

**TITLE 9. HEALTH SERVICES**  
**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES**  
**HEALTH CARE INSTITUTIONS: LICENSING**  
**ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES**

- R9-10-301. Definitions**
- R9-10-302. Supplemental Application Requirements**
- R9-10-303. Administration**
- R9-10-304. Quality Management**
- R9-10-305. Contracted Services**
- R9-10-306. Personnel and Staffing**
- R9-10-307. Patient Admission; Assessment**
- R9-10-308. Treatment Plan**
- R9-10-309. Discharge**
- R9-10-310. Transport; Transfer**
- R9-10-311. Patient Outings**
- R9-10-312. Patient Rights**
- R9-10-313. Patient Records**
- R9-10-314. Physical Health Services**
- R9-10-315. Behavioral Health Services**
- R9-10-316. Restraint and Seclusion**
- R9-10-317. Observation/stabilization Services**
- R9-10-318. Detoxification Services**
- R9-10-319. Medication Services**
- R9-10-320. Food Services**
- R9-10-321. Environmental Standards**
- R9-10-322. Fire and Safety Requirements**
- R9-10-323. Physical Plant Requirements**

## **R9-10-301. Definitions**

In addition to the definitions in R9-10-101, the following definitions apply in this Article unless otherwise specified:

1. "Admission" means written acceptance by a health care institution to provide medical services, nursing services, or health-related services to an individual.
2. "Ancillary services" means services other than behavioral health services or physical health services provided to a patient by or at a facility.
2. "Assessment" means an analysis of a patient's need for medical services, nursing services, and health-related services to determine which services a health care institution will provide to the patient.
3. "Authenticate" means to establish authorship of a document or an entry in a medical record by:
  - a. A written signature;
  - b. An individual's initials, if the individual's written signature appears on the document or in the medical record;
  - c. A rubber-stamp signature; or
  - d. An electronic signature code.
4. "Available" means:
  - a. For an individual, the ability to be contacted by any means possible such as telephone or pager;
  - b. For equipment or supplies, physically retrievable at a health care institution; or
  - c. For a document, retrievable in writing or electronically at a health care institution.
5. "Behavioral health inpatient facility" or "facility" means a health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
  - a. Have a limited or reduced ability to meet the individual's basic physical needs;
  - b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
  - c. Be a danger to self as defined in A.R.S. § 36-501;
  - d. Be a danger to others as defined in A.R.S. § 36-501;
  - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
  - f. Be gravely disabled as defined in A.R.S. § 36-501.

6. "Behavioral health issue" means an individual's condition related to a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
7. "Behavioral health paraprofessional" means an individual who is qualified according to a facility's policies and procedures to provide at or for a facility:
  - a. Behavioral health services under the supervision of a behavioral health professional, and
  - b. Ancillary services.
8. "Behavioral health professional" means an individual licensed under A.R.S. Title 32 whose scope of practice allows the individual to:
  - a. Independently provide behavioral health services, or
  - b. Provide behavioral health services under direct supervision as defined in A.A.C. R4-6-101.
9. "Behavioral health service" means the assessment, diagnosis, or treatment of an individual's behavioral health issue.
10. "Behavioral health technician" means an individual who is qualified according to a facility's policies and procedures to provide at or for a facility:
  - a. Behavioral health services under clinical oversight by a behavioral health professional, and
  - b. Ancillary services.
11. "Clinical oversight" means:
  - a. Monitoring the behavioral health services provided by a behavioral health technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures,
  - b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services,
  - c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services, and
  - d. Recommending training for a behavior health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.
12. "Crisis services" means immediate and unscheduled behavioral health services provided to an individual:
  - a. In response to the individual's behavioral health issue to prevent imminent harm to the individual, or
  - b. To stabilize or resolve an acute behavioral health issue.

