

Chapter 10 Health Care Institutions

Crosswalk: Article 19 Counseling Facilities and Article 10 Outpatient Treatment Centers

| <p align="center"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>  | <p align="center"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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| <p><b>R9-10-1901. Definitions</b><br/>In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article:</p> <ol style="list-style-type: none"> <li>"Affiliated outpatient treatment center" means a licensed outpatient treatment center authorized to provide behavioral health services that provides administrative support to a counseling facility that operates under the same governing authority as the outpatient treatment center.</li> </ol>  | <p><b>R9-10-1001. Definitions</b><br/>In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the following applies in this Article unless otherwise specified:</p> <ol style="list-style-type: none"> <li>"Emergency room services" means medical services provided to a patient in an emergency.</li> </ol>   |
| <p><b>R9-10-1902. Supplemental Application Requirements</b><br/>In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for an initial license shall submit, in a format provided by the Department:</p> <ol style="list-style-type: none"> <li>The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation;</li> <li>If applicable, a request to provide one of more of the following: <ol style="list-style-type: none"> <li>DUI screening,</li> <li>DUI education,</li> <li>DUI treatment, or</li> <li>Misdemeanor domestic violence offender treatment;</li> </ol> </li> <li><b>Whether the counseling facility has an affiliated outpatient treatment center;</b> and</li> <li><b>If the counseling facility has an affiliated outpatient treatment center:</b> <ol style="list-style-type: none"> <li>The affiliated outpatient treatment center's name, and</li> <li>Either: <ol style="list-style-type: none"> <li>The license number assigned to the affiliated outpatient treatment center by the Department; or</li> <li>If the affiliated outpatient treatment center is not currently licensed, the date the affiliated outpatient treatment center submitted an initial application for a health care institution license.</li> </ol> </li> </ol> </li> </ol> | <p><b>R9-10-1002. Supplemental Application Requirements</b><br/>In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for an initial license shall submit, in a format provided by the Department:</p> <ol style="list-style-type: none"> <li><b>The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation;</b> and</li> <li><b>A request to provide one or more of the following services:</b> <ol style="list-style-type: none"> <li>Behavioral health services and, if applicable; <ol style="list-style-type: none"> <li>Behavioral health observation/stabilization services,</li> <li>Behavioral health services to individuals under 18 years of age,</li> <li>Court-ordered evaluation,</li> <li>Court-ordered treatment,</li> <li>Crisis services,</li> <li>Opioid treatment services,</li> <li>Pre-petition screening,</li> <li>Respite services,</li> <li><b>DUI education,</b></li> <li><b>DUI screening,</b></li> <li><b>DUI treatment,</b> or</li> <li><b>Misdemeanor domestic violence offender treatment;</b></li> </ol> </li> <li>Diagnostic imaging services;</li> <li>Clinical laboratory services;</li> <li>Dialysis services;</li> <li>Emergency room services;</li> <li>Pain management services;</li> <li>Physical health services;</li> <li>Rehabilitation services;</li> <li>Sleep disorder services;</li> <li>Urgent care services provided in a freestanding urgent care center setting; or</li> <li>Counseling and, if applicable: <ol style="list-style-type: none"> <li>DUI education,</li> </ol> </li> </ol> </li> </ol> |

| <p align="center"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>   | <p align="center"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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|   | <ul style="list-style-type: none"> <li>ii. DUI screening,</li> <li>iii. DUI treatment, or</li> <li>iv. Misdemeanor domestic violence offender treatment.</li> </ul>  |
| <p><b>R9-10-1903. Administration</b></p> <p><b>A.</b> A governing authority shall:</p> <ul style="list-style-type: none"> <li>1. Consist of one of more individuals accountable for the organization, operation, and administration of a counseling facility;</li> <li>2. Establish, in writing: <ul style="list-style-type: none"> <li>a. The counseling facility's scope of services, and</li> <li>b. Qualifications for an administrator;</li> </ul> </li> <li>3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);</li> <li>4. Adopt a quality management program according to R9-10-1904;</li> <li>5. Review and evaluate the effectiveness of the quality management program in R9-10-1904 at least once every 12 months;</li> <li>6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is: <ul style="list-style-type: none"> <li>a. Expected not to be present on the premises for more than 30 calendar days, or</li> <li>b. Not present on the premises for more than 30 calendar days; and</li> </ul> </li> <li>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 an administrator and identify the name and qualifications of the new administrator.</li> </ul> <p><b>B.</b> An administrator:</p> <ul style="list-style-type: none"> <li>1. Is directly accountable to the governing authority for the daily operation of the counseling facility and all services provided by or at the counseling facility;</li> <li>2. Has the authority and responsibility to manage the counseling facility; and</li> <li>3. Except as provided in subsection (A)(6), designates in writing, an individual who is present on the counseling facility's premises and accountable for the counseling facility when the administrator is not available.</li> </ul> <p><b>C.</b> An administrator or the administrator of the counseling facility's affiliated outpatient treatment center's shall establish the policies and procedures required in subsections (D)(1) and (D)(2).</p> <p><b>D.</b> An administrator shall ensure that:</p> <ul style="list-style-type: none"> <li>1. Policies and procedures are documented and implemented to protect the health and safety of a patient that: <ul style="list-style-type: none"> <li>a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience, for personnel members, employees, volunteers, and students;</li> <li>b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;</li> <li>c. Include how a personnel member may submit a complaint relating to services provided to a patient; and</li> </ul> </li> </ul> | <p><b>R9-10-1003. Administration</b></p> <p><b>A.</b> If an outpatient treatment center is operating under a single group license issued to a hospital according to A.R.S. § 36-422(F) or (G), the hospital's governing authority is the governing authority for the outpatient treatment center.</p> <p><b>B.</b> A governing authority shall:</p> <ul style="list-style-type: none"> <li>1. Consist of one or more individuals accountable for the organization, operation, and administration of an outpatient treatment center;</li> <li>2. Establish, in writing: <ul style="list-style-type: none"> <li>a. An outpatient treatment center's scope of services, and</li> <li>b. Qualifications for an administrator;</li> </ul> </li> <li>3. Designate, in writing, an administrator who has the qualifications established in subsection (B)(2)(b);</li> <li>4. Adopt a quality management program according to R9-10-1004;</li> <li>5. Review and evaluate the effectiveness of the quality management program in R9-10-1004 at least once every 12 months;</li> <li>6. Designate, in writing, an acting administrator who has the qualifications established in subsection (B)(2)(b) if the administrator is: <ul style="list-style-type: none"> <li>a. Expected not to be present on an outpatient treatment center's premises for more than 30 calendar days, or</li> <li>b. Not present on an outpatient treatment center's premises for more than 30 calendar days; and</li> </ul> </li> <li>7. Except as provided in subsection (B)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in an administrator and identify the name and qualifications of the new administrator.</li> </ul> <p><b>C.</b> An administrator:</p> <ul style="list-style-type: none"> <li>1. Is directly accountable to the governing authority for the daily operation of the outpatient treatment center and all services provided by or at the outpatient treatment center;</li> <li>2. Has the authority and responsibility to manage the outpatient treatment center; and</li> <li>3. Except as provided in subsection (B)(6), designates, in writing, an individual who is present on the outpatient treatment center's premises and accountable for the outpatient treatment center when the administrator is not available.</li> </ul> <p><b>D.