

ARTICLE 11. HOME HEALTH AGENCIES

R9-10-1101. Definitions [Many of these terms are no longer used or are/will be defined in R9-10-101, for definitions used in more than one Article in the Chapter.]

In this Article, unless the context otherwise requires:

1. "Activities of daily living" means ambulating, communicating, bathing, toileting, grooming, feeding and homemaking.
2. "Advance directives" means a living will, prehospital medical care directive, or health care power of attorney.
- 3.1. "Branch office" means an office which operates a location other than a home health agency's main administrative office:
 - a. That operates under the license of a parent the home health agency, and
 - b. utilizes That is under the control of the same home health agency's administrator.
4. "Coordination" means the process by which the patient or patient's representative and caregivers exchange information and combine efforts to develop and revise the plan of care and provide services.
5. "Discharge summary" means a brief review of service, patient status, and reasons for discharge.
2. "Home health agency" means the same as in A.R.S. § 36-151.
3. "Home health aide" means an individual employed by a home health agency to provide home health services, under the direction of a registered nurse or a therapist.
- 6.4. "Home health aide services" means those tasks which are that are provided to a patient by a home health aide under the supervision direction of a registered nurse or a therapist.
7. "Home health care team" means the physician, patient or patient's representative, patient's family, and home health service providers.
5. "Home health services" means the same as in A.R.S. § 36-151.
6. "Home health services director" means an individual who provides direction for the home health services provided by or through a home health agency.
7. "Medical social services" means activities that assist a patient to cope with concerns about the patient's illness and may include:
 - a. Counseling, and
 - b. Helping to find resources to address the patient's concerns.
8. "Medications" means both prescription and nonprescription drugs used by the patient.

9. "Nurse" means an individual licensed pursuant to A.R.S. Title 32, Chapter 15.
10. "Occupational therapist" means an individual licensed pursuant to A.R.S. Title 32, Chapter 34.
11. "Occupational therapist assistant" means an individual licensed pursuant to A.R.S. Title 32, Chapter 34.
12. "Parent home health agency" means the licensed agency that develops and maintains administrative control of branch offices.
13. "Patient's representative" means a person acting on behalf of a patient under the written consent of the patient or the patient's legal guardian, or a surrogate pursuant to A.R.S. § 36-3201(13).
8. "Personnel member" means an individual who provides services to a patient on behalf of a home health agency.
14. "Personal care services" means assistance with activities of daily living and services which are not related to the treatment of a patient's illness or injury.
15. "Pharmacist" means an individual licensed pursuant to A.R.S. Title 32, Chapter 18.
16. "Physical therapist" means an individual licensed pursuant to A.R.S. Title 32, Chapter 19.
17. "Physician" means an individual licensed pursuant to A.R.S. Title 32, Chapters 13 and 17.
18. "Professional services" means medical social work, nutritional services, respiratory care services, and pharmaceutical services.
19. "Registered dietitian" means an individual who holds a bachelor's or master's degree in food and nutrition and is registered with the Commission on Dietetic Registration.
20. "Respiratory care practitioner" means an individual licensed pursuant to A.R.S. Title 32, Chapter 35.
21. "Social worker" means an individual who holds a master's degree from a school accredited by the Council on Social Work Education.
22. "Social work assistant" means an individual who holds a bachelor's degree in counseling, social work, psychology, or sociology.
23. "Speech language pathologist" means an individual who holds a Certificate in Clinical Competency in Speech Language Pathology from the American Speech Language Hearing Association.
24. "Therapy" means occupational therapy, physical therapy, or speech therapy.

R9-10-1102. Supplementary Application Requirements

In addition to the requirements in R9-10-105, an applicant for a license as a home health agency shall:

1. Include on a Department-provided application form:
 - a. The name and address of each proposed branch office, if applicable; and
 - b. The geographic region to be served by:
 - i. The proposed home health agency, and
 - ii. Each proposed branch office; and
2. Submit to the Department a copy of a valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1 for: [This is required under A.R.S. § 36-411.]
 - a. If the applicant is an individual, the applicant; or
 - b. If the applicant is a business organization, each individual with a 10% or greater ownership of the business organization.