13. "Current" means up-to-date and extending to the present time.
14. "Danger to others" has the same meaning as in A.R.S. § 36-501.
15. "Danger to self" has the same meaning as in A.R.S. § 36-501.
16. "Detoxification services" means behavioral health services and medical services provided to an individual to:
  - a. Reduce or eliminate the individual's dependence on alcohol or other drugs, or
  - b. Provide treatment for the individual's signs or symptoms of withdrawal from alcohol or other drugs.
17. "Discharge" means a documented termination of the medical services, nursing services, or health-related services provided by a health care institution to a patient.
18. "Employee" means an individual compensated by a facility to work for the facility.
19. "Incident" means an unexpected occurrence that harms or has the potential to harm a patient.
20. "Interval note" means documentation updating a patient's medical condition after a medical history and physical examination are performed.

*"Licensed capacity" means the total number of persons for whom the health care institution is authorized by the Department to provide services as required pursuant to this Chapter if the person is expected to stay in the health care institution for more than 24 hours. For a hospital, licensed capacity means only those beds specified on the hospital license. (A.R.S. § 36-401)*
21. "Licensed occupancy" means the total number of individuals for whom a facility is authorized by the Department to provide crisis services in an observation/stabilization unit.
22. "Medical history" means an account, based on information provided by a patient, of the patient's past and present medical conditions.
23. "Mental disorder" has the same meaning as in:
  - a. A.R.S. § 36-501; or
  - b. A.R.S. § 36-3701 for an individual receiving treatment as a sexually violent person according to A.R.S. Title 36, Chapter 37.
24. "Nurse" has the same meaning as "registered nurse" or "practical nurse" in A.R.S. § 32-1601.
25. "Observation chair" means a physical piece of equipment that is located in a designated area where observation/stabilization are provided and that allows an individual to fully recline and is used by the individual while receiving crisis services.
26. "Observation/stabilization services" means crisis services and continuous supervision provided to an individual for less than 24 consecutive hours.
27. "Outing" means a planned activity that:
  - a. Occurs away from the facility premises, and

- b. Is not part of a facility's daily routine.
28. "Patient's representative" means:
- a. The patient's legal guardian,
  - b. If the patient is under 18 years of age and not an emancipated minor, the patient's parent;
  - c. If the patient is 18 years of age or older or an emancipated minor, a individual acting on behalf of the patient with the written consent of the patient or the patient's legal guardian;  
or
  - d. A surrogate as defined in A.R.S. § 36-3201.
29. "Personnel member" means an individual who provides behavioral health services or physical health services at or on behalf of a facility.
30. "Progress note" means documentation of:
- a. A behavioral health service, nursing service, or medical service provided to a patient and the patient's response that is observed;
  - b. A patient's significant change in condition; or
  - c. A personnel member's observation of a patient's behavior.
31. "Registered nurse" means an individual licensed to practice professional nursing under A.R.S. Title 32, Chapter 15.
32. "Substance abuse" means an individual's misuse of alcohol or other drug or chemical that:
- a. Alters the individual's behavior or mental functioning;
  - b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
  - c. Impairs, reduces, or destroys the individual's social or economic functioning.
- "Supervision" means direct overseeing and inspection of the act of accomplishing a function or activity.*
33. "Transfer" means a facility discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending facility.
34. "Transport" means a facility sending a patient to another health care institution for outpatient services with the intent of returning the patient to the sending facility.

#### **R9-10-302. Supplemental Application Requirements**

In addition to the requirements in 9 A.A.C. 10, Article 1, an administrator shall submit a request to provide any of the following services with an initial application:

- 1. Inpatient services to individuals under 18 years of age including the licensed capacity requested;

2. Inpatient services to individuals 18 years of age and older including the licensed capacity requested;
3. Detoxification services;
4. Court-ordered pre-petition screening;
5. Court-ordered evaluation;
6. Court-ordered treatment; and
7. Observation/stabilization services including:
  - a. Licensed occupancy requested for providing observation/stabilization services to individuals under 18 years of age, and
  - b. Licensed occupancy requested for providing observation/stabilization services to individuals 18 years of age and older.