</b> An administrator shall ensure that:</p> <ul style="list-style-type: none"> <li>1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that: <ul style="list-style-type: none"> <li>a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;</li> <li>b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;</li> </ul> </li> </ul> |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>   | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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| <p>d. Cover the requirements in Title 36, Chapter 4, Article 11;</p> <p>2. Policies and procedures for services provided at or by a counseling facility are documented and implemented to protect the health and safety of a patient that:</p> <ol style="list-style-type: none"> <li>a. Cover patient screening, admission, assessment, discharge planning, and discharge;</li> <li>b. Cover medical records;</li> <li>c. Cover the provision of counseling;</li> <li>d. Include when general consent and informed consent are required;</li> <li>e. Cover telemedicine, if applicable;</li> <li>f. Cover specific steps for: <ol style="list-style-type: none"> <li>i. A patient or a patient's representative to file a complaint, and</li> <li>ii. A counseling facility to respond to a complaint; and</li> </ol> </li> <li>g. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;</li> </ol> <p>3. Counseling facility policies and procedures are:</p> <ol style="list-style-type: none"> <li>a. Reviewed at least once every three years and updated as needed, and</li> <li>b. Available to personnel members and employees;</li> </ol> <p>4. Unless otherwise stated:</p> <ol style="list-style-type: none"> <li>a. Documentation required by this Article is maintained and provided to the Department within two hours after a Department request; and</li> <li>b. When documentation or information is required by this Chapter to be submitted on behalf of a counseling facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the counseling facility;</li> </ol> <p>5. The following are conspicuously posted:</p> <ol style="list-style-type: none"> <li>a. The current license for the counseling facility issued by the Department;</li> <li>b. The name, address, and telephone number of the Department;</li> <li>c. A notice that a patient may file a complaint with the Department about the counseling facility;</li> <li>d. A list of patient rights;</li> <li>f. A map for evacuating the facility; and</li> <li>g. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(H), with patient information redacted, are available;</li> </ol> <p>6. Patient follow-up instructions are:</p> <ol style="list-style-type: none"> <li>a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the counseling facility unless the patient leaves against a personnel member's advice; and</li> <li>b. Documented in the patient's medical record; and</li> </ol> <p>7. Cardiopulmonary resuscitation training includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation.</p> <p>E. If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the</p> | <p>c. Include how a personnel member may submit a complaint relating to services provided to a patient;</p> <p>d. Cover the requirements in Title 36, Chapter 4, Article 11;</p> <p>e. Cover cardiopulmonary resuscitation training including:</p> <ol style="list-style-type: none"> <li>i. The method and content of cardiopulmonary resuscitation training which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation,</li> <li>ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,</li> <li>iii. The time-frame for renewal of cardiopulmonary resuscitation training, and</li> <li>iv. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;</li> </ol> <p>f. Cover first aid training;</p> <p>g. Include a method to identify a patient to ensure the patient receives the services ordered for the patient;</p> <p>h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;</p> <p>i. Cover health care directives;</p> <p>j. Cover medical records, including electronic medical records;</p> <p>k. Cover quality management, including incident report and supporting documentation; and</p> <p>l. Cover contracted services;</p> <p>2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that:</p> <ol style="list-style-type: none"> <li>a. Cover patient screening, admission, assessment, transport, transfer, discharge planning, and discharge;</li> <li>b. Cover the provision of medical services, nursing services, health-related services, and ancillary services;</li> <li>c. Include when general consent and informed consent are required;</li> <li>d. Cover obtaining, administering, storing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;</li> <li>e. Cover prescribing a controlled substance to minimize substance abuse by a patient;</li> <li>f. Cover infection control;</li> <li>g. Cover telemedicine, if applicable;</li> <li>h. Cover environmental services that affect patient care;</li> <li>i. Cover specific steps for: <ol style="list-style-type: none"> <li>i. A patient to file a complaint, and</li> <li>ii. An outpatient treatment center to respond to a complaint;</li> </ol> </li> <li>j. Cover smoking tobacco products on an outpatient treatment center's premises; and</li> </ol> |

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| <p>premises and not receiving services from a counseling facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:</p> <ol style="list-style-type: none"> <li>1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or</li> <li>2. For a patient under 18 years of age, according to A.R.S. § 13-3620.</li> </ol> <p><b>F.</b> If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from a counseling facility's employee or personnel member, an administrator shall:</p> <ol style="list-style-type: none"> <li>1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;</li> <li>2. Report the suspected abuse, neglect, or exploitation of the patient as follows:             <ol style="list-style-type: none"> <li>a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or</li> <li>b. For a patient under 18 years of age, according to A.R.S. § 13-3620;</li> </ol> </li> <li>3. Document:             <ol style="list-style-type: none"> <li>a. The suspected abuse, neglect, or exploitation;</li> <li>b. Any action taken according to subsection (F)(1); and</li> <li>c. The report in subsection (F)(2);</li> </ol> </li> <li>4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);</li> <li>5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):             <ol style="list-style-type: none"> <li>a. The dates, times, and description of the suspected abuse, neglect, or exploitation;</li> <li>b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;</li> <li>c. The names of witnesses to the suspected abuse, neglect, or exploitation; and</li> <li>d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and</li> </ol> </li> <li>6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.</li> </ol> | <ol style="list-style-type: none"> <li>k. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;</li> </ol> <ol style="list-style-type: none"> <li>3. Outpatient treatment center policies and procedures are:             <ol style="list-style-type: none"> <li>a. Reviewed at least once every three years and updated as needed, and</li> <li>b. Available to personnel members and employees;</li> </ol> </li> <li>4. Unless otherwise stated:             <ol style="list-style-type: none"> <li>a. Documentation required by this Article is provided to the Department within two hours after a Department request; and</li> <li>b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient treatment center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient treatment center;</li> </ol> </li> <li>5. The following are conspicuously posted:             <ol style="list-style-type: none"> <li>a. The current license for the outpatient treatment center issued by the Department;</li> <li>b. The name, address, and telephone number of the Department;</li> <li>c. A notice that a patient may file a complaint with the Department about the outpatient treatment center;</li> <li>d. One of the following:                 <ol style="list-style-type: none"> <li>i. A schedule of rates according to A.R.S. § 36-436.01(C), or</li> <li>ii. A notice that the schedule of rates required in A.R.S. § 36-436.01(C) is available for review upon request;</li> </ol> </li> <li>e. A list of patient rights;</li> <li>f. A map for evacuating the facility; and</li> <li>g. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(D), with patient information redacted, are available; and</li> </ol> </li> <li>6. Patient follow-up instructions are:             <ol style="list-style-type: none"> <li>a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the outpatient treatment center unless the patient leaves against a personnel member's advice; and</li> <li>b. Documented in the patient's medical record.</li> </ol> </li> </ol> <p><b>E.</b> If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from an outpatient treatment center's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:</p> <ol style="list-style-type: none"> <li>1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or</li> <li>2. For a patient under 18 years of age, according to A.R.S. § 13-3620.</li> </ol> <p><b>F.</b> If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from an outpatient treatment center's employee or personnel member, an administrator shall:</p> |

