis Denison, a former RN and 24/7 caregiver, who is in support of the rules. In the comment, they praised the evidence-based training requirements, the emphasis on person-centered care with regular assessments, and the inclusion of medical practitioner reviews for placement decisions. They also highlighted serious concerns about staffing shortages and the need for clear staffing guidelines, calling for broader efforts to educate and train caregivers. Overall, they urged the state to adopt the rules and continue developing regulations that prioritize patient well-being. The Department thanked Denison for the comment and participation in the rulemaking.

A comment was received from Becky Hill, managing owner of Hill Advocacy, LLC, long-time lobbyist, state licensing board member for long-term care, and daughter of an Alzheimer's patient, strongly supports the adoption of the draft memory care services rule as aligned with HB2764. She emphasizes the rule meets legislative intent without exceeding it. Hill urges GRRC to approve the rule, highlighting the urgent need for consistent, qualified care for individuals with dementia. The Department thanked Hill for the comment and participation in the rulemaking.

The Department received a comment from Jaime Roberts, CEO of Arizona LeadingAge expressed appreciation for the Department's stakeholder engagement and inclusion of several AzLA recommendations in the final Memory Care rules. However, AzLA raised concerns about vague and undefined staffing mandates in R9-10-816, which they believe could lead to inconsistent enforcement and operational challenges. They also raised concerns regarding enforcement interpretations related to Directed Care services and the requirement for secured environments, stating that residents who do not pose elopement risks should not be unnecessarily institutionalized. Furthermore, AzLA expressed concerns that the rules authorize memory care as a separate level of care and recommends deleting R9-10-816. Also stating that the Department is outside the statutory authority granted by the legislature. AzLA is disappointed by the rule language in R9-10-816(A)(4), "there is staffing to ensure adequate supervision and care for residents receiving memory care services." Stating this is subjective, vague, and unquantified standards. Other concerns were raised regarding language in R9-10-816(A)(6), which states "If applicable, staffing is increased to compensate for the evaluated care and service needs of residents at move-in or for the changing physical or cognitive needs of the residents." AzLA believes this rule introduces ambiguity into compliance monitoring and imposes potential financial and operational burdens without

guardrails and creates a liability for providers. AzLA also recommended that the Department amend the Enforcement Matrix (Table 1.2) to what they had suggested and provided to the Department during informal stakeholder meetings. Additional concerns included the need for a more detailed enforcement matrix and limitations on monitoring fees. AzLA urged ADHS to clarify and revise the rules. In response, the Department, thanked Roberts for the comments.

Diane Hyink submitted a comment to the Department in support of the rulemaking and shared a personal story of their family's experience navigating memory care services for their father, who had dementia. Despite choosing a facility that advertised specialized memory care, the family encountered serious issues, including inadequate behavior management, medication lapses, and a lack of support during a crisis following an elopement. These challenges resulted in multiple geriatric psychiatric hospitalizations and ultimately a 34-day stay due to the original facility's refusal to readmit him. They later found a dedicated memory care facility where their father received appropriate, compassionate care. Hyink supports the proposed rules and believes they are essential to ensure consistent standards, training, and safety measures for memory care services. The Department thanked Hyink for the comments, support, and for sharing their personal experiences with us.

Stephanie Smith submitted a comment to the Department in support of the rulemaking, emphasizing the critical need for specialized dementia training, person-centered care, and stronger oversight in facilities. Smith also shared a personal story regarding her father's experience and how dramatically dementia symptoms can vary. Smith supports the proposed rules and believes they are essential to ensure consistent standards, training, and safety measures for memory care services. The Department thanked Smith for the comments, support, and for sharing their personal experiences with us.

Steve Wagner submitted a comment in support of the memory care services rules. The comment highlighted the goals of HB2764 and expressed that the rules that allow effective enforcement and compliance in alignment with the bill.

The Arizona Health Care Cost Containment System (AHCCCS) AHCCCS appreciates the opportunity to comment on the proposed memory care regulations and emphasizes the importance of clarity and alignment with operational realities. Their comments included several suggestions to amend the rules. They suggested updating the definition of "opioid antagonist" to reflect over-the-counter availability, incorporating recruitment strategies into staff retention plans, and enhancing training with content on dementia-friendly environments. The Department let AHCCCS know that this amendment would be outside of the scope of this rulemaking. Other suggestions from AHCCCS included additional staff training topics for memory care services and include testing skills and knowledge from the training. The Department let AHCCCS know that A.A.C. R9-10-122(A)(1)(g)(ii) specifies that any additional relevant topics, which may include evidence-based information or facility-specific information. The topic list in A.A.C. R9-10-122(A)(1)(g)(ii)(15) are examples of training topics that would be appropriate. The intent of the rule was to be as flexible as possible and allow for a wide range of evidence-based topics. Furthermore, A.A.C. R9-10-122(A)(1)(e)(ii)(3) specifies that the testing method used to verify an individual has acquired the stated skills for each topic is required to be submitted to the Department in the application. AHCCCS also recommended amending the definition of 'elopement,' defining a clear explanation of controlled egress, defined as a safety measure in which
exit doors are designed to delay or restrict a resident's ability to leave a secured area, clearly state that accommodations and

progressive supports are intended to be individualized, and replace 'service needs' with 'individualized service needs.' The Department thanked AHCCCS for their comments and recommendations and let them know that the Department will discuss necessary amendments for the final rulemaking package.

Tory Roberg, representing the Alzheimer's Association, submitted comments strongly supporting the proposed rules, emphasizing that the changes are urgently needed to improve care. The comment commended the Department's stakeholder engagement efforts and urged final adoption of the rule package with several suggested non-substantive changes to improve clarity and alignment with evidence-based practices. The comment also highlighted the growing need for high-quality dementia care in Arizona due to the aging population and the prevalence of Alzheimer's, and it supports all proposed sections related to memory care, with specific recommendations to strengthen training curriculum, environmental design, and service planning to better align with nationally recognized Dementia Care Practice Recommendations. The Department thanked Roberg for the comments and support, and also stated that the Department would take into consideration the non-substantive suggested changes before submitting the final rulemaking package.

Brendon Blake, Director of Advocacy for AARP Arizona, expressed strong support for the proposed rules, thanking the Department for its collaborative approach and responsiveness to stakeholder input. The comment emphasized the importance of clearly defining and regulating memory care services, strengthening enforcement mechanisms to deter noncompliance, and including provisions around elopement prevention. AARP believes the rules strike a fair compromise and are a critical step toward improving care and accountability in long-term care settings, particularly for individuals with neurodegenerative conditions. The Department thanked Blake for the comments and support throughout this rulemaking process.

At the Oral Proceeding on April 8, 2025, 17 stakeholders attended, and 10 individuals provided formal oral comments on the rulemaking.

Diane Hyink, a member of the community and with the Alzheimer's Association, shared a personal story about her experience with her father in memory care and how important these rules are needed to ensure health and safety and proper memory care services. Hyink supports the proposed rules and mentioned that it is surprising that some of the new rules are not already current requirements.

Sean Mockbee, representing the Arizona Health Care Association, had questions related to implementation and the licensure title and also asked how does it look with adding memory care to the direct care license. The Department clarified that beds are specified to a specific level of care and everything would be considered for a directed care unit in comparison to supervisorial care. Furthermore, the Department explained that the way that the statute was written, memory care services are the same as directed care.

Dave Voepel with the Arizona Health Care Association asked the Department if the interpretation of memory care services being the same as directed care will be added to the rules. The Department clarified that directed care is defined in statute, and the

interpretation would not change unless there is a statute change.

Karen Barno with the Arizona Assisted Living Federation of America (AZALFA) brought up concerns with the implementation of the rules and becoming compliant as the rules transition. The Department clarified that per HB2764 the rules must be implemented by June 30, 2025 and the Department plans to provide technical assistance as needed.

Jaime Roberts with Arizona LeadingAge brought up that the stakeholder process discussion was that memory care would apply to all direct care and it appears that the rules have required a fourth level, then asked why is there a definition of memory care if there is no distinction. The Department referenced that the term "memory care" is defined in statute. The rules draft was amended to require that anyone with a direct care license would be required to be trained in memory care services. Roberts continued to ask questions about what if there is a resident who wants to age in place. The Department clarified that would be a personal level of care. Roberts had further questions regarding a locked facility and recommended that the rules be further amended to clarify that direct care be secured. Roberts also asked if the Department plans to go out to each direct care facility to ensure compliance with the new rules. The Department said yes, and that information can be provided as to where a resident can safely reside. Roberts stated that she believes there is a turn in how the Department is interpreting direct care. The Department thanked her for her comment and clarified that technical assistance with the rules and interpretation will be provided.

Sara Scolville-Weaver a member of the community and with the Alzheimer's Association, shared a personal story about her experience with memory care and finding services for her mother. Before choosing a facility, Sara Scolville-Weaver and her sister visited about 12 facilities before finding one they believed would be a good fit. The one they selected was in Chandler, their mother was placed in that facility for only three months while they experienced countless issues with the care received. There was not adequate staffing (1-15 staff ratio), lack of nutrition, lack of supervision, their mother walked so much that her feet bled every day from walking in a circular locked ward. Scolville-Weaver mentioned that she witnessed a woman in the hallway crawling for help on her hands and knees. When she would go to visit her mother, it was common to see her mother dirty, many times staff did not know where her mother was. When Scolville-Weaver would go to look for her mother she often found her mother in someone else's bed often with her pants soaked in urine. Another issue at the facility was that medication was not given regularly and many residents were not fed. When Scolville-Weaver took her mother out of the facility, her mother was left with a UTI and a blood clot. Scolville-Weaver expressed that she strongly supports the new memory care rules and believes they are necessary for health and safety.