R9-10-1102. R9-10-1103. Administration

A. A home health agency shall have a governing authority responsible for the agency's operations.

The governing authority shall:

1. Consist of one or more persons responsible for the organization and administration of the home health agency;
2. Establish the scope of services for the home health agency;
3. Adopt and update Approve the policies and procedures for the operation and administration of the home health agency;
4. Appoint an administrator to manage the agency who shall have:
 - a. Has at least three years of administrative or supervisory experience, which shall include of which at least two years of health care experience were in a health care institution licensed in this or another state; and
 - b. May also provide direction for the home health services provided by the home health agency if the administrator meets the requirements in subsection (B)(7);
5. Appoint, according to A.R.S. § 36-151(5)(b) a professional an advisory group which shall: that
 - a. Consist consists of four or more members that include:
 - i.a. One practicing A physician;;
 - ii.b. One A registered nurse who has at least one year of experience as a home health nurse providing home health services; and

- iii.c. Two or more ~~representatives from other health related professions~~ individuals who represent a medical, nursing, or health-related profession;
 - b. ~~Have 25% or more of its members who are not owners, employees, or contractors of the home health agency and who shall:~~
 - 6. Ensure that the advisory group appointed according to subsection (A)(5):
 - i.a. ~~Meet Meets~~ at least ~~once~~ every six ~~12~~ months;:
 - ii.b. ~~Record and maintain Documents~~ minutes of all meetings;:
 - iii. ~~Advise the agency on professional issues, and~~
 - iv.c. ~~Assist Assists~~ in establishing, reviewing, and evaluating policies and procedures for the home health agency;:
 - 7. For a home health agency that is a business organization, ensure that a copy of a valid fingerprint clearance card, issued according to A.R.S. Title 41, Chapter 12, Article 3.1, is submitted to the Department, as required by A.R.S. § 36-411, for each individual with a 10% or greater ownership of the business organization; and
 - 8. Adopt a quality management plan that complies with R9-10-1110.
- B. ~~The An administrator shall organize and manage the agency and shall be responsible for the following:~~
- 1. Reporting Be directly accountable to the governing authority for all services provided by or through the home health agency;
 - 2. Have the authority and responsibility for operating the home health agency;
 - 2.3. Maintaining communication with Act as a liaison between the governing authority, professional advisory group, staff, and community employees of the home health agency;
 - 3.4. Ensuring that the parent home health agency has the capability of providing supervision and services on a daily basis to the branch offices Establish, document, and implement policies and procedures that:
 - a. Include employee job descriptions, duties, and qualifications;
 - b. Cover orientation and in-service education for employees and volunteers;
 - c. Cover staffing and recordkeeping;
 - d. Cover patient admissions, rights, discharge instructions, and discharge;
 - e. Cover the provision of home health services and, if applicable, supportive services in the home health agency's scope of services;
 - f. Cover patient medical records, including electronic medical records;
 - g. Cover when informed consent is required and by whom informed consent may be given;

- h. Cover the actions to be taken in the event of an emergency;
 - i. Cover the receipt of and process for resolving complaints;
 - j. Cover health care directives;
 - k. Cover medication procurement, if applicable, and administration;
 - l. Cover contract services;
 - m. Cover equipment inspection and maintenance, if applicable;
 - n. Cover infection control; and
 - o. Cover quality management, including incident documentation;
- 5. Ensure that policies and procedures are:
 - a. Available to all employees and contractors of the home health agency, and
 - b. Reviewed at least once every 24 months and updated as needed;
- 6. Ensure that records of advisory group meetings are maintained for at least two years after the date of the meeting;
- 4.7. Appointing Appoint as a home health services director:
 - a. a supervising A physician who has at least two years of home health experience working for or with a home health agency, or
 - b. a supervising A registered nurse who has at least three years of nursing experience, which includes including at least two years of experience in home health care as a nurse providing home health services;
- 8. Designate, in writing, a physician or registered nurse, who has at least one year of experience providing home health services, to provide direction for the home health services provided by or through the home health agency in the absence of the home health services director;
- 5. Hiring staff in consultation with the supervising physician or registered nurse;
- 6. Ensuring staff orientation, education, and evaluation;
- 7. Ensuring that written contractual provisions are complied with by the providers of home health services;
- 8. Ensuring that providers of therapy and other professional services provide the agency with documentation of a degree, certification, or registration in good standing for the profession specified in R9-10-1101;
- 9. Ensuring Ensure that therapy and other professional services are provided, as follows:
 - a. Speech therapy or speech-language pathology services shall be are provided by a speech-language pathologist licensed according to A.R.S. Title 36, Chapter 17,