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|  | <ol style="list-style-type: none"> <li>1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;</li> <li>2. Report the suspected abuse, neglect, or exploitation of the patient as follows: <ol style="list-style-type: none"> <li>a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or</li> <li>b. For a patient under 18 years of age, according to A.R.S. § 13-3620;</li> </ol> </li> <li>3. Document: <ol style="list-style-type: none"> <li>a. The suspected abuse, neglect, or exploitation;</li> <li>b. Any action taken according to subsection (F)(1); and</li> <li>c. The report in subsection (F)(2);</li> </ol> </li> <li>4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);</li> <li>5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2): <ol style="list-style-type: none"> <li>a. The dates, times, and description of the suspected abuse, neglect, or exploitation;</li> <li>b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;</li> <li>c. The names of witnesses to the suspected abuse, neglect, or exploitation; and</li> <li>d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and</li> </ol> </li> <li>6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.</li> </ol> |
| <p><b>R9-10-1904. Quality Management</b><br/> An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes: <ol style="list-style-type: none"> <li>a. A method to identify, document, and evaluate incidents;</li> <li>b. A method to collect data to evaluate services provided to patients;</li> <li>c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;</li> <li>d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and</li> <li>e. The frequency of submitting a documented report required in subsection (2) to the governing authority;</li> </ol> </li> <li>2. A documented report is submitted to the governing authority that includes: <ol style="list-style-type: none"> <li>a. An identification of each concern about the delivery of services related to patient care, and</li> <li>b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and</li> </ol> </li> <li>3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is</li> </ol> | <p><b>R9-10-1004. Quality Management</b><br/> An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes: <ol style="list-style-type: none"> <li>a. A method to identify, document, and evaluate incidents;</li> <li>b. A method to collect data to evaluate services provided to patients;</li> <li>c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;</li> <li>d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and</li> <li>e. The frequency of submitting a documented report required in subsection (2) to the governing authority;</li> </ol> </li> <li>2. A documented report is submitted to the governing authority that includes: <ol style="list-style-type: none"> <li>a. An identification of each concern about the delivery of services related to patient care, and</li> <li>b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and</li> </ol> </li> <li>3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted</li> </ol>  |

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| <p>submitted to the governing authority.</p>   | <p>to the governing authority.</p>   |
| <p><b>R9-10-1905. Contracted Services</b><br/>An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. Contracted services are provided according to the requirements in this Article, and</li> <li>2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.</li> </ol>   | <p><b>R9-10-1005. Contracted Services</b><br/>An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. Contracted services are provided according to the requirements in this Article, and</li> <li>2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.</li> </ol>   |
| <p><b>R9-10-1906. Personnel</b><br/>An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. The qualifications, skills, and knowledge required for each type of personnel member: <ol style="list-style-type: none"> <li>a. Are based on: <ol style="list-style-type: none"> <li>i. The type of counseling expected to be provided by the personnel member according to the established job description, and</li> <li>ii. The acuity of the patients expected to be receiving the counseling from the personnel member according to the established job description; and</li> </ol> </li> <li>b. Include: <ol style="list-style-type: none"> <li>i. The specific skills and knowledge necessary for the personnel member to provide the counseling listed in the established job description,</li> <li>ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the counseling listed in the established job description, and</li> <li>iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the counseling listed in the established job description;</li> </ol> </li> </ol> </li> <li>2. A personnel member's skills and knowledge are verified and documented: <ol style="list-style-type: none"> <li>a. Before the personnel member provides counseling, and</li> <li>b. According to policies and procedures;</li> </ol> </li> <li>3. Sufficient personnel members are present on a counseling facility's premises during hours of clinical operation with the qualifications, skills, and knowledge necessary to: <ol style="list-style-type: none"> <li>a. Provide the counseling in the counseling facility's scope of services,</li> <li>b. Meet the needs of a patient, and</li> <li>c. Ensure the health and safety of a patient;</li> </ol> </li> <li>4. At least one personnel member with cardiopulmonary resuscitation training is present on a counseling facility's premises during hours of operation;</li> <li>5. At least one personnel member with first aid training is present on a counseling facility's premises during hours of operation;</li> <li>6. A personnel member only provides counseling the personnel member is qualified to provide;</li> <li>7. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;</li> </ol> | <p><b>R9-10-1006. Personnel</b><br/>An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. The qualifications, skills, and knowledge required for each type of personnel member: <ol style="list-style-type: none"> <li>a. Are based on: <ol style="list-style-type: none"> <li>i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and</li> <li>ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and</li> </ol> </li> <li>b. Include: <ol style="list-style-type: none"> <li>i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,</li> <li>ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and</li> <li>iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;</li> </ol> </li> </ol> </li> <li>2. A personnel member's skills and knowledge are verified and documented: <ol style="list-style-type: none"> <li>a. Before the personnel member provides physical health services or behavioral health services, and</li> <li>b. According to policies and procedures;</li> </ol> </li> <li>3. Sufficient personnel members are present on an outpatient treatment center's premises with the qualifications, skills, and knowledge necessary to: <ol style="list-style-type: none"> <li>a. Provide the services in the outpatient treatment center's scope of services,</li> <li>b. Meet the needs of a patient, and</li> <li>c. Ensure the health and safety of a patient;</li> </ol> </li> <li>4. A personnel member only provides physical health services or behavioral health services the personnel member is qualified to provide;</li> <li>5. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;</li> <li>6. A personnel member completes orientation before providing medical services, nursing services, or health-related services to a patient;</li> </ol> |

| <p align="center"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>   | <p align="center"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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| <p>8. A personnel member completes orientation before providing counseling to a patient;</p> <p>9. An individual's orientation is documented, to include:</p> <ol style="list-style-type: none"> <li>The individual's name,</li> <li>The date of the orientation, and</li> <li>The subject or topics covered in the orientation;</li> </ol> <p>10. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;</p> <p>11. A personnel member's in-service education is documented, to include:</p> <ol style="list-style-type: none"> <li>The personnel member's name,</li> <li>The date of the in-service education, and</li> <li>The subject or topics covered in the in-service education;</li> </ol> <p>12. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;</p> <p>13. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:</p> <ol style="list-style-type: none"> <li>The individual's name, date of birth, and contact telephone number;</li> <li>The individual's starting date of employment or volunteer service and, if applicable, the ending date; and</li> <li>Documentation of: <ol style="list-style-type: none"> <li>The individual's qualifications, including skills and knowledge applicable to the individual's job duties;</li> <li>The individual's education and experience applicable to the individual's job duties;</li> <li>The individual's completed orientation and in-service education as required by policies and procedures;</li> <li>The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;</li> <li>If the individual is a behavioral health technician, clinical oversight required in R9-10-115;</li> <li>The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable;</li> <li>If applicable, cardiopulmonary resuscitation training; and</li> <li>If applicable, first aid training; and</li> </ol> </li> </ol> <p>14. The record in subsection (13) is:</p> <ol style="list-style-type: none"> <li>Maintained while an individual provides services for or at the counseling facility and for at least 24 months after the last date the individual provided services for or at the counseling facility; and</li> <li>If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.