**R9-10-303. Administration**

- A. A governing authority shall:
  1. Consist of one or more individuals accountable for the organization, operation, and administration of a facility;
  2. Designate the scope of services provided by or at the facility;
  3. Designate an administrator who meets the qualifications established by the governing authority;
  4. Approve facility policies and procedures or designate an individual to approve facility policies and procedures;
  5. Approve contracted services or designate an individual to approve contracted services;
  6. Adopt a quality management program according to R9-10-304;
  7. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
  8. Appoint an acting administrator, in writing, if the administrator is expected to be absent for more than 30 days; and
  9. Except as provided in subsection (A)(8), notify the Department according to § A.R.S. 36-425(I) when there is a change in the administrator.
- B. An administrator shall:
  1. Be directly accountable to the governing authority for all services of the facility;
  2. Have the authority and responsibility to manage the facility;
  3. Act as a liaison between the governing authority and employees; and
  4. Except as provided in subsection (A)(8), designate, in writing, an individual who is available and accountable for facility services when the administrator is not available.
- C. An administrator shall ensure that:

1. Facility policies and procedures are established, documented, and implemented that:
  - a. Include personnel job descriptions, duties, and qualifications including required education, experience, skills, and knowledge for employees, volunteers, and interns;
  - b. Cover orientation and training for employees, volunteers, and interns;
  - c. Include how an employee may submit a complaint about services related to patient care;
  - d. Cover cardiopulmonary resuscitation training including:
    - i. The method and content of cardiopulmonary resuscitation training including a requirement for a personnel member to demonstrate resuscitation techniques;
    - ii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
    - iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
    - iv. The documentation that verifies personnel members have received cardiopulmonary resuscitation training;
  - e. Cover first aid training;
  - f. Include a method to identify a patient to ensure the patient receives physical health services and behavioral health services as ordered;
  - g. 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;
  - h. Cover health care directives according to § A.R.S. 36-3201;
  - i. Cover medical records, including electronic medical records;
  - j. Cover quality management, including incident documentation; and
  - k. Cover when individuals may visit patients in the facility;
2. Facility policies and procedures for facility services are established, documented, and implemented that:
  - a. Cover patient screening, admission, assessment, treatment plan, transport, transfer, discharge planning, and discharge;
  - b. Cover patient outings;
  - c. Cover when general consent and informed consent are required;
  - d. Cover the provision of ancillary services, behavioral health services, and physical health services listed in the facility's scope of services;
  - e. Cover restraint and seclusion;
  - f. Cover dispensing, administering, and disposing of medications, including provisions for inventory control and preventing diversion of controlled substances;
  - g. Cover infection control;

- h. Cover telemedicine, if applicable;
  - i. Cover environmental services that affect patient care;
  - j. Cover specific steps and deadlines for:
    - i. A patient to file a grievance,
    - ii. The facility to respond to and resolve a patient grievance; and
    - iii. The facility to obtain documentation of fingerprint clearance, if applicable;
  - k. Cover how incidents listed in R9-10-303(G) are reported and investigated;
  - l. Cover whether pets or other animals are allowed on the premises, including procedures to ensure that any pets or animals allowed on the premises do not endanger the health or safety of patients or the public;
  - m. Cover the establishment and use of a Human Subjects Review Committee if the facility is involved in research;
  - n. Cover the process for receiving a fee from and refunding a fee to an adult patient or a patient's representative;
  - o. Cover the process for obtaining patient preferences for social, recreational, or rehabilitative activities and meals and snacks;
  - p. Cover the security of a patient's possessions that are allowed on the premises;
  - q. Cover smoking and use of tobacco products on the premises; and
  - r. If a facility does not provide restraint and seclusion, cover how the facility will respond to a patient's sudden, intense, or out of control behavior to prevent harm to the patient or another individual;
3. Unless otherwise stated, documentation required by this Chapter is provided to the Department within two hours after the Department's request;
  4. Facility policies and procedures are reviewed at least once every 24 months and updated as needed; and
  5. Facility policies and procedures are available to employees.
- D. An administrator shall ensure that facility policy and procedures for behavioral health technicians and behavioral health paraprofessionals are established, documented, and implemented that:
1. Delineate the services a behavioral health technician or a behavioral health paraprofessional is allowed to provide at or for the facility;
  2. Delineate the methods used to provide clinical oversight including when clinical oversight is provided on an individual basis or in a group setting;
  3. If clinical oversight is provided electronically, ensure that:



- a. The clinical oversight is provided verbally with direct and immediate interaction between the individual providing and the individual receiving the clinical oversight;
  - b. A secure connection is used; and
  - c. The identities of the individual providing and the individual receiving the clinical oversight are verified before clinical oversight is provided;
4. For each week that a behavioral health technician provides services related to patient care at a facility, ensure that the behavioral health technician receives clinical oversight at least once during that week;
  5. Establish the duration of clinical oversight provided to a behavioral health technician to ensure that patient needs are met based on, for each behavioral health technician:
    - a. The scope and extent of the services provided;
    - b. The acuity of the patients receiving services; and
    - c. The number of patients provided services;
  6. Establish the process by which information pertaining to services provided by a behavioral health technician is provided to the individual who is responsible for clinical oversight of the behavioral health technician;
  7. Establish qualifications for individuals who provide clinical oversight to behavioral health technicians and supervision to behavioral health paraprofessionals;
  8. Ensure that when a behavioral health technician provides services under the practice of marriage and family therapy as defined in A.R.S. § 32-3251, the practice of professional counseling as defined in A.R.S. § 32-3251, the practice of social work as defined in A.R.S. § 32-3251, or the practice of substance abuse counseling as defined in A.R.S. § 32-3251, the behavioral health technician receives clinical oversight from an individual licensed pursuant to A.R.S. Title 32, Chapter 33 to provide the specific service being provided by the behavioral health technician;
  9. Ensure that clinical oversight provided to a behavioral health technician is documented in the behavioral health technician's personnel record; and
  10. Ensure that if a behavioral health paraprofessional provides services under the practice of marriage and family therapy as defined in A.R.S. § 32-3251, the practice of professional counseling as defined in A.R.S. § 32-3251, the practice of social work as defined in A.R.S. § 32-3251, or the practice of substance abuse counseling as defined in A.R.S. § 32-3251, the behavioral health paraprofessional is under the supervision of an individual licensed pursuant to A.R.S. Title 32, Chapter 33 to provide the specific service being provided by the behavioral health paraprofessional.

E. An administrator shall:

1. Designate a medical director who:
    - a. Provides direction for physical health services provided by or at the facility,
    - b. Is a medical practitioner; and
  2. Designate a clinical director who:
    - a. Provides direction for the behavioral health services provided by or at the facility;
    - b. Is a behavioral health professional; and
    - c. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(3) and (E)(2)(a) and (b).
- G. An administrator shall provide written notification to the Department:
1. Within one working day after a patient's death;
  2. Within two working days after a patient's suicide attempt or infliction of self-injury that results in the patient needing medical services; and
  3. Within three working days after a patient has an accident, emergency, or serious injury that results in the patient needing medical services.

**R9-10-304. Quality Management**

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
  - a. A method to identify, document, and evaluate incidents;
  - b. A method to collect data to evaluate the delivery of services related to patient care, including contracted services;
  - c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
  - 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
  - e. The frequency of submitting a documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
  - a. An identification of each concern about the delivery of services related to patient care; and
  - b. Any changes made or actions taken as a result of the identification of a concern about the delivery of services related to patient care; and

3. The report required in subsection (2) and the supporting documentation for the report are maintained on the facility premises for 12 months after the date the report is submitted to the governing authority.

#### **R9-10-305. Contracted Services**

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article;
2. A contract includes the responsibilities of each contractor; and
3. A documented list of current contracted services is maintained at the facility that includes:
  - a. The name of each contractor, and
  - b. A description of the contracted services provided.

#### **R9-10-306. Personnel and Staffing**

A. An administrator shall ensure that:

1. An employee is at least 21 years old;
2. An intern is at least 18 years old; and
3. A volunteer is at least 21 years old.

B. An administrator shall ensure that the facility has employees with the qualifications, education, experience, skills, and knowledge necessary to provide the facility's scope of services and to ensure the health and safety of the facility's patients.