- Article 4 or speech-language pathologist assistant licensed according to A.R.S. § 36-1940.04.;
- b. Nutritional services ~~shall be~~ are provided by a registered dietitian.;
 - c. Occupational therapy services ~~shall be~~ are provided by an occupational therapist or occupational ~~therapist~~ therapy assistant licensed according to A.R.S. Title 32, Chapter 34.;
 - d. Physical therapy services ~~shall be~~ are provided by a physical therapist licensed according to A.R.S. Title 32, Chapter 19, or a physical therapist assistant certified according to A.R.S. Title 32, Chapter 19.;
 - e. Respiratory care services ~~shall be~~ are provided by a respiratory ~~care practitioner~~ therapist or respiratory therapy technician licensed according to A.R.S. Title 32, Chapter 35 or ~~by~~ a registered nurse.;
 - f. Pharmacy services ~~shall be~~ are provided by a pharmacist licensed according to A.R.S. Title 32, Chapter 18. and
- 10.g. Medical social ~~work~~ services are provided:
- i. For medical social services under the practice of social work as defined in A.R.S. § 32-3251, by a clinical social worker, licensed according to A.R.S. § 32-3293, or may be provided by a licensed baccalaureate social work assistant worker under the supervision of a social worker, according to A.R.S. § 32-3291; and
 - ii. For other medical social services, by an individual with a master's or higher degree in social work. Each social worker shall have who has at least one year of social work experience in a health care setting or by a licensed baccalaureate social worker, according to A.R.S. § 32-3291;
10. Ensure that the services specified in subsection (B)(9) are provided to a patient only under an order by the patient's physician, registered nurse practitioner, or podiatrist, as applicable;
11. Maintaining the agency's administrative records, quality management activities, personnel records, and policies and procedures;
12. Designating, in writing, a physician or registered nurse who shall have one year of home health experience to act in the absence of the supervising physician or registered nurse to ensure that supervisory coverage shall be provided during all operating hours of the agency;

11. Unless otherwise stated, ensure that documentation required by this Article is provided to the Department within two hours after the Department's request; and
 - 13.12. Designating Designate, in writing, an individual to act who is responsible for services provided by the home health agency in the administrator's absence.
- C. ~~The supervising physician or registered nurse shall be responsible for the quality, coordination, and supervision of home health services, including the following:~~
1. ~~Implementing the agency's policies and procedures;~~
 2. ~~Participating in employment decisions affecting nursing, therapy, and other professional personnel;~~
 3. ~~Providing staff orientation, in-service education, and performance evaluations;~~
 4. ~~Coordinating, monitoring, and evaluating contractual services for all services not provided directly by the home health agency; and~~
 5. ~~Recordkeeping of training and education for staff.~~
- D. ~~The supervising physician or registered nurse may also function as the administrator of the home health agency.~~

R9-10-1103. R9-10-1104. Personnel

A. An administrator shall ensure that:

1. Except as specified in A.R.S. § 36-411(H), an employee provides to the administrator a copy of a:
 - a. Valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1; or
 - b. Fingerprint clearance card application showing that the employee submitted the application to the fingerprint division of the Department of Public Safety under A.R.S. § 41-1758.02 within 20 working days after becoming an employee;
2. A volunteer who is a personnel member:
 - a. Complies with subsection (A)(1)(a) or (b), or
 - b. Provides services to patients under the supervision of an individual who has a valid fingerprint clearance card; and
3. An employee or volunteer does not act as a personnel member unless the employee or volunteer meets the requirements of A.R.S. § 36-411.

A.B. Personnel shall provide services An administrator shall ensure that:

1. Personnel members are available to meet the needs of each patient, according to the patient's plan of care.;

- B-2. A personnel member, prior to being employed and annually thereafter, shall submit one of the following as before being employed and every 12 months after the starting date of employment, provides evidence of freedom from pulmonary infectious tuberculosis as required in R9-10-1???: and [Updated requirements that will be applicable to all health care institutions in which TB testing is required will be in Article 1.]
1. A report of a negative Mantoux skin test taken within six months of submitting the report, or
 2. A written statement from a physician stating that, upon an evaluation of a positive Mantoux skin test taken within six months of submitting the physician's statement or a history of a positive Mantoux skin test, the individual was found to be free from pulmonary tuberculosis.
- C. Personnel providing direct patient care shall attend orientation and six hours of in-service training per year, which may include time spent in orientation. Orientation shall include:
1. Patient care policies and procedures;
 2. Infection control policies and procedures; and
 3. Patient rights.
- D. Home health aides, prior to being assigned patient care tasks, shall complete a home health aide training program which shall include the following subjects:
1. Communication skills;
 2. Observation, reporting, documentation of patient status, and the care or service provided;
 3. Reading and recording temperature, pulse, and respiration;
 4. Basic infection control procedures;
 5. Basic elements of body functioning and changes in function that must be reported to a home health aide's supervisor;
 6. Maintenance of a clean, safe, and healthy environment;
 7. Recognizing emergencies and knowledge of emergency procedures;
 8. Physical, emotional, and developmental needs of the populations serviced by the home health agency;
 9. Techniques in providing personal hygiene and grooming;
 10. Activities of daily living;
 11. Transfer techniques;
 12. Range of motion and positioning;
 13. Nutrition and fluid intake; and
 14. Patient rights.

3. Within the first week of employment, a personnel member receives orientation that:
 - a. Is specific to the duties to be performed by the personnel member;
 - b. Includes training on:
 - i. Personnel policies;
 - ii. Patient rights;
 - iii. Basic infection control techniques, including hand washing and prevention of communicable diseases; and
 - iv. Patient care policies and procedures; and
 - c. For a home health aide, includes training on:
 - i. Communication skills;
 - ii. Recognizing emergencies and knowledge of emergency procedures;
 - iii. Physical, emotional, and developmental needs of the types of patients served by the home health agency;
 - iv. Changes in temperature, pulse, respiration, elimination, or other bodily functions that must be reported to a home health aide's supervisor;
 - v. Observing and documenting patient status and the care or services provided to a patient;
 - vi. Techniques in providing personal hygiene and grooming;
 - vii. Nutrition and fluid intake;
 - viii. Assistance with activities of daily living;
 - ix. Transfer techniques; and
 - x. Range of motion and positioning.

E.C. The An administrator shall ensure that a personnel record for each employee includes the following documentation:

1. Includes:
 - 1.a. Employee name and address The employee's name, date of birth, home address, and contact telephone number;
 - b. The name and telephone number of an individual to be notified in case of an emergency;
 - c. The starting date of employment and, if applicable, the ending date; and
 - d. As applicable, documentation of:
 - 2.i. Education and work experience Qualifications, including education, experience, skills, and knowledge applicable to the employee's job duties;

- ii. Work experience:
 - 3.iii. Verification of any professional license, License, certification, registration, and or education, requirements if necessary for the position held;
 - 4.iv. Initial proof Evidence of freedom from pulmonary infectious tuberculosis and annual verification statement, thereafter, as required in subsection (B)(2);
 - v. Compliance with the requirements in A.R.S. § 36-411; and
 - 5.vi. Orientation and in-service training records education; and
 - 6. Competence and performance evaluations of home health aide and personal care attendant skills.
2. Are maintained by the home health agency for at least two years after the last date the employee provided services for the home health agency.

R9-10-1104. R9-10-1105. Home Health Services

- A. The supervising physician or registered nurse shall ensure that nursing services shall be managed in accordance with the following:
 - 1. Unless a physician orders therapy services only, a registered nurse shall conduct patient assessments as follows:
 - a. The initial assessment shall be conducted within 72 hours of a patient's acceptance into a home health program and shall include a review of advance directives;
 - b. Reassessments shall be conducted within 62 day periods thereafter, according to the patient's needs and as the patient's condition warrants; and
 - c. The assessments shall include:
 - i. Patient needs, resources, family, and environment;
 - ii. Goals of patient care;
 - iii. Medications used by the patient, including the side effects and contraindications; and
 - iv. A listing of required medical supplies and durable medical goods.
 - 2. A registered nurse shall be responsible for the following:
 - a. Implementing a patient's plan of care;
 - b. Coordinating patient care with other members of the home health care team;