</li> </ol> | <p>7. An individual's orientation is documented, to include:</p> <ol style="list-style-type: none"> <li>The individual's name,</li> <li>The date of the orientation, and</li> <li>The subject or topics covered in the orientation;</li> </ol> <p>8. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;</p> <p>9. A personnel member's in-service education is documented, to include:</p> <ol style="list-style-type: none"> <li>The personnel member's name,</li> <li>The date of the in-service education, and</li> <li>The subject or topics covered in the in-service education;</li> </ol> <p>10. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;</p> <p>11. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:</p> <ol style="list-style-type: none"> <li>The individual's name, date of birth, and contact telephone number;</li> <li>The individual's starting date of employment or volunteer service and, if applicable, the ending date;</li> <li>Documentation of: <ol style="list-style-type: none"> <li>The individual's qualifications, including skills and knowledge applicable to the individual's job duties;</li> <li>The individual's education and experience applicable to the individual's job duties;</li> <li>The individual's completed orientation and in-service education as required by policies and procedures;</li> <li>The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;</li> <li>If the individual is a behavioral health technician, clinical oversight required in R9-10-115;</li> <li>The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable; and</li> <li>Cardiopulmonary resuscitation training, if the individual is required to have cardiopulmonary resuscitation training according to this Article or policies and procedures; and</li> </ol> </li> </ol> <p>12. The record in subsection (A)(11) is:</p> <ol style="list-style-type: none"> <li>Maintained while an individual provides services for or at the outpatient treatment center and for at least 24 months after the last date the employee or volunteer provided services for or at the outpatient treatment center; and</li> <li>If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.</li> </ol> |
| <p><b>R9-10-1907. Patient Rights</b><br/>A. An administrator shall ensure that at the time of admission, a patient or the</p>   | <p><b>R9-10-1008. Patient Rights</b><br/>A. An administrator shall ensure that:</p>  |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>   | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>  |
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| <p>patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C).</p> <p><b>B.</b> An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. A patient is treated with dignity, respect, and consideration;</li> <li>2. A patient as not subjected to: <ol style="list-style-type: none"> <li>a. Abuse;</li> <li>b. Neglect;</li> <li>c. Exploitation;</li> <li>d. Coercion;</li> <li>e. Manipulation;</li> <li>f. Sexual abuse;</li> <li>g. Sexual assault;</li> <li>h. Restraint or seclusion;</li> <li>i. Retaliation for submitting a complaint to the Department or another entity; or</li> <li>j. Misappropriation of personal and private property by a counseling facility's personnel member, employee, volunteer, or student; and</li> </ol> </li> <li>3. A patient or the patient's representative: <ol style="list-style-type: none"> <li>a. Either consents to or refuses counseling;</li> <li>b. May refuse or withdraw consent for receiving counseling before counseling is initiated;</li> <li>c. Is informed of the following: <ol style="list-style-type: none"> <li>i. The counseling facility's policy on health care directives, and</li> <li>ii. The patient complaint process;</li> </ol> </li> <li>d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to an counseling facility for identification and administrative purposes; and</li> <li>e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's: <ol style="list-style-type: none"> <li>i. Medical record, or</li> <li>ii. Financial records.</li> </ol> </li> </ol> </li> </ol> <p><b>C.</b> A patient has the following rights:</p> <ol style="list-style-type: none"> <li>1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;</li> <li>2. To receive counseling that supports and respects the patient's individuality, choices, strengths, and abilities;</li> <li>3. To receive privacy during counseling;</li> <li>4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;</li> <li>5. To receive a referral to another health care institution if the counseling facility is not authorized or not able to provide the counseling needed by the patient;</li> <li>6. To participate or have the patient's representative participate in the development of, or decisions concerning, the counseling provided to the patient;</li> </ol> | <ol style="list-style-type: none"> <li>1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;</li> <li>2. <b>At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and</b></li> <li>3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include: <ol style="list-style-type: none"> <li>a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and</li> <li>b. Where patient rights are posted as required in subsection (A)(1).</li> </ol> </li> </ol> <p><b>B.</b> <b>An administrator shall ensure that:</b></p> <ol style="list-style-type: none"> <li>1. <b>A patient is treated with dignity, respect, and consideration;</b></li> <li>2. <b>A patient as not subjected to:</b> <ol style="list-style-type: none"> <li>a. <b>Abuse;</b></li> <li>b. <b>Neglect;</b></li> <li>c. <b>Exploitation;</b></li> <li>d. <b>Coercion;</b></li> <li>e. <b>Manipulation;</b></li> <li>f. <b>Sexual abuse;</b></li> <li>g. <b>Sexual assault;</b></li> <li>h. Except as allowed in R9-10-1012(B), <b>restraint or seclusion;</b></li> <li>i. <b>Retaliation for submitting a complaint to the Department or another entity; or</b></li> <li>j. <b>Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and</b></li> </ol> </li> <li>3. <b>A patient or the patient's representative:</b> <ol style="list-style-type: none"> <li>a. Except in an emergency, <b>either consents to or refuses treatment;</b></li> <li>b. <b>May refuse or withdraw consent for treatment before treatment is initiated;</b></li> <li>c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;</li> <li>d. <b>Is informed of the following:</b> <ol style="list-style-type: none"> <li>i. <b>The outpatient treatment center's policy on health care directives, and</b></li> <li>ii. <b>The patient complaint process;</b></li> </ol> </li> <li>e. <b>Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and</b></li> <li>f. <b>Except as otherwise permitted by law, provides written consent to the release of information in the patient's:</b> <ol style="list-style-type: none"> <li>i. <b>Medical record, or</b></li> </ol> </li> </ol> </li> </ol> |

| <p align="center"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>  | <p align="center"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>  |
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| <ul style="list-style-type: none"> <li>7. To participate or refuse to participate in research or experimental treatment; and</li> <li>8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.</li> </ul>  | <ul style="list-style-type: none"> <li>ii. <b>Financial records.</b></li> <li>C. <b>A patient has the following rights:</b> <ul style="list-style-type: none"> <li>1. <b>Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;</b></li> <li>2. <b>To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;</b></li> <li>3. <b>To receive privacy in treatment and care for personal needs;</b></li> <li>4. <b>To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;</b></li> <li>5. <b>To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;</b></li> <li>6. <b>To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;</b></li> <li>7. <b>To participate or refuse to participate in research or experimental treatment; and</b></li> <li>8. <b>To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.</b></li> </ul> </li> </ul>  |