C. An administrator shall ensure that an individual who is a baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor is under direct supervision as defined in R4-6-101.

D. An administrator shall ensure that at the starting date of employment, volunteer service, or internship and every 12 months after, an employee, volunteer, or intern submits one of the following as evidence of freedom from infectious tuberculosis:

1. A report of a negative Mantoux skin test administered within six months before the report is submitted; or
2. If the employee has had a positive skin test for tuberculosis, a written statement from a medical practitioner dated within six months before the statement is submitted indicating that the employee is free from infectious tuberculosis.

E. An administrator shall ensure that a personnel record is maintained for each employee, volunteer, and intern that contains:

1. The employee's name, date of birth, home address, and contact telephone number;
2. The name and telephone number of an individual to be notified in case of an emergency;

3. The starting date of employment, volunteer service, or internship and, if applicable, the ending date; and
  4. As applicable, documentation of:
    - a. The employee's qualifications including education, experience, skills, and knowledge applicable to the employee's job duties;
    - b. The employee's work experience;
    - c. If the facility serves children, the employee's, volunteer's, or intern's compliance with the fingerprinting requirements in A.R.S. § 36-425.03;
    - d. The clinical oversight required in R9-10-303(D);
    - g. The employee's completion of the orientation required in subsection R9-10-303(C);
    - h. The employee's completion of the training required in subsection R9-10-306(I);
    - i. The employee's documentation of cardiopulmonary resuscitation training according to subsection R9-10-303(C)(1)(d) and first aid training, as required in subsection R9-10-306(J).
    - j. The employee's, volunteer's, or intern's freedom from infectious tuberculosis required in subsection (D)(2).
- F. An administrator shall ensure that personnel records are maintained:
1. Throughout an individual's period of employment, volunteer service, or internship; and
  2. For at least two years after the last date of the individual's employment, volunteer service, or internship.
- G. An administrator shall ensure that:
1. The clinical director develops and implements a written plan to provide personnel orientation specific to the duties of employees, volunteers, and interns;
  2. An employee, volunteer, or intern completes orientation before providing services related to patient care;
  3. An employee's, volunteer's or intern's orientation is documented, to include:
    - a. The employee's, volunteer's, or intern's name,
    - b. The date of the orientation, and
    - c. The subject or topics covered in the orientation.
  4. The clinical director develops and implements a written plan to provide personnel member training specific to the duties of the personnel member;
  5. A personnel member completes specific training during the first 12 months of employment and further training every 12 months after the personnel member's first 12 months of employment; and

6. A personnel member's training is documented, to include:
  - a. The personnel member's name,
  - b. The date of the training, and
  - c. The subject or topics covered in the training.
- H. An administrator shall ensure that at least one personnel member who is present at the facility during hours of operation has first-aid and cardiopulmonary resuscitation training specific to the populations served by the facility.
- I. An administrator shall ensure that:
  1. At least one personnel member is present and awake at the facility at all times when a patient is on the premises;
  2. In addition to the personnel member in subsection (I)(1), at least one personnel member is on-call and available to come to the facility when needed, and
  3. The facility has sufficient personnel members to provide general patient supervision and treatment and sufficient personnel members or employees to provide ancillary services to meet the scheduled and unscheduled needs of each patient.
- J. An administrator shall ensure that each facility has a daily staffing schedule that:
  1. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;
  2. Includes documentation of the employees who worked each day and the hours worked by each employee; and
  3. Is maintained for at least 12 months after the last date on the documentation.
- K. An administrator shall ensure that:
  1. A medical practitioner is present at the facility or on-call at all times;
  2. If the medical practitioner present at the facility is a registered nurse practitioner or a physician assistant, a physician is on-call;
  3. A nurse is present at the facility at all times; and
  4. A registered nurse who provides direction for the nursing services provided at the facility is present at the facility at least 40 hours every week.
- L. An administrator shall ensure that:
  1. If a patient requires services that the facility is not licensed or able to provide, a personnel member arranges for the patient to be transported to a hospital or another health care institution where the services can be provided; and

2. The facility maintains a written agreement with a hospital near the facility's location to provide medical services for patients who require medical services that the facility is not licensed or able to provide.