Faye McNeeley, a member of the community and with the Alzheimer's Association, shared a personal story about her daughter who is 55 and has early on-site Alzheimer's and is unable to work due to her condition. McNeeley discussed the difficulties in searching for a day programs for Alzheimer patients and is concerned about her daughter's care. McNeeley mentioned that she does not believe that eight hours of initial training is enough. However, McNeeley stated she strongly supports the rules.

Marie Isaacson with Isaacson Law Firm representing Arizona LeadingAge asked for clarity on the statute regarding memory care and direct care. The Department clarified that any facility licensed up to direct care will receive memory care services training.

Isaacson asked for info on the Department encouraging facilities to be licensed to the highest care. The Department mentioned that we don't want to impose that burden on a facility if the facilities never plan to provide directed care services. Isaacson asked if this is a new interpretation. The Department said this is not a new interpretation, not as of 2018. Isaacson then asked the Department that if she is licensed as direct care but does not have direct care resident does she have to comply with the direct care rules. The Department let her know that yes she would be required to comply with the direct care rules. Isaacson further asked if there is an evaluation of the physical plant standards by the Department before licensure. The Department explained the physical plant standards and explained that newer facilities are able to hire an architect for licensure, and that the Department would also conduct an on-site inspection. Isaacson asked the Department if a facility was originally licensed and approved, but now receives a citation, is there a special dispensation for those facilities since there are new standards. The Department explained that this could be a case by case situation and the Department provides technical assistance when needed. Isaacson further stated that she believes R9-10-815 should not be a stand alone Section and should be deleted entirely and incorporated in the direct care rules. Isaacson also stated that there is a lot of duplication with training and with direct care and memory care. Furthermore, Isaacson is not happy with the term "sufficient staffing" and "adequate supervision," stating that this is subjective and creates a liability. Lastly, Isaacson stated that she does not believe that if a resident is a wonderer that they should not be in a locked area.

Kay Huff with the Arizona Health Care Association stated that at one point in time facilities were encouraged by the Department to be licensed for directed care at one time. At the time, those facilities were not required to follow the direct care rules if there were no direct care residents. Huff also suggested that the Department add several definitions to the rules, including physical harm and psychosocial harm. The Department acknowledges that prior to 2013, when the rules were under the office of assisted living licensure, the rules indicated that the controlled egress for directed care services was only required when the directed care services were being provided to a resident. However, the rules have been recodified since then and the rules are not written to have the same interpretation today.

Tory Roberg with the Alzheimer's Association stated comments expressing her appreciation and support for the rules and believes the rules as a whole are strong and will lead to good outcomes.

Brendon Blake with AARP Arizona thanked the Department for the rules and believes that the new rules will increase the quality of care. Blake also stated that he believes that the enforcement penalties are appropriate for the rules and is strong support of the rules being finalized as is.

13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

There are no other matters prescribed by statute applicable specifically to the Department or this specific rulemaking.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The Department does not use a general permit. The Department believes that under A.R.S. § 41-1037(A)(3) that a general permit is not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The rules are not related to federal laws.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

Not applicable

14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

Not applicable

15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

16. The full text of the rules follows:

Rule text begins on the next page.

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES –

HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 1. GENERAL

ARTICLE 8. ASSISTED LIVING FACILITIES

ARTICLE 1. GENERAL

R9-10-101. Definitions

In addition to the definitions in A.R.S. §§ 36-401(A) and 36-439, the following definitions apply in this Chapter unless otherwise specified:

1. "Abortion clinic" No change
2. "Abuse" No change
    a. No change
        i. No change
        ii. No change
    b. No change
    c. No change
    d. No change
3. "Accredited" No change
4. "Active malignancy" No change
    a. No change
        i. No change
        ii. No change
        iii. No change
    b. No change
    c. No change
5. "Activities of daily living" No change
6. "Acuity" No change
7. "Acuity plan" No change
8. "Adjacent" No change
    a. No change
    b. No change
9. "Administrative completeness review time-frame" No change
10. "Administrative office" No change
11. "Admission" or "admitted" No change
12. "Adult" No change
13. "Adult behavioral health therapeutic home" No change
14. "Adult residential care institution" No change
15. "Adverse reaction" No change
16. "Affiliated counseling facility" No change
17. "Affiliated outpatient treatment center" No change
18. "Alternate licensing fee due date" No change
19. "Ancillary services" No change
20. "Anesthesiologist" No change
    a. No change
    b. No change
    c. No change
    d. No change
21. "Applicant" No change
    a. No change

b. No change

c. No change

d. No change

22. “Application packet” No change

a. No change

b. No change

c. No change

d. No change

23. “Assessment” No change

24. “Assistance in the self-administration of medication” No change

25. “Attending physician” No change

26. “Authenticate” No change

a. No change

b. No change

c. No change

d. No change

27. “Authorized service” No change

28. “Available” No change

a. No change

b. No change

c. No change

29. “Behavioral care” No change

a. No change

i. No change

(1) No change

(2) No change

ii. No change

b. No change

30. “Behavioral health facility” No change

31. “Behavioral health inpatient facility” No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

32. “Behavioral health issue” No change

33. “Behavioral health observation/stabilization services” No change

a. No change

b. No change

c. No change

34. “Behavioral health paraprofessional” No change

a. No change

b. No change

35. "Behavioral health professional" No change

a. No change

i. No change

ii. No change

b. No change

c. No change

d. No change

e. No change

f. No change

g. No change

36. "Behavioral health residential facility" No change

a. No change

b. No change

37. "Behavioral health respite home" No change

38. "Behavioral health specialized transitional facility" No change

39. "Behavioral health technician" No change

a. No change

b. No change

40. "Benzodiazepine" No change

41. "Biohazardous medical waste" No change

42. "Calendar day" No change

43. "Case manager" No change

44. "Certification" No change

45. "Certified health physicist" No change

46. "Change in ownership" No change

47. "Chief administrative officer" or "administrator" No change

48. "Clinical laboratory services" No change

49. "Clinical oversight" No change

a. No change

b. No change

c. No change

d. No change

50. "Clinical privileges" No change

51. "Collaborating health care institution" No change

a. No change

b. No change

52. "Common area" No change

a. No change

b. No change

c. No change

53. "Communicable disease" No change

54. "Conspicuously posted" No change

a. No change

b. No change

55. “Consultation” No change
56. “Contracted services” No change
57. “Contractor” No change
58. “Controlled substance” No change
59. “Counseling” No change
60. “Counseling facility” No change

a. No change

b. No change

61. “Court-ordered evaluation” No change
62. “Court-ordered treatment” No change
63. “Crisis services” No change
64. “Current” No change
65. “Daily living skills” No change
66. “Danger to others” No change
67. “Danger to self” No change
68. “Detoxification services” No change

a. No change

b. No change

69. “Diagnostic procedure” No change
70. “Dialysis” No change
71. “Dialysis services” No change
72. “Dialysis station” No change
73. “Dialyzer” No change
74. “Disaster” No change
75. “Discharge” No change
76. “Discharge instructions” No change
77. “Discharge planning” No change
78. “Discharge summary” No change
79. “Disinfect” No change
80. “Documentation” or “documented” No change
81. “Drill” No change
82. “Drug” No change
83. “Electronic” No change
84. “Electronic signature” No change
85. “Emergency” No change
86. “Emergency medical services provider” No change
87. “Emergency services” No change
88. “End-of-life” No change
89. “Environmental services” No change
90. “Equipment” No change
91. “Exploitation” No change

92. “Factory-built building” No change

93. “Family” or “family member” No change

94. “Follow-up instructions” No change

95. “Food services” No change

96. “Full-time” No change

97. “Garbage” No change

98. “General consent” No change

99. “General hospital” No change

100. “Gravely disabled” No change

101. “Habilitation services” No change

102. “Hazard” or “hazardous” No change

103. “Health care directive” No change

104. “Hemodialysis” No change

105. “Home health agency” No change

106. “Home health aide” No change

107. “Home health aide services” No change

108. “Home health services” No change

109. “Hospice inpatient facility” No change

110. “Hospital” No change

111. “Immediate” No change

112. “Immediate jeopardy” means a situation in which a patient or resident has suffered or is likely to suffer serious injury, serious harm, serious impairment, or death as a result of a licensee's noncompliance with one or more health and safety requirements.

~~112.~~113. “Incident” means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:

a. On the premises of a health care institution, or

b. Not on the premises of a health care institution but directly receiving physical health services or behavioral health ser-vices from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.

~~113.~~114. “Infection control” means to identify, prevent, monitor, and minimize infections.

~~114.~~115. “Infectious tuberculosis” has the same meaning as “infectious active tuberculosis” in A.A.C. R9-6-101.

~~115.~~116. “Informed consent” means:

a. Advising a patient of a proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic proce-dure; alternatives to the treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; and associated risks and possible complications; and

b. Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure from the patient or the patient’s representative.

~~116.~~117. “In-service education” means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.

~~117.~~118. “Interdisciplinary team” means a group of individuals consisting of a resident’s attending physician, a registered nurse responsible for the resident, and other individuals as determined in the resident’s comprehensive assessment or, if applicable, placement evaluation.

~~118.~~119. “Intermediate care facility for individuals with intellectual disabilities” or “ICF/IID” has the same meaning as in A.R.S. § 36-551.

~~119.~~120. “Interval note” means documentation updating a patient’s:

a. Medical condition after a medical history and physical examination is performed, or

b. Behavioral health issue after an assessment is performed.

~~120.~~121. "Isolation" means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.

~~121.~~122. "Leased facility" means a facility occupied or used during a set time period in exchange for compensation.

~~122.~~123. "License" means:

a. Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or

b. Written approval issued to an individual to practice a profession in this state.

~~123.~~124. "Licensed occupancy" means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.

~~124.~~125. "Licensee" means an owner approved by the Department to operate a health care institution.