| <p><b>R9-10-1908. Medical Records</b></p> <p>A. An administrator shall ensure that:</p> <ul style="list-style-type: none"> <li>1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;</li> <li>2. An entry in a patient's medical record is: <ul style="list-style-type: none"> <li>a. Recorded only by a personnel member authorized by policies and procedures to make the entry;</li> <li>b. Dated, legible, and authenticated; and</li> <li>c. Not changed to make the initial entry illegible;</li> </ul> </li> <li>3. An order is: <ul style="list-style-type: none"> <li>a. Dated when the order is entered in the patient's medical record and includes the time of the order;</li> <li>b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and</li> <li>c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;</li> </ul> </li> <li>4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;</li> <li>5. A patient's medical record is available to an individual: <ul style="list-style-type: none"> <li>a. Authorized according to policies and procedures to access the patient's medical record;</li> <li>b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or</li> <li>c. As permitted by law; and</li> </ul> </li> </ul> | <p><b>R9-10-1009. Medical Records</b></p> <p>A. <b>An administrator shall ensure that:</b></p> <ul style="list-style-type: none"> <li>1. <b>A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;</b></li> <li>2. <b>An entry in a patient's medical record is:</b> <ul style="list-style-type: none"> <li>a. <b>Recorded only by a personnel member authorized by policies and procedures to make the entry;</b></li> <li>b. <b>Dated, legible, and authenticated; and</b></li> <li>c. <b>Not changed to make the initial entry illegible;</b></li> </ul> </li> <li>3. <b>An order is:</b> <ul style="list-style-type: none"> <li>a. <b>Dated when the order is entered in the patient's medical record and includes the time of the order;</b></li> <li>b. <b>Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and</b></li> <li>c. <b>If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;</b></li> </ul> </li> <li>4. <b>If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;</b></li> <li>5. <b>A patient's medical record is available to an individual:</b> <ul style="list-style-type: none"> <li>a. <b>Authorized according to policies and procedures to access the patient's medical record;</b></li> <li>b. <b>If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or</b></li> <li>c. <b>As permitted by law;</b></li> </ul> </li> </ul> |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>   | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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| <p>6. A patient's medical record is protected from loss, damage, or unauthorized use.</p> <p><b>B.</b> If a counseling facility maintains patients' medical records electronically, an administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. Safeguards exist to prevent unauthorized access, and</li> <li>2. The date and time of an entry in a medical record is recorded by the computer's internal clock.</li> </ol> <p><b>C.</b> An administrator shall ensure that a patient's medical record contains:</p> <ol style="list-style-type: none"> <li>1. Patient information that includes: <ol style="list-style-type: none"> <li>a. The patient's name and address; and</li> <li>b. The patient's date of birth;</li> </ol> </li> <li>2. A diagnosis or reason for counseling;</li> <li>3. Documentation of general consent and, if applicable, informed consent for counseling by the patient or the patient's representative;</li> <li>4. If applicable, the name and contact information of the patient's representative and: <ol style="list-style-type: none"> <li>a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or</li> <li>b. If the patient's representative: <ol style="list-style-type: none"> <li>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</li> <li>ii. Is a legal guardian, a copy of the court order establishing guardianship;</li> </ol> </li> </ol> </li> <li>5. Documentation of medical history;</li> <li>6. Orders;</li> <li>7. Assessment;</li> <li>8. Interval notes;</li> <li>9. Progress notes;</li> <li>10. Documentation of counseling provided to the patient;</li> <li>11. The name of each individual providing counseling;</li> <li>12. Disposition of the patient upon discharge;</li> <li>13. Documentation of the patient's follow-up instructions provided to the patient;</li> <li>14. A discharge summary; and</li> <li>15. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual.</li> </ol> | <p>6. Policies and procedures include the maximum time-frame to retrieve a patient's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and</p> <p>7. A patient's medical record is protected from loss, damage, or unauthorized use.</p> <p><b>B.</b> If an outpatient treatment center maintains patients' medical records electronically, an administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. Safeguards exist to prevent unauthorized access, and</li> <li>2. The date and time of an entry in a medical record is recorded by the computer's internal clock.</li> </ol> <p><b>C.</b> An administrator shall ensure that a patient's medical record contains:</p> <ol style="list-style-type: none"> <li>1. Patient information that includes: <ol style="list-style-type: none"> <li>a. Except as specified in A.A.C. R9-6-1005, the patient's name and address;</li> <li>b. The patient's date of birth; and</li> <li>c. Any known allergies, including medication allergies;</li> </ol> </li> <li>2. A diagnosis or reason for outpatient treatment center services;</li> <li>3. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;</li> <li>4. If applicable, the name and contact information of the patient's representative and: <ol style="list-style-type: none"> <li>a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or</li> <li>b. If the patient's representative: <ol style="list-style-type: none"> <li>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</li> <li>ii. Is a legal guardian, a copy of the court order establishing guardianship;</li> </ol> </li> </ol> </li> <li>5. Documentation of medical history and, if applicable, results of a physical examination;</li> <li>6. Orders;</li> <li>7. Assessment;</li> <li>8. Treatment plans;</li> <li>9. Interval notes;</li> <li>10. Progress notes;</li> <li>11. Documentation of outpatient treatment center services provided to the patient;</li> <li>12. The name of each individual providing treatment or a diagnostic procedure;</li> <li>13. Disposition of the patient upon discharge;</li> <li>14. Documentation of the patient's follow-up instructions provided to the patient;</li> <li>15. A discharge summary;</li> </ol> |

| <p align="center"><b>Article 19, Counseling Facilities</b><br/> '<b>NEW ARTICLE</b>'<br/> (Yellow highlights not in Article 10)</p>  | <p align="center"><b>Article 10, Outpatient Treatment Centers</b><br/> '<b>CURRENT RULES</b>'<br/> (Yellow highlights are in Article 19)</p>  |
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|  | <p>16. If applicable:</p> <ul style="list-style-type: none"> <li>a. Laboratory reports,</li> <li>b. Radiologic reports,</li> <li>c. Sleep disorder reports,</li> <li>d. Diagnostic reports, and</li> <li>e. Consultation reports;</li> </ul> <p>17. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual, other than actions taken while providing behavioral health observation/stabilization services; and</p> <p>18. Documentation of a medication administered to the patient that includes:</p> <ul style="list-style-type: none"> <li>a. The date and time of administration;</li> <li>b. The name, strength, dosage, and route of administration;</li> <li>c. For a medication administered for pain: <ul style="list-style-type: none"> <li>i. An assessment of the patient's pain before administering the medication, and</li> <li>ii. The effect of the medication administered;</li> </ul> </li> <li>d. For a psychotropic medication: <ul style="list-style-type: none"> <li>i. An assessment of the patient's behavior before administering the psychotropic medication, and</li> <li>ii. The effect of the psychotropic medication administered;</li> </ul> </li> <li>e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication;</li> <li>f. Any adverse reaction a patient has to the medication; and</li> <li>g. For prepacked or sample medication provided to the patient for self-administration, the name, strength, dosage, amount, route of administration, and expiration date.</li> </ul> |
| <p><b>R9-10-1909. Counseling</b></p> <p><b>A.</b> An administrator of a counseling facility shall ensure that:</p> <ul style="list-style-type: none"> <li>1. Counseling provided at the counseling facility is provided under the direction of a behavioral health professional;</li> <li>2. A personnel member who provides counseling is: <ul style="list-style-type: none"> <li>a. At least 21 years of age; or</li> <li>b. At least 18 years of age and is licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice; and</li> </ul> </li> <li>3. If a counseling facility provides counseling to a patient who is less than 18 years of age, the owner and an employee or a volunteer comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.</li> </ul> <p><b>B.</b> An administrator of a counseling facility shall ensure that:</p> <ul style="list-style-type: none"> <li>1. Before counseling for a patient is initiated, a behavioral health assessment for the patient that complies with the requirements in this Section is: <ul style="list-style-type: none"> <li>a. Completed;</li> </ul> </li> </ul> | <p><b>R9-10-1011. Behavioral Health Services</b></p> <p><b>A.</b> An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:</p> <ul style="list-style-type: none"> <li>1. The outpatient treatment center does not provide a behavioral health service the outpatient treatment center is not authorized to provide;</li> <li>2. The behavioral health services provided by or at the outpatient treatment center: <ul style="list-style-type: none"> <li>a. Are provided under the direction of a behavioral health professional; and</li> <li>b. Comply with the requirements: <ul style="list-style-type: none"> <li>i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115, and</li> <li>ii. For an assessment, in subsection (B);</li> </ul> </li> </ul> </li> <li>3. A personnel member who provides behavioral health services is: <ul style="list-style-type: none"> <li>a. At least 21 years of age; or</li> <li>b. At least 18 years of age and is licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice;</li> </ul> </li> </ul>  |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b></p> <p style="text-align: center;"><b>'NEW ARTICLE'</b></p> <p style="text-align: center;">(Yellow highlights not in Article 10)</p>   | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b></p> <p style="text-align: center;"><b>'CURRENT RULES'</b></p> <p style="text-align: center;">(Yellow highlights are in Article 19)</p>  |