- e. ~~Assigning a licensed practical nurse to provide nursing services in accordance with home health agency policies;~~
 - d. ~~Supervising home health aides and assigning written patient care duties to individual home health aides;~~
 - e. ~~Informing the patient's physician of changes in a patient's condition and needs;~~
 - f. ~~Summarizing the patient's status for submission to the physician, every 62 days or more often, as the patient's condition warrants;~~
 - g. ~~Ensuring that the findings and ongoing services are documented in the medical record for each patient contact;~~
 - h. ~~Participating in the preparation of patient transfer, discharge plan, and discharge summary;~~
 - i. ~~Documenting verbal orders received from the physician in the medical record;~~
 - j. ~~Conducting supervisory visits to the patient who is receiving home health aide services to determine the quality of care being given by the home health aide, according to the following schedule:~~
 - i. ~~Every two weeks when home health aide services together with either nursing services or therapy services are being provided; or~~
 - ii. ~~Every 62 days while only home health aide services are being provided; and~~
 - k. ~~Evaluating, by direct observation of performance, the competency of the home health aide and personal care attendant.~~
- B. ~~The supervising physician or registered nurse shall ensure that home health aide services are provided under the supervision of a registered nurse as follows:~~
- 1. ~~Home health aide services shall be provided by an individual who has completed a home health aide training program pursuant to R9 10 1103(D) or by an individual who is in good standing with the State Board of Nursing, Nurse Aide Register.~~
 - 2. ~~Each home health aide shall:~~
 - a. ~~Perform only those tasks assigned, in writing, by the registered nurse or a therapist pursuant to subsection (C)(4);~~
 - b. ~~Report any observations of change in a patient's condition to the registered nurse; and~~
 - c. ~~Document care provided in the patient's medical record.~~
- C. ~~The supervising physician or registered nurse shall ensure that providers of therapy and other professional services comply with the following:~~

1. The services shall be ordered by a physician and provided in accordance with the patient's plan of care.
 2. A therapist or individual providing professional services shall:
 - a. Assist the physician in evaluating the patient's needs;
 - b. Participate in developing, evaluating, and revising the plan of care and establishing goals;
 - c. Coordinate patient care with other members of the home health care team;
 - d. Ensure that the findings and ongoing services are documented in the medical record; and
 - e. Participate in the preparation of the patient transfer, discharge plan, and discharge summary.
 3. A therapist or provider of professional services shall document any physician orders received pertaining to their respective therapy or professional services.
 4. A therapist may supervise a home health aide when a physician orders home health aide and therapy services only. As a supervisor, the therapist shall:
 - a. Assign patient care duties, in writing, to the home health aide;
 - b. Comply with the assessment requirements in subsection (A)(1); and
 - c. Comply with the registered nurse visitation requirements in subsection (A)(2)(j)(i).
- A.** An administrator shall ensure that an individual admitted to the home health agency has an order from a physician, registered nurse practitioner, or podiatrist for home health services.
- B.** An administrator shall ensure that the home health services director provides direction for home health services provided by or through the home health agency.
- C.** A home health services director shall ensure that nursing services are provided by a registered nurse or practical nurse, according to the home health agency's policies and procedures.
- D.** A home health services director shall ensure that a registered nurse:
1. Unless a patient's physician or registered nurse practitioner orders only speech therapy, occupational therapy, or physical therapy for the patient, within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts an initial assessment of the patient to determine:
 - a. The needs of the patient;
 - b. Resources available to address the patient's needs;
 - c. The patient's home and family environment;
 - d. Goals for patient care;

- e. Medications used by the patient, including non-compliance, drug interactions, side effects, and contraindications; and
 - f. Medical supplies or equipment needed by the patient;
2. Reviews a patient's health care directives at the time of the initial assessment;
 3. Implements a patient's plan of care, developed as specified in R9-10-1107;
 4. Coordinates patient care with other individuals providing home health services or other services to the patient;
 5. Immediately informs the patient's physician or registered nurse practitioner of a change in a patient's condition that requires medical services; and
 6. At least every 60 calendar days until a patient is discharged:
 - a. Reassesses the patient based on the patient's plan of care, needs, and medical condition; and
 - b. Summarizes the patient's condition and needs for the patient's physician, registered nurse practitioner, or podiatrist, as applicable.
- E.** A home health services director shall ensure that:
1. A patient's condition and the services provided to the patient are documented in the patient's medical record after each patient contact; and
 2. Verbal orders from a patient's physician, registered nurse practitioner, or podiatrist, as applicable, are:
 - a. Except as specified in subsection (F)(2)(d), received by a registered nurse and documented by the registered nurse in the patient's medical record; and
 - b. Authenticated by the patient's physician, registered nurse practitioner, or podiatrist, as applicable, with a signature, within 30 days.
- F.** A home health services director shall ensure that:
1. A registered nurse:
 - a. Except as specified in subsection (F)(2)(b)(i) and (ii):
 - i. Assigns tasks in writing to a home health aide who is providing home health services to a patient; and
 - ii. Verifies the competency of the home health aide in performing assigned tasks;
 - b. Except as specified in subsection (F)(2)(b)(iii), provides direction for the home health aide services provided to a patient; and