~~125.~~126. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.

~~126.~~127. "Medical condition" means the state of a patient's physical or mental health, including the patient's illness, injury, or disease.

~~127.~~128. "Medical director" means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.

~~128.~~129. "Medical history" means an account of a patient's health, including past and present illnesses, diseases, or medical conditions.

~~129.~~130. "Medical practitioner" means a physician, physician assistant, or registered nurse practitioner.

~~130.~~131. "Medical record" has the same meaning as "medical records" in A.R.S. § 12-2291.

~~131.~~132. "Medical staff" means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.

~~132.~~133. "Medical staff bylaws" means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.

~~133~~134. "Medical staff member" means an individual who is part of the medical staff of a health care institution.

~~134.~~135. "Medication" means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:

a. Biologicals as defined in A.A.C. R18-13-1401,

b. Prescription medication as defined in A.R.S. § 32-1901, or

c. Nonprescription drug as defined in A.R.S. § 32-1901.

~~135.~~136. "Medication administration" means restricting a patient's access to the patient's medication and providing the medication to the patient or applying the medication to the patient's body, as ordered by a medical practitioner.

~~136.~~137. "Medication error" means:

a. The failure to administer an ordered medication;

b. The administration of a medication not ordered; or

c. The administration of a medication:

i. In an incorrect dosage,

ii. More than 60 minutes before or after the ordered time of administration unless ordered to do so, or

iii. By an incorrect route of administration.

~~137.~~138. "Mental disorder" means the same as in A.R.S. § 36-501.

~~138.~~139. "Mobile clinic" means a movable structure that:

a. Is not physically attached to a health care institution's facility;

b. Provides medical services, nursing services, behavioral health services, or health related service to an outpatient under the direction of the health care institution's personnel; and

c. Is not intended to remain in one location indefinitely.

~~139.~~140. "Monitor" or "monitoring" means to check systematically on a specific condition or situation.

~~140.~~141. "Neglect" has the same meaning:

a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and

b. For an individual 18 years of age or older, as in A.R.S. § 46-451.

~~141.~~142. "Nephrologist" means a physician who is board eligible or board certified in nephrology by a professional credentialing board.

~~142.~~143. "Nurse" has the same meaning as "registered nurse" or "practical nurse" as defined in A.R.S. § 32-1601.

~~143.~~144. "Nursing care institution administrator" means an individual licensed according to A.R.S. Title 36, Chapter 4, Article 6.

~~144.~~145. "Nursing personnel" means individuals authorized according to A.R.S. Title 32, Chapter 15 to provide nursing services.

~~145.~~146. "Observation chair" means a physical piece of equipment that:

a. Is located in a designated area where behavioral health observation/stabilization services are provided,

b. Allows an individual to fully recline, and

c. Is used by the individual while receiving crisis services.

~~146.~~147. "Occupational therapist" has the same meaning as in A.R.S. § 32-3401.

~~147.~~148. "Occupational therapy assistant" has the same meaning as in A.R.S. § 32-3401.

~~148.~~149. "Ombudsman" means a resident advocate who performs the duties described in A.R.S. § 46-452.02.

~~149.~~150. "On-call" means a time during which an individual is available and required to come to a health care institution when requested by the health care institution.

~~150.~~151. "Opioid" means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of "opiate" in A.R.S. § 36-2501.

~~151.~~152. "Opioid agonist treatment medication" means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of ~~premises~~ opioid-related substance use disorder.

~~152.~~153. "Opioid antagonist" means a prescription medication, as defined in A.R.S. § 32-1901, that:

a. Is approved by the U.S. Department of Health and Human Services, Food and Drug Administration; and

b. When administered, reverses, in whole or in part, the pharmacological effects of an opioid in the body.

~~153.~~154. "Opioid treatment" means providing medical services, nursing services, behavioral health services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opioid-related substance use disorder.

~~154.~~155. "Order" means instructions to provide:

a. Physical health services to a patient from a medical practitioner or as otherwise provided by law; or

b. Behavioral health services to a patient from a behavioral health professional.

~~155.~~156. "Orientation" means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.

~~156.~~157. "Outing" means a social or recreational activity that:

a. Occurs away from the premises,

b. Is not part of a behavioral health inpatient facility's or behavioral health residential facility's daily routine, and

c. Lasts longer than four hours.

~~157.~~158. "Outpatient surgical center" means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia ser-vices to a patient whose recovery, in the opinions of the patient's surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.

~~158.~~159. "Outpatient treatment center" means a class of health care institution without inpatient beds that provides physical health services, or physical health services and behavioral health services, including medication services for the diagnosis and treatment of patients.

~~159.~~160. "Overall time-frame" means the same as in A.R.S. § 41-1072.

~~161.~~161. "Owner" means a person who appoints, elects, or designates a health care institution's governing authority.

~~161.~~162. “Pain management clinic” has the same meaning as in A.R.S. § 36-448.01.

~~162.~~163. “Participant” means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.

~~163.~~164. “Participant’s representative” means the same as “patient’s representative” for a participant.

~~164.~~165. “Patient” means an individual receiving physical health services or behavioral health services from a health care institution.

~~165.~~166. “Patient’s representative” means:

a. A patient’s legal guardian;

b. If a patient is less than 18 years of age and not an emancipated minor, the patient’s parent;

c. If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient’s legal guardian; or

d. A surrogate as defined in A.R.S. § 36-3201.

~~166.~~167. “Person” means the same as in A.R.S. § 1-215 and includes a governmental agency.

~~167.~~168. “Personnel member” means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.

~~168.~~169. “Pest control program” means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient’s health and safety is not at risk.

~~169.~~170. “Pharmacist” has the same meaning as in A.R.S. § 32-1901.

~~170.~~171. “Physical examination” means to observe, test, or inspect an individual’s body to evaluate health or determine the cause of illness, injury, or disease.

~~171.~~172. “Physical health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s medical condition.

~~172.~~173. “Physical therapist” has the same meaning as in A.R.S. § 32-2001.

~~173.~~174. “Physical therapist assistant” has the same meaning as in A.R.S. § 32-2001.

~~174.~~175. “Physician assistant” has the same meaning as in A.R.S. § 32-2501.

~~175.~~176. “Placement evaluation” means the same as in A.R.S. § 36-551.

~~176.~~177. “Pre-petition screening” has the same meaning as “prepetition screening” in A.R.S. § 36-501.

~~177.~~178. “Premises” means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a resident or patient.

~~178.~~179. “Prescribe” means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user’s behalf, a specific dose of a specific medication in a specific quantity and route of administration.

~~179.~~180. “Professional credentialing board” means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.

~~180.~~181. “Progress note” means documentation by a medical staff member, nurse, or personnel member of:

a. An observed patient response to a physical health service or behavioral health service provided to the patient,

b. A patient’s significant change in condition, or

c. Observed behavior of a patient related to the patient’s medical condition or behavioral health issue.

~~181.~~182. “PRN” means pro re nata or given as needed.

~~182.~~183. “Project” means specific construction or modification of a facility stated on an architectural plans and specifications approval application.

~~183.~~184. “Provider” means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual’s place of residence.

~~184.~~185. “Provisional license” means the Department’s written approval to operate a health care institution issued to an applicant or licensee that is not in substantial compliance with the applicable laws and rules for the health care institution.

~~185.~~186. “Psychotropic medication” means a chemical substance that:

a. Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and

b. Is provided to a patient to address the patient’s behavioral health issue.

~~186.~~187. “Quality management program” means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.

~~187.~~188. “Recovery care center” has the same meaning as in A.R.S. § 36-448.51.

~~188.~~189. “Referral” means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.

~~189.~~190. “Registered dietitian” means an individual approved to work as a dietitian by the American Dietetic Association’s Commission on Dietetic Registration.

~~190.~~191. “Registered nurse” has the same meaning as in A.R.S. § 32-1601.

~~191.~~192. “Registered nurse practitioner” has the same meaning as A.R.S. § 32-1601.

~~192.~~193. “Regular basis” means at recurring, fixed, or uniform intervals.

~~193.~~194. “Rehabilitation services” means medical services provided to a patient to restore or to optimize functional capability.

~~194.~~195. “Research” means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.

~~195.~~196. “Resident” means an individual living in and receiving physical health services or behavioral health services, including rehabilitation services or habilitation services if applicable, from a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.

~~196.~~197. “Resident’s representative” means the same as “patient’s representative” for a resident.

~~197.~~198. “Respiratory care services” has the same meaning as “practice of respiratory care” as defined in A.R.S. § 32-3501.

~~198.~~199. “Respiratory therapist” has the same meaning as in A.R.S. § 32-3501.

~~199.~~200. “Respite capacity” means the total number of children who do not stay overnight for whom an outpatient treatment center or a behavioral health residential facility is authorized by the Department to provide respite services on the premises of the outpatient treatment center or behavioral health residential facility.

~~200.~~201. “Respite services” means respite care services provided to an individual who is receiving behavioral health services.

~~201.~~202. “Restraint” means any physical or chemical method of restricting a patient’s freedom of movement, physical activity, or access to the patient’s own body.

~~202.~~203. “Risk” means potential for an adverse outcome.

~~203.~~204. “Room” means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.

~~204.~~205. “Rural general hospital” means a subclass of hospital:

a. Having 50 or fewer inpatient beds,

b. Located more than 20 surface miles from a general hospital or another rural general hospital, and

c. Requesting to be and being licensed as a rural general hospital rather than a general hospital.

~~205.~~206. “Satellite facility” has the same meaning as in A.R.S. § 36-422.

~~206.~~207. “Scope of services” means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.

~~207.~~208. “Seclusion” means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.

~~208.~~209. “Sedative-hypnotic medication” means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.