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| <ul style="list-style-type: none"> <li>b. Obtained from a behavioral health provider other than the counseling facility,</li> <li>c. Available in the patient's medical record maintained by the counseling facility, or</li> <li>d. Available in the patient's integrated medical record maintained by the counseling facility's affiliated outpatient treatment center;</li> </ul> <ol style="list-style-type: none"> <li>2. A behavioral health assessment that is obtained from a behavioral health provider other than the counseling facility or available in a medical record or integrated medical record had been completed within 12 months before the date of the patient's current admission;</li> <li>3. If a behavioral health assessment is obtained from a behavioral health provider other than the counseling facility or is available in the counseling facility's medical record for the patient or the counseling facility's affiliated outpatient treatment center's integrated medical record for the patient the information in the behavioral health assessment is reviewed and updated if additional information that affects the patient's behavioral health assessment is identified;</li> <li>4. The review and update of the patient's assessment information in subsection (B)(3) is documented in the patient's medical record within 48 hours after the review is completed;</li> <li>5. If a behavioral health assessment is conducted by a: <ol style="list-style-type: none"> <li>a. Behavioral health technician or a registered nurse, within 72 hours a behavioral health professional certified or licensed to provide the counseling needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the counseling needed by the patient; or</li> <li>b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the counseling needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the counseling needed by the patient;</li> </ol> </li> <li>6. A behavioral health assessment: <ol style="list-style-type: none"> <li>a. Documents a patient's: <ol style="list-style-type: none"> <li>i. Presenting issue;</li> <li>ii. Substance use history;</li> <li>iii. Co-occurring disorder;</li> <li>iv. Medical condition and history;</li> <li>v. Legal history, including: <ol style="list-style-type: none"> <li>(1) Custody,</li> <li>(2) Guardianship, and</li> <li>(3) Pending litigation;</li> </ol> </li> <li>vi. Criminal justice record;</li> <li>vii. Family history;</li> <li>viii. Behavioral health treatment history; and</li> <li>ix. Symptoms reported by the patient or the patient's representation</li> </ol> </li> </ol> </li> </ol> | <p style="text-align: center;">and</p> <ol style="list-style-type: none"> <li>4. If an outpatient treatment center provides behavioral health services to a patient who is less than 18 years of age, the owner and an employee or a volunteer comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.</li> </ol> <ol style="list-style-type: none"> <li>B. An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that: <ol style="list-style-type: none"> <li>1. Except as provided in subsection (B)(2), a behavioral health assessment for a patient is completed before treatment for the patient is initiated;</li> <li>2. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the outpatient treatment center or the outpatient treatment center has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission: <ol style="list-style-type: none"> <li>a. The patient's assessment information is reviewed and updated if additional information that affects the patient's assessment is identified, and</li> <li>b. The review and update of the patient's assessment information is documented in the patient's medical record within 48 hours after the review is completed;</li> </ol> </li> </ol> </li> <li>3. If a behavioral health assessment is conducted by a: <ol style="list-style-type: none"> <li>a. Behavioral health technician or a registered nurse, within 72 hours a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the patient; or</li> <li>b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the behavioral health services needed by the patient;</li> </ol> </li> <li>4. A behavioral health assessment: <ol style="list-style-type: none"> <li>a. Documents a patient's: <ol style="list-style-type: none"> <li>i. Presenting issue;</li> <li>ii. Substance abuse history;</li> <li>iii. Co-occurring disorder;</li> <li>iv. Medical condition and history;</li> <li>v. Legal history, including: <ol style="list-style-type: none"> <li>(1) Custody,</li> <li>(2) Guardianship, and</li> <li>(3) Pending litigation;</li> </ol> </li> <li>vi. Criminal justice record;</li> <li>vii. Family history;</li> <li>viii. Behavioral health treatment history; and</li> </ol> </li> </ol> </li> </ol> |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>  | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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| <p>and referrals needed by the patient, if any;</p> <p>b. Includes:</p> <ol style="list-style-type: none"> <li>i. Recommendations for further assessment or examination of the patient's needs;</li> <li>ii. Counseling including type, frequency, and number of hours, that will be provided to the patient; and</li> <li>iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and</li> </ol> <p>c. Is documented in patient's medical record;</p> <p>7. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;</p> <p>8. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;</p> <p>9. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;</p> <p>10. Documentation of the request in subsection (B)(6) and the opportunity in subsection (B)(7) is in the patient's medical record;</p> <p>11. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;</p> <p>12. If information in subsection (B)(4)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;</p> <p>13. Counseling is:</p> <ol style="list-style-type: none"> <li>a. Offered as described in the counseling facility's scope of services,</li> <li>b. Provided according to the frequency and number of hours identified in the patient's assessment, and</li> <li>c. Provided by a behavioral health professional or a behavioral health technician;</li> </ol> <p>14. A personnel member providing counseling to address a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and</p> <p>15. Each counseling session is documented in the patient's medical record to include:</p> <ol style="list-style-type: none"> <li>a. The date of the counseling session;</li> <li>b. The amount of time spent in the counseling session;</li> <li>c. Whether the counseling was individual counseling, family counseling, or group counseling;</li> <li>d. The treatment goals addressed in the counseling session; and</li> <li>e. The signature of the personnel member who provided the counseling and the date signed.</li> </ol> <p>C. An administrator may request to provide any of the following to individuals required to attend by a referring court:</p> <ol style="list-style-type: none"> <li>1. DUI screening,</li> </ol> | <p>ix. Symptoms reported by the patient and referrals needed by the patient, if any;</p> <p>b. Includes:</p> <ol style="list-style-type: none"> <li>i. Recommendations for further assessment or examination of the patient's needs;</li> <li>ii. The behavioral health services, physical health services, or ancillary services that will be provided to the patient; and</li> <li>iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and</li> </ol> <p>c. Is documented in patient's medical record;</p> <p>5. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;</p> <p>6. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;</p> <p>7. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;</p> <p>8. Documentation of the request in subsection (B)(6) and the opportunity in subsection (B)(7) is in the patient's medical record;</p> <p>9. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;</p> <p>10. If information in subsection (B)(4)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;</p> <p>11. Counseling is:</p> <ol style="list-style-type: none"> <li>a. Offered as described in the outpatient treatment center's scope of services,</li> <li>b. Provided according to the frequency and number of hours identified in the patient's assessment, and</li> <li>c. Provided by a behavioral health professional or a behavioral health technician;</li> </ol> <p>12. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and</p> <p>13. Each counseling session is documented in the patient's medical record to include:</p> <ol style="list-style-type: none"> <li>a. The date of the counseling session;</li> <li>b. The amount of time spent in the counseling session;</li> <li>c. Whether the counseling was individual counseling, family counseling, or group counseling;</li> <li>d. The treatment goals addressed in the counseling session; and</li> <li>e. The signature of the personnel member who provided the counseling and the date signed.</li> </ol> <p>C. An administrator of an outpatient treatment center authorized to provide behavioral health services may request to provide any of the following to</p> |