**R9-10-307. Patient Admission; Assessment**

A. An administrator shall ensure that:

1. A patient is admitted based upon the patient's presenting behavioral health issue and treatment needs and the facility's ability and authority to provide physical health services, behavioral health services, and ancillary services consistent with the patient's treatment needs;
2. A patient is admitted on the order of a medical practitioner;
3. A medical practitioner, authorized by facility policies and procedures to accept a patient for admission, is available at all times;
4. Except in an emergency or as provided in subsections (A)(6) and (A)(7), general consent is obtained from an adult patient or the patient's representative before or at the time of admission;
5. The general consent obtained in subsection (A)(4) or the lack of consent in an emergency is documented in the patient's medical record;
6. General consent is not required from a patient receiving a court-ordered evaluation or court-ordered treatment;
7. General consent is not required from a patient receiving treatment according to A.R.S. § 36-512;
8. A medical practitioner performs a medical history and physical examination on a patient within 30 days before admission or within 48 hours after admission and documents the medical history and physical examination in the patient's medical record within 48 hours after admission; and
9. If a medical practitioner performs a medical history and physical examination on a patient before admission, the medical practitioner enters an interval note into the patient's medical record at the time of admission.

B. An administrator shall ensure that:

1. Except when a patient needs crisis services, an assessment for a patient is completed before treatment for the patient is initiated, and
2. If an assessment is conducted by a:
  - a. Behavioral health technician, within 24 hours a behavioral health professional reviews and signs the assessment to ensure that the assessment identifies the physical health services and behavioral health services needed by the patient; or
  - b. Behavioral health paraprofessional, a behavioral health professional supervises the behavioral health paraprofessional during the completion of the assessment and signs the

assessment to ensure that the assessment identifies the physical health services and behavioral health services needed by the patient.

C. An administrator shall ensure that:

1. An assessment:

a. Addresses a patient's:

- i. Presenting issue;
- ii. Substance abuse history;
- iii. Co-occurring disorder;
- iv. Medical condition and history;
- v. Legal history, including:
  - (1) Custody,
  - (2) Guardianship, and
  - (3) Pending litigation,
- vi. Court-ordered evaluation,
- vii. Court-ordered treatment, and
- viii. Criminal justice record;
- ix. Family history;
- x. Behavioral health treatment history; and
- xi. Symptoms reported by the patient and referrals needed by the patient, if any;

b. Includes:

- i. Recommendations for further assessment or examination of the patient's needs;
- ii. Treatment that will be provided to the patient until the patient's treatment plan is completed;
- iii. Ancillary services or other services that will be provided to the patient until the patient's treatment plan is completed; and
- iv. The signature and date signed of the personnel member conducting the assessment;

c. Is documented in patient's medical record; and

2. 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.

D. An administrator shall ensure that:

1. A request for participation in a patient's assessment is made to the patient or the patient's representative,

2. An opportunity for participation in the patient's assessment is provided to the patient or the patient's representative, and
  3. Documentation of the request in subsection (D)(1) and the opportunity in subsection (D)(2) is in the patient's medical record.
- E. An administrator shall ensure that, except for a patient receiving crisis services, a patient's assessment information is documented in the medical record within 48 hours after completing the assessment.
- F. An administrator shall ensure that:
1. A patient's assessment information is reviewed and updated when additional information that affects the patient's assessment is identified, and
  2. A review and update of a patient's assessment information is documented in the medical record within 48 hours after the review is completed.