~~209.~~210. “Self-administration of medication” means a patient having access to and control of the patient’s medication and may include the patient receiving limited support while taking the medication.

~~210.~~211. “Sexual abuse” means the same as in A.R.S. § 13-1404(A).

~~211.~~212. “Sexual assault” means the same as in A.R.S. § 13-1406(A).

~~212.~~213. “Shift” means the beginning and ending time of a continuous work period established by a health care institution’s policies and procedures.

~~213.~~214. “Short-acting opioid antagonist” means an opioid antagonist that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.

~~214.~~215. “Signature” means:

a. A handwritten or stamped representation of an individual’s name or a symbol intended to represent an individual’s name, or

b. An electronic signature.

~~215.~~216. “Significant change” means an observable deterioration or improvement in a patient’s physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.

~~216.~~217. “Single group license” means a license that includes authorization to operate health care institutions according to A.R.S. § 36-422(F) or (G).

~~217.~~218. “Speech-language pathologist” means an individual licensed according to A.R.S. Title 36, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.

~~218.~~219. “Special hospital” means a subclass of hospital that:

a. Is licensed to provide hospital services within a specific branch of medicine; or

b. Limits admission according to age, gender, type of disease, or medical condition.

~~219.~~220. “Student” means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.

~~220.~~221. “Substance abuse” means an individual’s misuse of alcohol or other drug or chemical that:

a. Alters the individual’s behavior or mental functioning;

b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and

c. Impairs, reduces, or destroys the individual’s social or economic functioning.

~~221.~~222. “Substance abuse transitional facility” means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.

~~222.~~223. “Substance use disorder” means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.

~~223.~~224. “Substance use risk” means an individual’s unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.

~~224.~~225. “Substantial” when used in connection with a modification means:

a. An addition or removal of an authorized service;

b. The addition or removal of a colocator;

c. A change in a health care institution’s licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;

d. A change in the physical plant, including facilities or equipment, that costs more than $300,000; or

e. A change in the building where a health care institution is located that affects compliance with:

i. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or

ii. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.

~~225.~~226. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.

~~226.~~227. "Supportive services" has the same meaning as in A.R.S. § 36-151.

~~227.~~228. "Surgical procedure" means the excision of or incision in a patient's body for the:

a. Correction of a deformity or defect;

b. Repair of an injury; or

c. Diagnosis, amelioration, or cure of disease.

~~228.~~229. "Swimming pool" has the same meaning as "semipublic swimming pool" in A.A.C. R18-5-201.

~~229.~~230. "System" means interrelated, interacting, or interdependent elements that form a whole.

~~230.~~231. "Tapering" means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.

~~231.~~232. "Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.

~~232.~~233. "Telemedicine" has the same meaning as in A.R.S. § 36-3601.

~~233.~~234. "Therapeutic diet" means foods or the manner in which food is to be prepared that are ordered for a patient.

~~234.~~235. "Therapist" means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.

~~235.~~236. "Time-out" means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.

~~236.~~237. "Transfer" means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending health care institution.

~~237.~~238. "Transport" means a licensed health care institution:

a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or

b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.

~~238.~~239. "Treatment" means a procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.

~~239.~~240. "Treatment plan" means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.

~~240.~~241. "Unclassified health care institution" means a health care institution not classified or subclassified in statute or in rule.

~~241.~~242. "Vascular access" means the point on a patient's body where blood lines are connected for hemodialysis.

~~242.~~243. "Volunteer" means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.

~~243.~~244. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.

R9-10-102. Health Care Institution Classes and Subclasses; Requirements

A. No change

1. No change
2. No change
3. No change

4. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change
11. No change
12. No change
13. No change
14. No change
15. No change
16. No change
17. No change
18. No change
19. No change
20. No change
21. No change
22. No change
23. No change
24. No change
25. No change
26. No change

B. No change

C. No change

D. No change

1. No change
2. No change

E. The Department may conduct on-site monitoring inspections of health care institutions that are found to not be in substantial compliance with the applicable licensure requirements specified in this Chapter, as outlined in Table 1.2.

R9-10-106. Fees

A. No change

1. No change
2. No change
3. No change

B. No change

C. No change

1. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change

2. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
3. No change
4. No change
   a. No change
   b. No change
   c. No change
   d. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
6. No change
7. No change
   a. No change
   b. No change

D. No change

E. No change

F. No change

G. No change

H. The Department may charge up to $1,000 per visit for an on-site monitoring inspection fee, as determined by a provider agreement or notice, according to A.R.S. § 36-405(D).

I. If the Department provides in-service training to a health care institution that requests in-service training relating to regulatory compliance outside of the survey process, the Department may charge up to $500 an hour for the in-service training, according to A.R.S. § 36-405(E).

R9-10-111. Enforcement Actions

A. If the Department determines that an applicant or licensee is violating applicable statutes ~~and~~ or rules, the Department may take action according to A.R.S. Title 36, Chapter 4, R9-10-112 or, Table 1.2.~~:~~

~~1. Issue a provisional license to the applicant or licensee under A.R.S. § 36-425,~~

~~2. Assess a civil penalty under A.R.S. § 36-431.01,~~

~~3. Impose an intermediate sanction under A.R.S. § 36-427,~~

~~4. Remove a licensee and appoint another person to continue operation of the health care institution pending further action under A.R.S. § 36-429,~~

~~5. Suspend or revoke a license under A.R.S. § 36-427 and R9-10-112,~~

~~6. Deny a license under A.R.S. § 36-425 and R9-10-112, or~~

~~7. Issue an injunction under A.R.S. § 36-430.~~

~~**B.** In determining which action in subsection (A) is appropriate, the Department shall consider the direct risk to the life, health, or safety of a patient in the health care institution based on:~~

~~1. Repeated violations of statutes or rules,~~

~~2. Pattern of violations,~~

~~3. Types of violation,~~

~~4. Severity of violation, and~~

~~5. Number of violations.~~

B. The Department may impose civil money penalties on a licensed health care institution that violates Title 36 or this Chapter, with penalties assessed per resident or patient impacted by the violation as determined by the Department based on the following factors:

1. The civil penalty may be up to $1,000 per violation, pursuant to A.R.S. § 36-431.01, if one or more of the following aggravating factors apply:
   a. The violation is repeated;
   b. Actual harm occurred;
   c. The violation poses a potential threat for actual harm or to health and safety, including to patients, staff, or residents;
   d. Immediate jeopardy exists due to the type and severity of the violation;
   e. The licensee fails to correct the violation in a reasonable timely manner, which may be a threat to health and safety;
   f. The length of time the violation occurred;
   g. Patterns of noncompliance; or
   h. The total number of violations; and
2. In determining the final penalty, the Department shall consider and reduce the penalty if one or more of the following mitigating factors apply:
   a. The violation was isolated,
   b. No actual harm occurred,
   c. No immediate jeopardy was present,
   d. The facility reported the violation to the Department,
   e. The facility promptly corrected the violation,
   f. The number of persons affected by the violation,
   g. The size of the facility and the financial impact of the penalty, or
   h. The length of time the violation occurred.

R9-10-121. Disease Prevention and Control

A. No change

1. No change
2. No change

B. No change

1. No change
2. No change
3. No change

C. No change

1. No change

2. No change

3. No change

4. No change

D. An administrator or manager, as applicable, shall ensure that:

1. Except as provided in subsection (E), before entering the facility, each individual, including a personnel member, employee, or visitor, is screened for fever or respiratory symptoms indicative of a communicable disease;

2. If an individual refuses to be screened, the individual is excluded from entry to the facility;

3. If an individual is determined to have a fever or respiratory symptoms, the individual is excluded from entry to the facility until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner;

4. If an individual, other than a resident, develops a fever or respiratory symptoms while in the facility, the individual is required to leave the facility and not return until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner; and

5. If insufficient personnel members are available to meet the needs of all residents in the facility, the administrator or manager, as applicable, implements the disaster plan required in R9-10-424, R9-10-523, or ~~R9-10-818~~ R9-10-819, as applicable, which may include moving a resident to a different facility.

E. No change

F. No change

1. No change

2. No change

a. No change

b. No change

i. No change

ii. No change

c. No change

i. No change

ii. No change

d. No change

i. No change

ii. No change

e. No change

G. No change

1. No change

2. No change

3. No change

R9-10-122. Memory Care Services Training Program Application and Renewal

A. An applicant shall apply for approval to operate a memory care services training program by submitting:

1. An application in a Department-provided format that contains:

a. The name of the entity;

b. The name, telephone number, and e-mail address of the individual in charge of the proposed memory care services training program;

c. The address where the memory care services training program records are maintained;

d. The address and telephone number of each facility from which training services will be provided;

e. A description of the minimum eight hours of initial memory care services training for staff and contractors, that includes:

i. One of the following:

(1) Dementia care training curriculum from a nationally recognized organization; or

(2) The evidence-based information presented for each of the following required topics, along with any additional relevant topics:

aa. Understanding cognitive impairments and the impact on residents, including the progression of the neurodegenerative disease;

bb. Communication techniques with cognitively impaired residents;

cc. Managing challenging behaviors such as aggression, wandering, and agitation;

dd. Techniques for promoting dignity, comfort, and emotional well-being of residents;

ee. Implementation of individualized service planning for residents receiving memory care services;

ff. Emergency and safety protocols specific to memory care;

gg. Recognizing, preventing, and reporting abuse, neglect, or exploitation;

hh. Activities of daily living specific to residents receiving memory care services;

ii. Palliative care and end-of-life training; and

jj. Medication management and administration; and

ii. In addition to R9-10-122(A)(1)(e)(i):

(1) The amount of time allotted to each topic,

(2) The skills an individual is expected to acquire for each topic, and

(3) The testing method used to verify an individual has acquired the stated skills for each topic;

f. A description of the minimum four hours of annual memory care services training for staff and contractors, including:

i. The evidence-based information presented for each of the following required topics, along with any additional relevant topics:

(1) Managing challenging behaviors such as aggression, wandering, and agitation;

(2) Techniques for promoting dignity, comfort, and emotional well-being of residents;

(3) Recognizing, preventing, reporting abuse, neglect, or exploitation; and

(4) Implementation of individualized service planning for residents receiving memory care services;

ii. The amount of time allotted to each topic;

iii. The skills an individual is expected to acquire for each topic; and

iv. The testing method used to verify an individual has acquired the stated skills for each topic;

g. A description of the minimum four hours of memory care services training for a manager, including:

i. The evidence-based information presented for each of the following required topics:

(1) Development and implementation of individualized service planning for residents receiving memory care services, and

(2) Staffing levels and resource allocation;

ii. Any additional relevant topics, which may include evidence-based information or facility-specific information, such as:

(1) Supervisory skills for leading interdisciplinary teams;

(2) Effective delegation and team-building strategies;

(3) Conflict resolution and managing workplace dynamics;

(4) In-depth understanding of state regulations specific to memory care services;

(5) Monitoring care outcomes and resident satisfaction;

(6) Engaging with families during crises or challenging situations;

(7) Leading meetings and facilitating collaboration among staff;

(8) Advocacy for residents and families;

(9) Coaching and mentoring staff for professional growth;

(10) Staying updated on advancements in dementia care;

(11) Developing emergency protocols;

(12) Cultural competency to ensure inclusivity and sensitivity in care;

(13) Strategies to improve staff retention and job satisfaction;

(14) Supporting mental health and wellness among team members;

(15) Room assignments, operations, and environmental standards; or

(16) Identification and implementation of control measures for infectious diseases;

iii. The amount of time allotted to each topic;

iv. The skills an individual is expected to acquire for each topic; and

v. The testing method used to verify an individual has acquired the stated skills for each topic;

h. Whether the applicant agrees to allow the Department to submit supplemental requests for information as specified in subsection (H)(2); and

i. The signature of the individual in charge of the proposed memory care services training program and the date signed; and

2. A copy of the materials used for providing the memory care services training program.

B. The memory care services training program shall include in-person components and may incorporate online components. The in-person component shall include a demonstration of the individual's skills and knowledge necessary to provide memory care services.

C. The memory care services training program shall review the topics and materials provided in the memory care services training at least once every 12 months to ensure the information is current and evidence-based, and if necessary, update the materials based on the most up-to-date source(s) for evidence-based practice(s).

D. For annual renewal, at least 60 days before the expiration of approval, a memory care services training program shall submit to the Department, in a Department-provided format:

1. The memory care services training program's approval number; and

2. The information in subsection (A).

E. For an application for an approval of a memory care services training program, the administrative review time-frame is 30 calendar days, the substantive review time-frame is 30 calendar days, and the overall time-frame is 60 calendar days.

F. Within 30 calendar days after the receipt of an application in subsection (A), the Department shall:

1. Issue an approval of the applicant's memory care services training program;

2. Provide a notice of administrative completeness to the applicant that submitted the application; or

3. Provide a notice of deficiencies to the applicant that submitted the application, including a list of the information or documents needed to complete the application.

G. If the Department provides a notice of deficiencies to an applicant:

1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant;
2. If the applicant does not submit the missing information or documents to the Department within 30 calendar days, the Department shall consider the application withdrawn; and
3. If the applicant submits the missing information or documents to the Department within 30 calendar days, the substantive review time-frame begins on the date the Department receives the missing information or documents.

H. Within the substantive review time-frame, the Department:

1. Shall issue or deny an approval of a memory care services training program; and
2. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.

I. If the Department issues a written comprehensive request or a supplemental request for information:

1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives the information requested, and
2. The applicant shall submit to the Department the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

J. The Department shall issue:

1. An approval for an applicant to operate a memory care services training program if the Department determines that the applicant and the application comply with A.R.S. § 36-405.03 and this Section, or
2. A denial for an applicant that includes the reason for the denial and the process for appeal of the Department's decision if:
   a. The Department determines that the applicant does not comply with A.R.S. § 36-405.03 and this Section, or
   b. The applicant does not submit information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

K. The Department may deny, revoke, or suspend an approval to operate a memory care services training program if a memory care services training program provider or an applicant applying to operate a memory care services training program:

1. Provides false or misleading information to the Department,
2. Does not comply with the applicable statutes and rules,
3. Issues a training certificate of completion to an individual who did not,
   a. Complete the memory care services training program, or
   b. Demonstrate the skills the individual was expected to acquire, or
4. Does not implement the memory care services training program as described in or use the materials submitted with the application.

L. In determining which action in subsection (K) is appropriate, the Department shall consider the following:

1. Repeated violations of statutes or rules,
2. Pattern of non-compliance,
3. Types of violations,
4. Severity of violations, and
5. Number of violations.

R9-10-123. Notification of Change

A. A memory care services training program provider shall notify the Department in writing at least 30 days before the effective date of:

1. Termination of the provision of the memory care services training program, or
2. A change in the:
   a. Name under which the memory care services training program provider does business,
   b. Address or telephone number of a facility where memory care services trainings are provided,
   c. Administrator, or
   d. Memory care services training program topics provided, and

B. The Department shall review the notification of change for subsection (A) and:

1. If the information complies with the requirements in this Article, the Department shall approve the change, or
2. If the information does not comply with the requirements in this Article, the Department shall send notification to the memory care services training program provider with reasons for the determination of non-compliance.

C. The Department may conduct an on-site inspection as part of the notification of change process.

D. The memory care services training program provider retains the existing expiration date of the application approval.

R9-10-124. Administration, Monitoring

A. A memory care services training program provider shall designate an administrator who meets the qualifications established by the memory care services training program provider.

B. An applicant or memory care services training program provider shall provide the Department access to records and all areas of a facility according to A.R.S. § 41-1009 within two hours after the Department's request.

R9-10-125. Memory Care Services Trainer Eligibility

A. An individual is eligible to be a memory care services trainer if the individual:

1. Is a registered nurse with:
   a. A Certified Dementia Practitioner (CDP) or an equivalent certification, demonstrating knowledge in dementia care best practices and behavioral management;
   b. An Alzheimer's Disease and Dementia Care Training (ADCT) certification or an equivalent program recognized by a national or state accrediting body;
   c. A Gerontological Nurse Certification (RN-BC) issued by the American Nurses Credentialing Center or an equivalent certification specializing in the care of older adults;
   d. An End-of-Life and Palliative Care Certification from a recognized body, emphasizing care for late-stage dementia and end-of-life situations; or
   e. Two years of experience providing memory care services; or
2. Has a current memory care services certificate of completion.

B. An individual, who is not a registered nurse, is eligible to become a memory care services trainer,

1. If the individual has a:
   a. Bachelor's degree or higher in a relevant field, including but not limited to:
      i. Gerontology,
      ii. Psychology,
      iii. Social Work,
      iv. Education, or
      v. Nursing-related disciplines; or
   b. Minimum of three years of direct experience in memory care, dementia care, or a related field, such as:
      i. Providing care for individuals with Alzheimer's disease or other forms of dementia, or
      ii. Developing and implementing memory care programs; and

2. Holds one or more of the following certifications:
   a. Certified Dementia Practitioner (CDP),
   b. Certified Alzheimer's Disease and Dementia Care Trainer (CADDCT),
   c. Certified Activity Director (ADC) with a specialization in memory care, or
   d. Any equivalent certification recognized by a national accrediting body;
3. Demonstrates experience in adult education or staff training, including:
   a. Conducting workshops, seminars, or training sessions in a health care or memory care setting; or
   b. Developing training materials specific to memory care;
4. Has completed cultural competency training to ensure inclusivity and sensitivity in care and training approaches;
5. Possesses strong communication skills and the ability to tailor training to diverse audiences, including care staff and family members; or
6. Has a valid certificate of completion issued according to R9-10-126.

C. An individual is ineligible to become a memory care services trainer if the individual has:
1. A history of substantiated allegation(s) of abuse, neglect, or exploitation of vulnerable individual(s); or
2. A record of disciplinary action(s) related to professional misconduct.

R9-10-126. Memory Care Services Certificate of Completion

A. Memory care services training programs, approved by the Department according to R9-10-122, shall provide staff and contractors who complete the training, a certificate of completion that may be used to work at an assisted living facility that is licensed to provide directed care services with the following information:
1. The title of the certificate is clearly stated as, "Certificate of Completion";
2. The name, address, e-mail address, and telephone number of the individual completing the memory care services training;
3. Title of the training program;
4. Name of the training organization or provider;
5. Contact information for the training organization;
6. The date the individual successfully completed the memory care services training;
7. The address where the memory care services training and assessment was held;
8. The name of the memory care services trainer;
9. The number of hours completed;
10. The training topics covered;
11. A statement confirming the trainee's successful completion of the training;
12. Signature of the trainer; and
13. Date of issuance.

B. A memory care services trainer shall ensure that each individual seeking a memory care services certificate of completion has completed comprehensive training, demonstrated understanding of the topics covered in R9-10-122(A), and achieved a passing score of at least 70% on an examination covering the applicable topics.

C. The memory care services training program and an assisted living facility providing memory care services shall maintain a record of the certificate of completion that is kept on file and available with the information specific in subsection (A).

D. A memory care services trainer shall comply with:
1. A.R.S. § 36-405.03, and
2. Applicable requirements in this Article.

E. A Department-approved training program shall issue the certificate of completion to the individual who has successfully completed the training program within 10 calendar days of completion.

F. An assisted living facility may accept a certificate of completion issued under this section if:

1. The certificate is issued by a Department-approved training program; and
2. The certificate holder does not have a lapse of working at an assisted living facility that is licensed to provide directed care services for a period of 12 or more consecutive months, pursuant to A.R.S. § 36-405.03.