- c. Except as specified in subsection (F)(2)(e)(ii), meets with a patient who is receiving home health aide services to assess the home health services provided by the home health aide:
 - i. Every two weeks when the patient is also receiving nursing services or therapy services, and
 - ii. Every 60 days when the patient is only receiving home health aide services;
- 2. When a patient's physician or registered nurse practitioner orders speech therapy, occupational therapy, or physical therapy for the patient, an individual specified in R9-10-1103(B)(9)(a), (c), or (d), as applicable:
 - a. Provides the applicable therapy service to the patient according to the patient's plan of care;
 - b. If a home health aide is assigned to assist the patient in performing activities related to the therapy service:
 - i. Assigns tasks in writing to the home health aide who is assisting the patient;
 - ii. Verifies the competency of the home health aide in performing assigned tasks; and
 - iii. Provides direction to the home health aide in performing the assigned tasks related to the therapy service;
 - c. Coordinates the provision of the therapy service to the patient with the registered nurse providing direction for other home health services for the patient;
 - d. Documents in the patient's medical record any orders by the patient's physician or registered nurse practitioner received concerning the therapy service; and
 - e. If the only home health services ordered for the patient are speech therapy, occupational therapy, or physical therapy:
 - i. Within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts an initial assessment of the patient as specified in subsections (D)(1)(a) through(f); and
 - ii. Meets with a patient who is receiving home health services from a home health aide every two weeks to assess the home health services provided by the home health aide; and
- 3. A home health aide:

- a. Is only assigned to provide services the home health aide can competently perform; and
- b. Only performs tasks assigned to the home health aide in writing by a registered nurse or as specified in subsection (F)(2)(b)(i).

R9-10-1105. R9-10-1106. Supportive Services

- A. Supportive services do not require a physician order and shall be provided in accordance with agency policies.
- B. Supportive services may include a personal care attendant who is employed by the agency to provide personal care services only. A registered nurse shall assign personal care tasks, in writing, to the attendant and shall ensure that the attendant documents all care provided in the patient's medical record.
- A. A governing authority may include supportive services, including personal care services, in the scope of services for a home health agency.
- B. An administrator:
 - 1. May allow:
 - a. Supportive services to be provided to a patient without an order from a physician, registered nurse practitioner, or podiatrist; and
 - b. A personnel member who is not a home health aide to perform personal care services; and
 - 2. Shall ensure that:
 - a. Supportive services are provided to a patient according to the home health agency's policies and procedures;
 - b. A registered nurse:
 - i. Assesses a patient's need for supportive services,
 - ii. Assigns specific tasks in writing to a home health aide providing supportive services other than personal care services,
 - iii. Assigns specific tasks in writing to a personnel member providing personal care services,
 - iv. Provides direction for supportive services, and
 - v. Includes supportive services in the reassessment of a patient required in R9-10-1105(D)(6); and
 - c. Supportive services are documented in a patient's medical record.

R9-10-1106, R9-10-1107. Plan of Care

- A. ~~Home health services shall be provided by the home health agency in accordance with a written plan of care established and authorized by a physician in consultation with the patient and other members of the home health care team.~~
- B. ~~The plan of care shall be based on the patient's diagnosis and the assessment of the patient's immediate and long term needs and shall include the following:~~
 - 1. ~~Diagnosis;~~
 - 2. ~~Surgery dates relevant to home health services;~~
 - 3. ~~Mental status;~~
 - 4. ~~Functional limitations;~~
 - 5. ~~Rehabilitation potential;~~
 - 6. ~~Type and frequency of services to be provided;~~
 - 7. ~~Treatments, medications, and any drug allergies;~~
 - 8. ~~Therapy and professional services, procedures, and modalities including the amount, frequency, and duration of service;~~
 - 9. ~~Activities permitted;~~
 - 10. ~~Nutritional requirements; and~~
 - 11. ~~Safety measures to protect against injury.~~
- C. ~~Staff shall document, in the medical record, any verbal order for either the initiation or modification to the plan of care and shall include in the record the physician's verifying signature which shall be obtained within 30 days of the order.~~
- D. ~~The home health care team shall review the plan of care every 62 days or more often, as the patient's need or condition warrants. The review shall include the authorization by the physician for the continuation of the patient's plan of care or the revision thereof.~~
- A. An administrator shall ensure that a plan of care is developed for each patient:
 - 1. Based on an assessment of the patient as required in R9-10-1105(D)(1) or (F)(2)(e)(i);
 - 2. With participation from:
 - a. The patient's physician, registered nurse practitioner, or podiatrist, as applicable;
and
 - b. A registered nurse;
 - 3. That includes:
 - a. The patient's diagnosis;
 - b. The patient's health care directives;
 - c. Surgery dates relevant to home health services, if applicable;