| <p align="center"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>  | <p align="center"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>  |
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| <ul style="list-style-type: none"> <li>2. DUI education,</li> <li>3. DUI treatment, or</li> <li>4. Misdemeanor domestic violence offender treatment.</li> </ul> <p><b>D.</b> An administrator authorized to provide the services in subsection (C):</p> <ul style="list-style-type: none"> <li>1. Shall comply with the requirements for the specific service in 9 A.A.C. 20, and</li> <li>2. May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.</li> </ul>   | <p><b>individuals required to attend by a referring court:</b></p> <ul style="list-style-type: none"> <li>1. <b>DUI screening,</b></li> <li>2. <b>DUI education,</b></li> <li>3. <b>DUI treatment, or</b></li> <li>4. <b>Misdemeanor domestic violence offender treatment.</b></li> </ul> <p><b>D.</b> <b>An administrator of an outpatient treatment center authorized to provide the services in subsection (C):</b></p> <ul style="list-style-type: none"> <li>1. <b>Shall comply with the requirements for the specific service in 9 A.A.C. 20, and</b></li> <li>2. <b>May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.</b></li> </ul>   |
| <p><b>R9-10-1910. Physical Plant, Environmental Services, and Equipment Standards</b></p> <p><b>A.</b> An administrator shall ensure that a counseling facility has either:</p> <ul style="list-style-type: none"> <li>1. Both of the following: <ul style="list-style-type: none"> <li>a. A smoke detector installed in each hallway of the counseling facility that is: <ul style="list-style-type: none"> <li>i. Maintained in an operable condition;</li> <li>ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and</li> <li>iii. Tested monthly; and</li> </ul> </li> <li>b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that: <ul style="list-style-type: none"> <li>i. Is available at the counseling facility;</li> <li>ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;</li> <li>iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and</li> <li>iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person; or</li> </ul> </li> </ul> </li> <li>2. Both of the following that are tested and serviced at least once every 12 months: <ul style="list-style-type: none"> <li>a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in A.A.C. R9-1-412, that is in working order; and</li> <li>b. A sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in A.A.C. R9-1-412, that is in working order.</li> </ul> </li> </ul> <p><b>B.</b> An administrator shall ensure that documentation of a test required in subsection (A) is maintained for at least 12 months after the date of the test.</p> <p><b>C.</b> An administrator shall ensure that on a counseling facility's premises:</p> <ul style="list-style-type: none"> <li>1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit</li> </ul> | <p><b>R9-10-1029. Emergency and Safety Standards</b></p> <p><b>A.</b> An administrator shall ensure that policies and procedures for providing emergency treatment are established, documented, and implemented that protect the health and safety of patients and include:</p> <ul style="list-style-type: none"> <li>1. A list of the medications, supplies, and equipment required on the premises for the emergency treatment provided by the outpatient treatment center;</li> <li>2. A system to ensure medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;</li> <li>3. A requirement that a cart or a container is available for emergency treatment that contains the medication, supplies, and equipment specified in the outpatient treatment center's policies and procedures; and</li> <li>4. A method to verify and document that the contents of the cart or container are available for emergency treatment.</li> </ul> <p><b>B.</b> An administrator shall ensure that emergency treatment is provided to a patient admitted to the outpatient treatment center according to the outpatient treatment center's policies and procedures.</p> <p><b>C.</b> An administrator shall ensure that:</p> <ul style="list-style-type: none"> <li>1. A disaster plan is developed, documented, maintained in a location accessible to personnel members, and, if necessary, implemented that includes: <ul style="list-style-type: none"> <li>a. Procedures for protecting the health and safety of patients and other individuals on the premises;</li> <li>b. Assigned responsibilities for each personnel member, employee, or volunteer;</li> <li>c. Instructions for the evacuation of patients and other individuals on the premises; and</li> <li>d. Arrangements to provide medical services, nursing services, and health-related services to meet patients' needs;</li> </ul> </li> <li>2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;</li> <li>3. An evacuation drill is conducted on each shift at least once every 12 months;</li> <li>4. A disaster plan review required in subsection (C)(2) or an evacuation drill required in subsection (C)(3) is documented as follows: <ul style="list-style-type: none"> <li>a. The date and time of the evacuation drill or disaster plan review;</li> <li>b. The name of each personnel member, employee, or volunteer participating in the evacuation drill or disaster plan review;</li> </ul> </li> </ul> |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b><br/><b>'NEW ARTICLE'</b><br/>(Yellow highlights not in Article 10)</p>  | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b><br/><b>'CURRENT RULES'</b><br/>(Yellow highlights are in Article 19)</p>   |
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| <p>signs;</p> <ol style="list-style-type: none"> <li>2. Corridors and exits are kept clear of any obstructions;</li> <li>3. A patient can exit through any exit during hours of clinical operation;</li> <li>4. An extension cord is not used instead of permanent electrical wiring; and</li> <li>5. Each electrical outlet and electrical switch has a cover plate that is in good repair.</li> </ol> <p><b>D.</b> An administrator shall:</p> <ol style="list-style-type: none"> <li>1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,</li> <li>2. Make any repairs or corrections stated on the fire inspection report, and</li> <li>3. Maintain documentation of a current fire inspection.</li> </ol> <p><b>E.</b> An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. A counseling facility's premises are: <ol style="list-style-type: none"> <li>a. Sufficient to provide the counseling facility's scope of services;</li> <li>b. Cleaned and disinfected to prevent, minimize, and control illness and infection; and</li> <li>c. Free from a condition or situation that may cause an individual to suffer physical injury;</li> </ol> </li> <li>2. If a bathroom is on the premises, the bathroom contains: <ol style="list-style-type: none"> <li>a. A working sink with running water,</li> <li>b. A working toilet that flushes and has a seat,</li> <li>c. Toilet tissue,</li> <li>d. Soap for hand washing,</li> <li>e. Paper towels or a mechanical air hand dryer,</li> <li>f. Lighting, and</li> <li>g. A means of ventilation;</li> </ol> </li> <li>3. If a bathroom is not on the premises, a bathroom is: <ol style="list-style-type: none"> <li>a. Available for a patient's use,</li> <li>b. Located in a building in contiguous proximity to the counseling facility, and</li> <li>c. Free from a condition or situation that may cause an individual using the bathroom to suffer a physical injury; and</li> </ol> </li> <li>4. A tobacco smoke-free environment is maintained on the premises.</li> </ol> | <ol style="list-style-type: none"> <li>c. A critique of the evacuation drill or disaster plan review; and</li> <li>d. If applicable, recommendations for improvement;</li> </ol> <ol style="list-style-type: none"> <li>5. Documentation required in subsection (C)(4) is maintained for at least 12 months after the date of the evacuation drill or disaster plan review; and</li> <li>6. An evacuation path is conspicuously posted on each hallway of each floor of the outpatient treatment center.</li> </ol> <p><b>D.</b> An administrator shall ensure that an outpatient treatment center has either:</p> <ol style="list-style-type: none"> <li>1. Both of the following that are tested and serviced at least once every 12 months: <ol style="list-style-type: none"> <li>a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in A.A.C. R9-1-412, that is in working order; and</li> <li>b. A sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in A.A.C. R9-1-412, that is in working order; or</li> </ol> </li> <li>2. The following: <ol style="list-style-type: none"> <li>a. A smoke detector installed in each hallway of the outpatient treatment center that is: <ol style="list-style-type: none"> <li>i. Maintained in an operable condition;</li> <li>ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and</li> <li>iii. Tested monthly; and</li> </ol> </li> <li>b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that: <ol style="list-style-type: none"> <li>i. Is available at the outpatient treatment center;</li> <li>ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;</li> <li>iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and</li> <li>iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person.</li> </ol> </li> </ol> </li> </ol> <p><b>E.</b> An administrator shall ensure that documentation of a test required in subsection (D) is maintained for at least 12 months after the date of the test.</p> <p><b>F.</b> An administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit signs;</li> <li>2. Except as provided in subsection (G), a corridor in the outpatient treatment center is at least 44 inches wide;</li> <li>3. Corridors and exits are kept clear of any obstructions;</li> <li>4. A patient can exit through any exit during hours of operation;</li> <li>5. An extension cord is not used instead of permanent electrical wiring;</li> <li>6. Each electrical outlet and electrical switch has a cover plate that is in good</li> </ol> |