G. Before the date of issuance of a memory care services certificate of completion, an individual seeking the certificate shall complete the minimum eight hours of initial memory care services training and complete the minimum four hours of annual continuing education training within the preceding 12 consecutive months and achieve a passing score of at least 70% on an examination covering the memory care services training topics specified in R9-10-122(A).

Table 1.2. Violation Severity and Remedy Matrix

Severity Level	Criteria	Action
Level 1	If the violation is isolated and has no actual physical or psychosocial harm with no potential of physical or psychosocial harm.	Technical Assistance, or Written plan of correction.
Level 2	If the violation is isolated and has no actual physical or psychosocial harm, with potential for minimal physical or psychosocial harm.	Written plan of correction, Provider agreement, or Civil money penalties up to $500.
Level 3	If the violation is isolated and has no actual physical or psychosocial harm, with potential for more than minimal physical or psychosocial harm.	Written plan of correction, Directed plan of correction, Provider agreement, On-site monitoring inspection fee up to $500, or Civil money penalties up to $1,000.
Level 4	The violation resulted in actual physical or psychosocial harm that is not immediate jeopardy; The licensee provided false or misleading information; The licensee fails to correct the violation in a reasonable timely manner, which may be a threat to health and safety; or If the violation is repeated, or if there is a pattern with no actual physical or psychosocial harm, with potential for minimal or more than minimal physical or psychosocial harm.	Written plan of correction, On-site plan of correction, or Provider agreement. On-site monitoring inspection fee up to $750, Civil money penalties, Suspension, Intermediate sanctions, or Revocation.
Level 5	Immediate jeopardy to health and safety.	Directed plan of correction; Provider agreement; On-site monitoring inspection fee up to $1,000; Civil money penalties; Suspension; Intermediate sanctions; Revocation; or Other remedies, as applicable, in Title 41, Chapter 6.

ARTICLE 8. ASSISTED LIVING FACILITIES

R9-10-801. Definitions

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

1. "Accept" or "acceptance" No change
   a. No change
   b. No change
2. "Assistant caregiver" No change
3. "Assisted living services" means supervisory care services, personal care services, directed care services, behavioral care, memory care services, or ancillary services provided to a resident by or on behalf of an assisted living facility.
4. "Caregiver" No change
5. "Elopement" means when a resident who is cognitively, physically, mentally, emotionally, or chemically impaired wanders away, walks away, runs away, or otherwise leaves the premises of an assisted living facility authorized to provide directed care services unsupervised or unnoticed, without the knowledge of the licensee's personnel.

~~5.~~6. "Manager" means an individual designated by a governing authority to act on behalf of the governing authority in the ~~onsite~~ on-site management of the assisted living facility.

~~6.~~7. "Medication organizer" means a container that is designed to hold doses of medication and is divided according to date or time increments.

8. "Memory care services" means the same as defined in A.R.S. § 36-405.03(D).

~~7.~~9. "Primary care provider" means a physician, a physician's assistant, or registered nurse practitioner who directs a resident's medical services.

~~8.~~10. "Residency agreement" means a document signed by a resident or the resident's representative and a manager, detailing the terms of residency.

~~9.~~11. "Service plan" means a written description of a resident's need for supervisory care services, personal care services, directed care services, ancillary services, or behavioral health services and the specific assisted living services to be provided to the resident.

~~10.~~12. "Termination of residency" or "terminate residency" means a resident is no longer living in and receiving assisted living services from an assisted living facility.

R9-10-803. Administration

A. A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of an assisted living facility;
2. Establish, in writing, an assisted living facility's scope of services;
3. Designate, in writing, a manager who:
   a. Is 21 years of age or older; and
   b. Except for the manager of an adult foster care home, has either a:
      i. Certificate as an assisted living facility manager issued under A.R.S. § 36-446.04(C), or
      ii. A temporary certificate as an assisted living facility manager issued under A.R.S. § 36-446.06;
4. Adopt a quality management program that complies with R9-10-804;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting manager who has the qualifications established in subsection (A)(3), if the manager is:
   a. Expected not to be present on the assisted living facility's premises for more than 30 calendar days, or
   b. Not present on the assisted living facility's premises 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 manager and identify the name and qualifications of the new manager;

8. Ensure that a manager or caregiver who is able to read, write, understand, and communicate in English is on an assisted living facility's premises; ~~and~~

9. Ensure compliance with A.R.S. § 36-411~~.~~ and

10. Ensure the health, safety, or welfare of a resident is not placed at risk of harm.

B. No change

1. No change
2. No change
3. No change
   a. No change
   b. No change

C. No change

1. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
   f. No change
   g. No change
   h. No change
   i. No change
   j. No change
      i. No change
      ii. No change
   k. No change
      i. No change
      ii. No change
      iii. No change
   l. No change
   m. No change
   n. No change
   o. No change
   p. No change
      i. No change
      ii. No change
   q. No change
   r. No change

s. No change

t. No change

u. No change

v. No change

w. No change

x. No change

2. No change

3. No change

D. No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

d. No change

4. No change

E. No change

1. No change

2. No change

F. No change

1. No change

2. No change

3. No change

G. No change

1. No change

2. No change

a. No change

b. No change

c. No change

d. No change

3. No change

4. No change

H. A manager shall permit the Department to interview an employee, a volunteer, ~~or~~ a resident, or a resident's representative as part of a compliance survey or a complaint investigation.

I. No change

J. No change

1. No change

2. No change

3. No change

a. No change

b. No change

c. No change

4. No change

5. No change

a. No change

b. No change

c. No change

d. No change

6. No change

K. A manager shall provide written notification to the Department of a resident's:

1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; ~~and~~

2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency services provider~~.~~; and

3. Elopement, within 24 hours of the elopement being discovered.

L. No change

1. No change

a. No change

b. No change

c. No change

2. No change

a. No change

b. No change

c. No change

M. No change

1. No change

2. No change

3. No change

R9-10-806. Personnel

A. No change

1. No change

a. No change

b. No change

i. No change

ii. No change

iii. No change

iv. No change

(1) No change

(2) No change

(3) No change

(4) No change

2. No change

a. No change

b. No change

3. No change

a. No change

i. No change

ii. No change

b. No change

i. No change

ii. No change

iii. No change

4. No change

a. No change

b. No change

5. No change

a. No change

b. No change

c. No change

6. No change

7. No change

8. No change

a. No change

b. No change

9. No change

10. No change

B. No change

1. No change

a. No change

i. No change

ii. No change

b. No change

2. No change

3. No change

4. No change

a. No change

b. No change

i. No change

ii. No change

C. A manager shall ensure that a personnel record for each 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, the 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 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 in policies and procedures;

v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;

vi. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(8);

vii. Cardiopulmonary resuscitation training, if required for the individual in this Article or policies and procedures;

viii First aid training, if required for the individual in this Article or policies and procedures; ~~and~~

ix. Compliance with the requirements in A.R.S. § 36-411(A) and (C); and

x. The certificate of completion, according to R9-10-126;

2. Is maintained:

a. Throughout the individual's period of providing services in or for the assisted living facility, and

b. For at least 24 months after the last date the individual provided services in or for the assisted living facility; and

3. For a manager, a caregiver, or an assistant caregiver who has not provided physical health services or behavioral health services at or for the assisted living facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.

R9-10-808. Service Plans

A. Except as required in subsection (B), a manager shall ensure that a resident has a ~~written~~ service plan that is established, documented, and implemented that:

1. Is completed no later than 14 calendar days after the resident's date of acceptance;

2. Is developed with assistance and review from:

a. The resident or resident's representative,

b. The manager, and

c. Any individual requested by the resident or the resident's representative;

3. Includes the following:

a. A description of the resident's medical or health problems, including physical, behavioral, cognitive, or functional conditions or impairments;

b. The level of service the resident is expected to receive;

c. The amount, type, and frequency of assisted living services and ancillary services being provided to the resident, including medication administration or assistance in the self-administration of medication;

d. For a resident who requires intermittent nursing services or medication administration, review by a nurse or medical practitioner;

e. For a resident who requires behavioral care:

i. Any of the following that is necessary to provide assistance with the resident's psychosocial interactions to manage the resident's behavior:

(1) The psychosocial interactions or behaviors for which the resident requires assistance,

(2) Psychotropic medications ordered for the resident,

(3) Planned strategies and actions for changing the resident's psychosocial interactions or behaviors, and

(4) Goals for changes in the resident's psychosocial interactions or behaviors; and

ii. Review by a medical practitioner or behavioral health professional; and

f. For a resident who will be storing medication in the resident's bedroom or residential unit, how the medication will be stored and controlled;

4. Is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f):

a. No later than 14 calendar days after a significant change in the resident's physical, cognitive, or functional condition; and

b. As follows:

i. At least once every 12 months for a resident receiving supervisory care services,

ii. At least once every six months for a resident receiving personal care services, and

iii. At least once every three months for a resident receiving directed care services; and

5. When initially developed and when updated, is signed and dated by:

a. The resident or resident's representative;

b. The manager;

c. If a review is required in subsection (A)(3)(d), the nurse or medical practitioner who reviewed the service plan; and

d. If a review is required in subsection (A)(3)(e)(ii), the medical practitioner or behavioral health professional who reviewed the service plan.