- d. The patient's cognitive awareness of self, location, and time;
- e. Functional abilities and limitations;
- f. Goals for functional rehabilitation, if applicable;
- g. The type, duration, and frequency of each service to be provided;
- h. Treatments the patient is receiving from a source other than the home health agency;
- i. Medications and herbal supplements reported by the patient or patient's representative as being used by the patient and the dose, route of administration, and schedule for administration of each medication or herbal supplement;
- j. Any known drug allergies;
- k. Nutritional requirements and preferences;
- l. Specific measures to improve the patient's safety and protect the patient against injury; and
- m. A discharge plan for the patient including, if applicable, a plan for assessing the accomplishment of treatment or therapy goals for the patient.

B. An administrator shall ensure that:

- 1. Home health services are provided to a patient by the home health agency according to the patient's plan of care.
- 2. The patient's plan of care is reviewed and updated:
 - a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of the services being provided;
 - b. If the patient's physician, registered nurse practitioner, or podiatrist, as applicable, orders a change in the plan of care; and
 - c. At least every 60 days; and
- 3. The patient's physician, registered nurse practitioner, or podiatrist, as applicable, authenticates the plan of care with a signature within 30 days after the plan of care is initially developed and whenever the plan of care is reviewed or updated.

- C. Staff shall document, in the medical record, any verbal order for either the initiation or modification to the plan of care and shall include in the record the physician's verifying signature which shall be obtained within 30 days of the order.**
- D. The home health care team shall review the plan of care every 62 days or more often, as the patient's need or condition warrants. The review shall include the authorization by the physician for the continuation of the patient's plan of care or the revision thereof.**

R9-10-1107. R9-10-1108. Patient Rights

- A. The administrator shall establish a written policy regarding the rights of patients and shall ensure the agency's compliance thereto.
- B. The agency shall give each patient or patient's representative a list of patient rights prior to services being provided.
- C. Personnel shall ensure that language barriers or physical handicaps do not prevent each patient or patient's representative from becoming aware of the following patient rights:
 - 1. To be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs;
 - 2. To receive medical, nursing, therapeutic, and personal care in accordance with the patient's plan of care;
 - 3. To refuse treatment or withdraw consent for treatment;
 - 4. To participate in the development of the plan of care and any modification thereof;
 - 5. To have personal and private property treated respectfully and not subject to misappropriation;
 - 6. To have financial and medical records kept in confidence. The release of such records shall be by written consent of the patient or patient's representative, except as otherwise required or permitted by law;
 - 7. To be informed of the following:
 - a. Financial liability prior to obtaining services or prior to a change in rates, charges or services;
 - b. Notice of third party coverage for agency services; and
 - c. The process for registering a complaint with the Office of Health Care Licensure about agency services; and
 - 8. To exercise other civil rights and religious liberties, including the right to submit grievances to the agency, free from restraint, interference, coercion, discrimination, or reprisal.
- A. An administrator shall ensure that:
 - 1. A patient:
 - a. Has privacy in treatment and care for personal needs; and
 - b. Is free from the following:
 - i. The intentional infliction of physical, mental, or emotional pain unrelated to the patient's medical condition or treatment;
 - ii. Exploitation;

- iii. Sexual abuse according to A.R.S. § 13-1404; and
 - iv. Sexual assault according to A.R.S. § 13-1406; and
 - 2. A patient or patient's representative:
 - a. Either consents to or refuses treatment;
 - b. Can withdraw consent for treatment before treatment is initiated;
 - c. Is given the opportunity to participate in the development and updating of the patient's plan of care;
 - d. Is informed of:
 - i. Home health services provided by or through the home health agency;
 - ii. The rates and charges for services before the services are initiated and before a change in rates, charges, or services;
 - iii. A copy of the home health agency's procedures on health care directives; and
 - iv. A copy the process for filing a complaint; and
 - e. May submit complaints without retaliation.
- B.** An administrator shall ensure that:
- 1. A patient's personal and private property are not subject to misappropriation; and
 - 2. A patient's financial records are kept confidential and not released without the written consent of the patient or patient's representative, except as otherwise required or permitted by law.
- C.** An administrator shall ensure that, before or at the time a patient first receives services by or through the home health agency, the patient or patient's representative receives a copy of a patient's rights.