**R9-10-308. Treatment Plan**

- A. An administrator shall ensure that a treatment plan is developed and implemented for each patient that is:
1. Based on the assessment and on-going changes to the assessment of the patient;
  2. Completed:
    - a. By a behavioral health professional or a behavioral health technician under the clinical oversight of a behavioral health professional, and
    - b. Except when a patient needs crisis services, before the patient receives physical health services or behavioral health services;
  3. Documented in the patient's medical record within 48 hours after the patient first receives physical health services or behavioral health services;
  4. Includes:
    - a. The patient's presenting issue;
    - b. When the patient receives crisis services, the physical health services, behavioral health services, or ancillary services to be provided to the patient until completion of the treatment plan;
    - c. The signature of the patient or the patient's representative and dated signed, or documentation of the refusal to sign;
    - d. The date when the patient's treatment plan will be reviewed;
    - e. If a discharge date has been determined, the treatment needed after discharge; and
    - f. The signature of the personnel member who developed the treatment plan and the date signed;



5. If the treatment plan was completed by a behavioral health technician, reviewed and signed by a behavioral health professional within 24 hours to ensure that the treatment plan is complete and accurate and meets the patient's treatment needs; and
  6. Is reviewed and updated on an on-going basis:
    - a. According to the review date specified in the treatment plan,
    - b. When a treatment goal is accomplished or changes,
    - c. When additional information that affects the patient's assessment is identified, and
    - d. When a patient has a significant change in condition or experiences an event that affects treatment.
- B. An administrator shall ensure that:
1. A request for participation in developing a patient's treatment plan is made to the patient or the patient's representative,
  2. An opportunity for participation in developing the patient's treatment plan is provided to the patient or the patient's representative, and
  3. Documentation of the request in subsection (B)(1) and the opportunity in subsection (B)(2) is in the patient's medical record.
- C. An administrator shall ensure that a treatment plan to resolve or address a crisis situation is documented in a patient's medical record:
1. Within 24 hours of the identification of the patient's crisis situation; or
  2. Before the date of the patient's:
    - a. If the patient is an outpatient, admission to an inpatient bed,
    - b. Transfer;
    - c. Discharge with or without a referral.

**R9-10-309. Discharge**

- A. An administrator shall ensure that a discharge plan for a patient is:
1. Developed that:
    - a. Identifies any specific needs of the patient after discharge,
    - b. Is completed before discharge occurs,
    - c. Includes a description of the level of care that may meet the patient's assessed and anticipated needs after discharge, and
    - d. Is documented in the patient's medical record within 48 hours after the discharge plan is completed; and
  2. Provided to the patient or the patient's representative before the discharge occurs.
- B. An administrator shall ensure that:

1. A request for participation in developing a patient's discharge plan is made to the patient or the patient's representative,
  2. An opportunity for participation in developing the patient's discharge plan is provided to the patient or the patient's representative, and
  3. Documentation of the request in subsection (B)(1) and the opportunity in subsection (B)(2) is in the patient's medical record.
- C. An administrator shall ensure that a patient is discharged from a facility:
1. When the patient's treatment goals are achieved, as documented in the patient's treatment plan; or
  2. When the patient's treatment needs are not consistent with the services that the facility is authorized or able to provide.
- D. An administrator shall ensure that there is a documented discharge order by a medical practitioner before a patient is discharged unless the patient leaves the facility against a medical practitioner's advice.
- E. An administrator shall ensure that, at the time of discharge, a patient receives a referral for treatment or ancillary services that the patient may need after discharge, if applicable.
- F. If a patient is discharged to any location other than a health care institution, an administrator shall ensure that:
- a. There are documented discharge instructions, and
  - b. The patient or the patient's representative is provided with a copy of the discharge instructions.
- G. An administrator shall ensure that a discharge summary:
1. Is entered into the medical record within 7 days after a patient's discharge; and
  2. Includes:
    - a. The following information completed by a medical practitioner or a behavioral health professional:
      - i. The patient's presenting issue and other physical health and behavioral health issues identified in the patient's treatment plan;
      - ii. A summary of the treatment provided to the patient;
      - iii. The patient's progress in meeting treatment goals, including treatment goals that were and were not achieved; and
      - iv. The name, dosage, and frequency of each medication for the patient ordered at the time of the patient's discharge by a medical practitioner at the facility; and
    - b. A description of the disposition of the patient's possessions, funds, or medications brought to the facility by the patient.
- H. An administrator shall ensure that a patient who is dependent upon a prescribed medication is offered detoxification services, opioid treatment, or a written referral to detoxification services or opioid

treatment before the patient is discharged from the facility if a medical practitioner for the facility will not be prescribing the medication for the patient at or after discharge.