B. For a resident receiving respite care services, a manager shall ensure that:

1. No change

a. No change

i. No change

ii. No change

b. No change

2. No change

C. No change

1. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

g. No change

2. No change

a. No change

i. No change

ii. No change

iii. No change

b. No change

c. No change

d. No change

D. No change

E. No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
    d. No change
3. No change
4. No change

F. No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change

R9-10-811. Medical Records

A. No change

1. No change
2. No change
    a. No change
    b. No change
    c. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change
5. No change

B. No change

1. No change
2. No change

C. A manager shall ensure that a resident's medical record contains:

1. Resident information that includes:
    a. The resident's name, and
    b. The resident's date of birth;
2. The names, addresses, and telephone numbers of:
    a. The resident's primary care provider;
    b. Other persons, such as a home health agency or hospice service agency, involved in the care of the resident; and
    c. An individual to be contacted in the event of an emergency, significant change in the resident's condition, or termination of residency;
3. If applicable, the name and contact information of the resident's representative and:
    a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or

b. If the resident's representative:

i. 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; or

ii. Is a legal guardian, a copy of the court order establishing guardianship;

4. The date of acceptance and, if applicable, the date of termination of residency;

5. Documentation of the resident's needs required in R9-10-807(B);

6. Documentation of general consent and informed consent, if applicable;

7. Except as allowed in R9-10-808(B)(2), documentation of freedom from infectious tuberculosis as required in R9-10-807(A);

8. A copy of the resident's health care directive, if applicable;

9. The resident's signed residency agreement and any amendments;

10. Resident's service plan and updates;

11. Documentation of assisted living services provided to the resident;

12. A medication order from a medical practitioner for each medication that is administered to the resident or for which the resident receives assistance in the self-administration of the medication;

13. Documentation of medication administered to the resident or for which the resident received assistance in the self-administration of medication that includes:

a. The date and time of administration or assistance;

b. The name, strength, dosage, and route of administration;

c. The name and signature of the individual administering or providing assistance in the self-administration of medication; and

d. An unexpected reaction the resident has to the medication;

14. Documentation of the resident's refusal of a medication, if applicable;

15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;

16. If applicable, documentation of a determination by a medical practitioner that evacuation from the assisted living facility during an evacuation drill would cause harm to the resident;

17. Documentation of notification of the resident of the availability of vaccination for influenza and pneumonia, according to A.R.S. § 36-406(1)(d);

18. Documentation of the resident's orientation to exits from the assisted living facility required in ~~R9-10-818(B)~~ R9-10-819(B);

19. If a resident is receiving behavioral health services other than behavioral care, documentation of the determination in R9-10-813(3);

20. If a resident is receiving behavioral care, documentation of the determination in R9-10-812(3);

21. If applicable, for a resident who is unable to direct self-care, the information required in R9-10-815(F);

22. Documentation of any significant change in a resident's behavior, physical, cognitive, or functional condition and the action taken by a manager or caregiver to address the resident's changing needs;

23. Documentation of the notification required in R9-10-803(G) if the resident is incapable of handling financial affairs; and

24. If the resident no longer resides and receives assisted living services from the assisted living facility:

a. A written notice of termination of residency; or

b. If the resident terminated residency, the date the resident terminated residency.

R9-10-815. Directed Care Services

A. No change

B. No change

1. No change
2. No change

C. In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving directed care services includes:

1. The requirements in R9-10-814(F)(1) through (3);
2. If applicable, the determination in R9-10-814(B)(2)(b)(iii);
3. Cognitive stimulation and activities to maximize functioning;
4. Strategies to ensure a resident's personal safety;
5. Encouragement to eat meals and snacks;
6. Documentation:
   a. Of the resident's weight, or
   b. From a medical practitioner stating that weighing the resident is contraindicated; ~~and~~
7. Coordination of communications with the resident's representative, family members, and, if applicable, other individuals identified in the resident's service plan~~.~~; and
8. If the resident is receiving memory care services:
   a. Identification of specialized environmental features to support memory care services, such as secure areas to prevent wandering and spaces designed for cognitive stimulation and engagement;
   b. Strategies for providing person-centered care that aligns with the principles of dementia-friendly environments, including familiar surroundings, optimized sensory stimulation, and meaningful activities; and
   c. Strategies for administering medications as ordered.

D. No change

E. No change

1. No change
2. No change

F. A manager of an assisted living facility authorized to provide directed care services shall ensure that:

1. Policies and procedures are established, documented, and implemented that ensure the safety of a resident who may wander;
2. There is a means of exiting the facility for a resident who does not have a key, special knowledge for egress, or the ability to expend increased physical effort that meets one of the following:
   a. Provides access to an outside area that:
      i. Allows the resident to be at least 30 feet away from the facility that is secure, and
      ii. ~~Controls~~ Monitors or alerts employees of the egress of a resident from the facility;
   b. Provides access to an outside area:
      i. From which a resident may exit to a location at least 30 feet away from the facility that is secure, and
      ii. ~~Controls~~ Monitors or alerts employees of the egress of a resident from the facility; or
   c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the International Building Code incorporated by reference in R9-10-104.01; and

3. A caregiver or an assistant caregiver complies with the requirements for incidents in R9-10-804 when a resident who is unable to direct self-care wanders into an area not designated by the governing authority for use by the resident.

~~R9-10-816.~~ **~~Medication Services~~ Repealed**

~~**A.** A manager shall ensure that:~~

~~1. Policies and procedures for medication services include:~~

~~a. Procedures for preventing, responding to, and reporting a medication error;~~

~~b. Procedures for responding to and reporting an unexpected reaction to a medication;~~

~~c. Procedures to ensure that a resident's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;~~

~~d. Procedures for:~~

~~i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and~~

~~ii. Monitoring a resident who self-administers medication;~~

~~e. Procedures for assisting a resident in procuring medication; and~~

~~f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and~~

~~2. If a verbal order for a resident's medication is received from a medical practitioner by the assisted living facility:~~

~~a. The manager or a caregiver takes the verbal order from the medical practitioner,~~

~~b. The verbal order is documented in the resident's medical record, and~~

~~c. A written order verifying the verbal order is obtained from the medical practitioner within 14 calendar days after receiving the verbal order.~~

~~**B.** If an assisted living facility provides medication administration, a manager shall ensure that:~~

~~1. Medication is stored by the assisted living facility;~~

~~2. Policies and procedures for medication administration:~~

~~a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;~~

~~b. Include a process for documenting an individual, authorized, according to the definition of "administer" in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;~~

~~c. Ensure that medication is administered to a resident only as prescribed; and~~

~~d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record; and~~

~~3. A medication administered to a resident:~~

~~a. Is administered by an individual under direction of a medical practitioner,~~

~~b. Is administered in compliance with a medication order, and~~

~~c. Is documented in the resident's medical record.~~

~~**C.** If an assisted living facility provides assistance in the self-administration of medication, a manager shall ensure that:~~

~~1. A resident's medication is stored by the assisted living facility;~~

~~2. The following assistance is provided to a resident:~~

~~a. A reminder when it is time to take the medication;~~

~~b. Opening the medication container or medication organizer for the resident;~~

~~c. Observing the resident while the resident removes the medication from the container or medication organizer;~~

~~d. Except when a resident uses a medication organizer, verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:~~

~~i. The resident taking the medication is the individual stated on the medication container label,~~

~~ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and~~

~~iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label;~~

~~e. For a resident using a medication organizer, verifying that the resident is taking the medication in the medication organizer according to the schedule specified on the medical practitioner's order; or~~

~~f. Observing the resident while the resident takes the medication;~~

~~3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or nurse; and~~

~~4. Assistance in 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.~~

~~**D.** A manager shall ensure that:~~

~~1. A current drug reference guide is available for use by personnel members, and~~

~~2. A current toxicology reference guide is available for use by personnel members.~~

~~**E.** A manager shall ensure that a resident's medication organizer is only filled by:~~

~~1. The resident;~~

~~2. The resident's representative;~~

~~3. A family member of the resident;~~

~~4. A personnel member of a home health agency or hospice service agency; or~~

~~5. The manager or a caregiver who has been designated and is under the direction of a medical practitioner, according to subsection (B)(2)(b).~~

~~**F.** When medication is stored by an assisted living facility, a manager shall ensure that:~~

~~1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;~~

~~2. Medication is stored according to the instructions on the medication container; and~~

~~3. Policies and procedures are established, documented, and implemented for:~~

~~a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;~~

~~b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;~~

~~c. A medication recall and notification of residents who received recalled medication; and~~

~~d. Storing, inventorying, and dispensing controlled substances.~~

~~**G.** A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.~~

~~**H.** If medication is stored by a resident in the resident's bedroom or residential unit, a manager shall ensure that:~~

~~1. The medication is stored according to the resident's service plan; or~~

~~2. If the medication is not being stored according to the resident's service plan, the resident's service plan is updated to include how the medication is being stored by the resident.~~

R9-10-816. Memory Care Services

A. If an assisted living facility is authorized to provide directed care services, a manager shall ensure that:

1. Policies and procedures for memory care services are established, documented, and implemented to cover the following:
    a. Skills and knowledge necessary for the personnel member to provide the expected memory care services;
    b. Interventions used for behavior management;
    c. Systems to accommodate visitors, staff, and residents who do not need controlled egress;
    d. The requirements in R9-10-815(C)(8) regarding the prevention of unsafe wandering or exit seeking, which may include the use of tracking systems;
    e. Promotion of nutrition and hydration care;
    f. Evacuation and emergency procedures specific to residents receiving memory care services, that include the requirements in R9-10-819(A)(5);
    g. Prevention techniques of elopement and responding to elopement incidents promptly and effectively;
    h. Monitoring residents receiving memory care services in outdoor areas on the premises;
    i. Specialized environmental features to support memory care that include:
        i. Secure areas to prevent wandering and spaces designed for cognitive stimulation and engagement; and
        ii. Strategies for providing person-centered care that aligns with the principles of dementia-friendly environments, including familiar surroundings, optimized sensory stimulation, and meaningful activities; and
    j. Specialized accommodations and progressive support for activities of daily living tailored to persons living with dementia following evidence-based best practices;
2. Activities that match the resident's cognitive ability, memory, attention span, language, reasoning ability, and physical function;
3. For a resident who requests or receives memory care services from the assisted living facility, a medical practitioner:
    a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for memory care services;
    b. Reviews the assisted living facility's scope of services; and
    c. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility;
4. There is staffing to ensure adequate supervision and care for residents receiving memory care services;
5. In an assisted living facility where residents are housed in two or more detached buildings, or if a building has distinct and segregated areas, a designated caregiver must be awake and available in each building and each segregated area at all times; and
6. If applicable, staffing is increased to compensate for the evaluated care and service needs of residents at move-in or for the changing physical or cognitive needs of the residents.