| <p style="text-align: center;"><b>Article 19, Counseling Facilities</b><br/> '<b>NEW ARTICLE</b>'<br/> (Yellow highlights not in Article 10)</p> | <p style="text-align: center;"><b>Article 10, Outpatient Treatment Centers</b><br/> '<b>CURRENT RULES</b>'<br/> (Yellow highlights are in Article 19)</p>   |
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|  | <p><b>repair;</b></p> <ol style="list-style-type: none"> <li>7. If applicable, a sign is placed at the entrance of a room or an area indicating that oxygen is in use; and</li> <li>8. Oxygen and medical gas containers: <ol style="list-style-type: none"> <li>a. Are maintained in a secured, upright position; and</li> <li>b. Are stored in a room with a door: <ol style="list-style-type: none"> <li>i. In a building with sprinklers, at least five feet from any combustible materials; or</li> <li>ii. In a building without sprinklers, at least 20 feet from any combustible materials.</li> </ol> </li> </ol> </li> </ol> <p>G. If an outpatient treatment center licensed before October 1, 2013 has a corridor less than 44 inches wide, an administrator shall ensure that:</p> <ol style="list-style-type: none"> <li>1. The corridor is wide enough to allow for: <ol style="list-style-type: none"> <li>a. Unobstructed movement of patients within the outpatient treatment center, and</li> <li>b. The safe evacuation of patients from the outpatient treatment center; and</li> </ol> </li> <li>2. The corridor is used only as a passageway.</li> </ol> <p>H. <b>An administrator shall:</b></p> <ol style="list-style-type: none"> <li>1. <b>Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,</b></li> <li>2. <b>Make any repairs or corrections stated on the fire inspection report, and</b></li> <li>3. <b>Maintain documentation of a current fire inspection.</b></li> </ol> <p><b>R9-10-1030. Physical Plant, Environmental Services, and Equipment Standards</b></p> <p>A. <b>An administrator shall ensure that:</b></p> <ol style="list-style-type: none"> <li>1. An outpatient treatment center's <b>premises are:</b> <ol style="list-style-type: none"> <li>a. <b>Sufficient to provide the outpatient treatment center's scope of services;</b></li> <li>b. <b>Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and</b></li> <li>c. <b>Free from a condition or situation that may cause an individual to suffer physical injury;</b></li> </ol> </li> <li>2. Except as provided in subsection (B), if an outpatient treatment center collects urine or stool specimens from a patient, the outpatient treatment center has at least one <b>bathroom on the premises that:</b> <ol style="list-style-type: none"> <li>a. <b>Contains:</b> <ol style="list-style-type: none"> <li>i. <b>A working sink with running water,</b></li> <li>ii. <b>A working toilet that flushes and has a seat,</b></li> <li>iii. <b>Toilet tissue,</b></li> <li>iv. <b>Soap for hand washing,</b></li> <li>v. <b>Paper towels or a mechanical air hand dryer,</b></li> <li>vi. <b>Lighting, and</b></li> <li>vii. <b>A means of ventilation;</b> and</li> </ol> </li> </ol> </li> </ol> |

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|   | <ul style="list-style-type: none"> <li>b. Is for the exclusive use of the outpatient treatment center;</li> <li>3. A pest control program is implemented and documented;</li> <li>4. <b>A tobacco smoke-free environment is maintained on the premises;</b></li> <li>5. A refrigerator used to store a medication is: <ul style="list-style-type: none"> <li>a. Maintained in working order, and</li> <li>b. Only used to store medications;</li> </ul> </li> <li>6. Equipment at the outpatient treatment center is: <ul style="list-style-type: none"> <li>a. Sufficient to provide the outpatient treatment center's scope of services;</li> <li>b. Maintained in working condition;</li> <li>c. Used according to the manufacturer's recommendations; and</li> <li>d. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and</li> </ul> </li> <li>7. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of testing, calibration, or repair.</li> <li>B. An outpatient treatment center may have a bathroom used for the collection of a patient's urine or stool that is not for the exclusive use of the outpatient treatment center if: <ul style="list-style-type: none"> <li>1. The bathroom is located in the same contiguous building as the outpatient treatment center's premises,</li> <li>2. The bathroom is of a sufficient size to support the outpatient treatment center's scope of services, and</li> <li>3. There is a documented agreement between the licensee and the owner of the building stating that the bathroom complies with the requirements in this Section and allowing the Department access to the bathroom to verify compliance.</li> </ul> </li> <li>C. If an outpatient treatment center has a bathroom that is not for the exclusive use of the outpatient treatment center as allowed in subsection (B), an administrator shall ensure that: <ul style="list-style-type: none"> <li>1. Policies and procedures are established, documented, and implemented to: <ul style="list-style-type: none"> <li>a. Protect the health and safety of an individual using the bathroom; and</li> <li>b. Ensure that the bathroom is cleaned and sanitized to prevent, minimize, and control illness and infection;</li> </ul> </li> <li>2. Documented instructions are provided to a patient that cover: <ul style="list-style-type: none"> <li>a. Infection control measures when a patient uses the bathroom, and</li> <li>b. The safe return of a urine or stool specimen to the outpatient treatment center;</li> </ul> </li> <li>3. The bathroom complies with the requirements in subsection (A)(2)(a); and</li> </ul> </li> <li>4. The bathroom is free from a condition or situation that may cause an individual using the bathroom to suffer a physical injury.</li> </ul> |
| <p><b>R9-10-1911. Affiliated Outpatient Treatment Centers</b></p> <ul style="list-style-type: none"> <li>A. An administrator of an affiliated outpatient treatment center may maintain the following information, required in this Article and integrated with information required in 9 A.A.C. 10, Article 10, for one or more of the affiliated outpatient</li> </ul> |   |

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| <p>treatment center's counseling facilities:</p> <ol style="list-style-type: none"> <li>1. Quality management plan, documented incidents, and reports required in R9-10-1904;</li> <li>2. Contracted services information in R9-10-1905;</li> <li>3. Orientation plan, in-service education plan, and personnel records in R9-10-1906; and</li> <li>4. Medical records in R9-10-1908.</li> </ol> <p><b>B.</b> If an administrator of an affiliated outpatient treatment center maintains integrated files (medical records) according to subsection (A), the administrator shall develop, document, and implement a method of identifying the information in the integrated files to ensure that:</p> <ol style="list-style-type: none"> <li>1. If the quality management plan is integrated, the incidents documented, concerns identified, and changes or actions taken are identified for each facility;</li> <li>2. If a person provides contracted services at more than one facility, the types of services the person provides at each facility is identified in the contract information;</li> <li>3. If an orientation plan is applicable to more than one facility, the orientation a personnel member is expected to obtain at each facility is identified in the orientation plan;</li> <li>4. If an in-service education plan is applicable to more than one facility, the in-service education a personnel member is expected to obtain at each facility is identified in the orientation plan;</li> <li>5. If a personnel member provides counseling at more than one facility, the following is identified in the personnel member's record:           <ol style="list-style-type: none"> <li>a. The days and hours the personnel member provides counseling for each facility;</li> <li>b. If the personnel member's job description is different for each facility:               <ol style="list-style-type: none"> <li>i. Each job description for the personnel member; and</li> <li>ii. Verification of the skills and knowledge to provide counseling according to the personnel member's job description; and</li> </ol> </li> <li>c. If a personnel member is a behavioral health technician, documentation of the clinical oversight provided to the personnel member, based on the number and acuity of the patients to whom the personnel member provided counseling at each facility; and</li> </ol> </li> <li>6. If a patient receives counseling at more than one facility, the counseling received and any information related to the counseling received at each facility is identified in the patient's medical record.</li> </ol> |   |