R9-10-1108. R9-10-1109. Medical Records

- A.** The administrator shall ensure the maintenance of policies and procedures governing the protection and confidentiality of medical records.
- B.** Each agency shall maintain a medical record for each patient which contains the following:
 - 1. Patient name and address, name of patient's representative, caretaker, and physician;
 - 2. Written acknowledgment that the patient received a copy of patient rights prior to the beginning of care;
 - 3. Documentation concerning advance directives;
 - 4. Medical history, current diagnoses, and findings;
 - 5. Plan of care;

6. ~~Physician orders;~~
7. ~~Initial and periodic assessments and progress notes that are dated, signed by the person providing the service, and filed weekly;~~
8. ~~Documentation of each patient contact for care or services;~~
9. ~~Reports of patient home health service conferences;~~
10. ~~Reports of patient summaries sent to the physician;~~
11. ~~Reports of contacts with the physician by staff and the patient;~~
12. ~~Supervisory reports on home health aide and personal care services; and~~
13. ~~Patient transfer or discharge plan and discharge summary.~~

C. ~~Medical records shall be maintained for five years beyond the last date of service provided. If the patient is a minor, the medical record shall be retained for three years after the patient reaches 18 years of age.~~

A. An administrator shall ensure that a medical record is established and maintained for each patient according to A.R.S. § 12-2297 and the home health agency's policies and procedures.

B. An administrator shall ensure that the medical record for a patient includes the following information:

1. The patient name, address, date of birth, and telephone number;
2. The name and telephone number of the patient's representative, if applicable;
3. The name and telephone number of the patient's physician or registered nurse practitioner;
4. The name and telephone number of the patient's podiatrist, if applicable;
5. The patient's health care directives;
6. The patient's medical history and current diagnoses;
7. The medications used by the patient;
8. Any known allergies;
9. The initial assessment of the patient;
10. The patient's plan of care;
11. Orders by the patient's physician, registered nurse practitioner, or podiatrist, as applicable;
12. Documentation of tasks assigned to a home health aide or other personnel member;
13. Progress notes for each patient contact including:
 - a. The date of the patient contact,
 - b. The services provided,
 - b. A description of the patient's condition, and

- c. Instructions given to the patient or patient's representative;
- 14. Documentation for each medication that a personnel member administers to the patient or assists the patient to self-administer, including:
 - a. The dose, route of administration, and date and time of administration; and
 - b. Adverse reactions that may be related to the administration of the medication;
- 15. Documentation of coordination of patient care;
- 16. Copies of patient summary reports sent to the patient's physician, registered nurse practitioner, or podiatrist, as applicable;
- 17. Documentation of contacts with the patient's physician, registered nurse practitioner, or podiatrist, as applicable, by a personnel member and the patient;
- 18. Reports of meetings with the patient to assess the home health services and supportive services provided to the patient;
- 19. The patient transfer or discharge plan; and
- 20. If applicable, discharge instructions and the discharge summary.

R9-10-1109, R9-10-1110. Quality Management

- A. The administrator shall ensure implementation and maintenance of a quality management program that monitors and evaluates the provision of patient care including contracted services.
- B. The quality management plan shall be in writing and describe the objectives, scope, and process for improving quality of care which shall include the monitoring of activities.
- C. Each quarter, a group of health care professionals, representing the home health services provided during the previous quarter, shall review a 10% sample or 30 medical records, whichever is lesser. The review shall:
 - 1. Ensure that policies and procedures are followed in providing services directly or under contract; and
 - 2. Be documented as part of the quality management process.
- D. The administrator shall maintain a record of quality management activities and ensure that any conclusions and recommendations on findings of quality management activities are reported to the governing authority.

An administrator shall ensure that:

- 1. A plan for a quality management program for the home health agency is established, documented, and implemented that includes:
 - a. A method to identify, document, and evaluate incidents;

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