B. A manager shall ensure that staff obtain a certificate of completion, as specified in R9-10-126, including the minimum eight hours of initial memory care services training within the first 30 days of hire or provide a copy of a certificate of completion, as specified in R9-10-126, obtained within the preceding 12 months from the date of hire. If a staff member or contractor has not worked at an assisted living facility that is licensed to provide directed care services for a period of 12 months, the staff member or contractor must complete the minimum eight hours of initial memory care services training within 30 days after the date of hire, rehire, or returning to work.

C. In addition to the minimum eight hours of initial memory care services training, a manager shall complete a minimum of four hours of memory care services training specific to assisted living facility managers.

D. Each resident receiving memory care services must have a service plan that meets the requirements specified in R9-10-815(C).

E. Service planning for residents receiving memory care services shall be person-centered involving comprehensive assessments that consider the resident's medical history, preference, and social context, and should actively include input from the resident and the resident's representative. Service planning for residents receiving memory care services shall be individualized, regularly reviewed according to R9-10-808, and adjusted to meet the changing needs of residents as their condition progresses.

F. The assisted living facility shall only admit or retain residents whose cognitive and physical care needs can be safely managed within the area or areas in an assisted living facility where memory care services are provided.

G. An assisted living facility authorized to provide directed care services and is providing memory care services shall incorporate evidence-based specialized environmental features that:

1. Use clear, easy-to-understand signage and visual cues to help residents navigate their surroundings;
2. Reduce environmental factors that may cause confusion or distress, such as loud noises or overly bright lighting;
3. Prevent residents from accessing materials, furnishings, equipment, activities, or treatments that may pose a health or safety risk;
4. Support resident movement and engagement;
5. Promote independence and overall well-being;
6. Ensure easy access and intuitive wayfinding; and
7. Facilitate engagement and encourage participation in meaningful daily tasks and activities.

R9-10-817. Medication Services

A. A manager shall ensure that:

1. Policies and procedures for medication services include:
   a. Procedures for preventing, responding to, and reporting a medication error;
   b. Procedures for responding to and reporting an unexpected reaction to a medication;
   c. Procedures to ensure that a resident's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
   d. Procedures for:
      i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
      ii. Monitoring a resident who self-administers medication;
   e. Procedures for assisting a resident in procuring medication;
   f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
   g. Procedures for administering medication to residents receiving memory care services; and
2. If a verbal order for a resident's medication is received from a medical practitioner by the assisted living facility:
   a. The manager or a caregiver takes the verbal order from the medical practitioner,
   b. The verbal order is documented in the resident's medical record, and
   c. A written order verifying the verbal order is obtained from the medical practitioner within 14 calendar days after receiving the verbal order.

B. If an assisted living facility provides medication administration, a manager shall ensure that:

1. Medication is stored by the assisted living facility;
2. Policies and procedures for medication administration:
   a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;

b. Include a process for documenting an individual authorized, according to the definition of "administer" in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;

c. Ensure that medication is administered to a resident only as prescribed; and

d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record; and

3. A medication administered to a resident:

a. Is administered by an individual under the direction of a medical practitioner,

b. Is administered in compliance with a medication order, and

c. Is documented in the resident's medical record.

C. If an assisted living facility provides assistance in the self-administration of medication, a manager shall ensure that:

1. A resident's medication is stored by the assisted living facility;

2. The following assistance is provided to a resident:

a. A reminder when it is time to take the medication;

b. Opening the medication container or medication organizer for the resident;

c. Observing the resident while the resident removes the medication from the container or medication organizer;

d. Except when a resident uses a medication organizer, verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:

i. The resident taking the medication is the individual stated on the medication container label,

ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and

iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label;

e. For a resident using a medication organizer, verifying that the resident is taking the medication in the medication organizer according to the schedule specified on the medical practitioner's order; or

f. Observing the resident while the resident takes the medication;

3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or nurse; and

4. Assistance in 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.

D. A manager shall ensure that:

1. A current drug reference guide is available for use by personnel members, and

2. A current toxicology reference guide is available for use by personnel members.

E. A manager shall ensure that a resident's medication organizer is only filled by:

1. The resident;

2. The resident's representative;

3. A family member of the resident;

4. A personnel member of a home health agency or hospice service agency; or

5. The manager or a caregiver who has been designated and is under the direction of a medical practitioner, according to subsection (B)(2)(b).

F. When medication is stored by an assisted living facility, a manager shall ensure that:

1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
2. Medication is stored according to the instructions on the medication container; and
3. Policies and procedures are established, documented, and implemented for:
   a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
   b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
   c. A medication recall and notification of residents who received recalled medication; and
   d. Storing, inventorying, and dispensing controlled substances.

G. A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.

H. If medication is stored by a resident in the resident's bedroom or residential unit, a manager shall ensure that:

1. The medication is stored according to the resident's service plan; or
2. If the medication is not being stored according to the resident's service plan, the resident's service plan is updated to include how the medication is being stored by the resident.

~~R9-10-817.~~ R9-10-818. Food Services

A. No change

1. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change

B. No change

1. No change
2. No change

C. No change

1. No change
2. No change
3. No change
   a. No change
   b. No change

4. No change
    a. No change
    b. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
        v. No change
        vi. No change
5. No change
6. No change
7. No change

D. No change

1. No change
2. No change

~~R9-10-818.~~ R9-10-819. Emergency and Safety Standards

A. A manager shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to caregivers and assistant caregivers, and, if necessary, implemented that includes:
    a. When, how, and where residents will be relocated;
    b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
    c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
    d. A plan for obtaining food and water for individuals present in the assisted living facility or the assisted living facility'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 the disaster plan review required in subsection (A)(2) includes:
    a. The date and time of the disaster plan review;
    b. The name of each 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. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and residents:
    a. Is conducted at least once every six months; and
    b. Includes all individuals on the premises except for:
        i. A resident whose medical record contains documentation that evacuation from the assisted living facility would cause harm to the resident, and
        ii. Sufficient caregivers to ensure the health and safety of residents not evacuated according to subsection (A)(5)(b)(i);
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;

b. The amount of time taken for employees and residents to evacuate the assisted living facility;

c. If applicable:

i. An identification of residents needing assistance for evacuation, and

ii. An identification of residents who were not evacuated;

d. Any problems encountered in conducting the evacuation drill; and

e. Recommendations for improvement, if applicable; and

7. If the assisted living facility is authorized to provide directed care services, an elopement drill for employees:

a. Conduct an elopement drill every six months on each shift and document the date, time, and description of each drill; and

b. Immediately investigate any elopement and notify the designated family member(s), legal guardian, or other responsible person within 24 hours.

~~7.~~8. An evacuation path is conspicuously posted in each hallway of each floor of the assisted living facility.

B. No change

1. No change

2. No change

C. No change

D. No change

1. No change

2. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

E. No change

1. No change

a. No change

b. No change

2. No change

a. No change

b. No change

3. No change

4. No change

5. No change

F. No change

1. No change

2. No change

3. No change

a. No change

b. No change

4. No change

a. No change

i. No change

ii. No change

iii. No change

iv. No change

b. No change

5. No change

6. No change

G. No change

1. No change

2. No change

~~R9-10-819.~~ R9-10-820. Environmental Standards

A. No change

1. No change

a. No change

b. No change

2. No change

3. No change

a. No change

b. No change

4. No change

5. No change

a. No change

b. No change

6. No change

7. No change

8. No change

9. No change

10. No change

11. No change

12. No change

13. No change

a. No change

b. No change

c. No change

14. No change

a. No change

b. No change

c. No change

15. No change

a. No change

b. No change

c. No change

16. No change

B. No change

1. No change
    a. No change
        i. No change
        ii. No change
        iii. No change
    b. No change
2. No change
3. No change

~~R9-10-820.~~ R9-10-821. Physical Plant Standards

A. No change

1. No change
2. No change

B. No change

1. No change
    a. No change
    b. No change
2. No change
3. No change
4. No change
    a. No change
    b. No change
    c. No change
        i. No change
        ii. No change
        iii. No change
        iv. No change
        v. No change
        vi. No change
        vii. No change
5. No change
    a. No change
    b. No change
    c. No change
6. No change
7. No change

C. No change

1. No change
2. No change
3. No change
    a. No change
    b. No change
    c. No change

d. No change

e. No change

f. No change

g. No change

D. No change

1. No change

2. No change

    a. No change

    b. No change

    c. No change

3. No change

4. No change

    a. No change

    b. No change

        i. No change

        ii. No change

    c. No change

    d. No change

    e. No change

    f. No change

5. No change

    a. No change

    b. No change

    c. No change

6. No change

    a. No change

    b. No change

    c. No change

        i. No change

        ii. No change

        iii. No change

        iv. No change

        v. No change

        vi. No change

        vii. No change

        viii. No change

    d. No change

    e. No change

        i. No change

        ii. No change

        iii. No change

        iv. No change

    f. No change

i. No change

ii. No change

7. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

E. No change

1. No change

2. No change

3. No change

F. No change

1. No change

a. No change

b. No change

c. No change

d. No change

e. No change

f. No change

i. No change

ii. No change

iii. No change

2. No change

3. No change

G. No change