**R9-10-310. Transport; Transfer**

A. For a transport of a patient, the administrator of the sending facility shall ensure that:

1. Facility policies and procedures:

- a. Specify the process by which the sending facility personnel members coordinate the transport and the services provided to a patient to protect the health and safety of the patient;
- b. Require an evaluation of the patient by a medical practitioner or registered nurse before transporting the patient and after the patient's return;
- c. Specify the sending facility's patient medical records that are required to accompany the patient, including the medical records related to the services to be provided to the patient at the receiving health care institution or other facility;
- d. Specify how the sending facility communicates patient medical record information that the sending facility does not provide at the time of transport but is requested by the receiving health care institution or other facility; and
- e. Specify how a medical practitioner or registered nurse practitioner explains the risks and benefits of the transport to the patient or the patient's representative based on the:
  - i. Patient's condition, and
  - ii. Mode of transport; and

2. Documentation in the patient's medical record includes:

- a. Consent for transport by the patient or the patient's representative or why consent could not be obtained;
- b. The acceptance of the patient by and communication with an individual at the receiving health care institution or other facility;
- c. The date and the time of the transport to the receiving health care institution or other facility;
- d. The date and time of the patient's return to the sending facility, if applicable;
- e. The mode of transportation; and
- f. The type of personnel member assisting in the transport if an order requires that a patient be assisted during transport.

B. For a transport of a patient, an administrator of the receiving facility shall ensure that:

1. Facility policies and procedures:

- a. Specify the process by which the receiving facility personnel members coordinate the transport and the services provided to a patient to protect the health and safety of the patient;
  - b. Require an evaluation of the patient by a medical practitioner or registered nurse upon the arrival of the patient and before the patient is returned to the sending facility;
  - c. Specify the receiving facility's patient medical records required to accompany the patient when the patient is returned to the sending facility, if applicable;
  - d. Specify how the receiving facility's personnel members communicate patient medical record information to the sending facility that is not provided at the time of the patient's return; and
2. Documentation in the patient's medical record includes:
- a. The date and the time the patient arrives at the receiving facility;
  - b. The services provided to the patient at the receiving facility;
  - c. Any adverse reaction or negative outcome the patient experiences at the receiving facility;
  - d. The date and time of the receiving facility returns the patient return to the sending facility, if applicable;
  - e. The mode of transportation to return the patient to the sending hospital, if applicable; and
  - f. The type of personnel member assisting in the transport if an order requires that a patient be assisted during transport.
- C. For a transfer of a patient to a receiving health care institution, the administrator of the sending facility shall ensure that:
1. Facility policies and procedures:
    - a. Specify the process by which the sending facility personnel members coordinate the transfer and the services provided to a patient to protect the health and safety of the patient during the transfer;
    - b. Require an evaluation of the patient by a medical practitioner or registered nurse of the sending facility before the patient is transferred;
    - c. Specify how the sending facility communicates patient medical record information that the sending facility does not provide at the time of transport but is requested by the receiving health care institution or other facility; and
    - d. Specify how a medical practitioner or registered nurse practitioner explains the risks and benefits of the transfer to the patient or the patient's representative based on the:
      - i. Patient's condition, and

- ii. Mode of transport; and
  2. One of the following accompanies the patient during the transfer:
    - a. A copy of the patient's medical record for the current admission; or
    - b. All of the following for the current admission:
      - i. A medical practitioner's or behavioral health professional's summary of behavioral health and physical health services provided to the patient;
      - ii. A treatment plan containing current information;
      - iii. A record of medications administered to the patient for seven days before the date of the transfer;
      - iv. Medical practitioner's orders in effect at the time of transfer; and
      - v. Any known allergy; and
  3. Documentation in the patient's medical record includes:
    - a. Consent for transfer by the patient or the patient's representative, except in an emergency;
    - b. The acceptance of the patient by and communication with an individual at the receiving health care institution;
    - c. The date and the time of the transfer to the receiving health care;
    - d. The mode of transportation; and
    - e. The type of personnel member assisting in the transfer if an order requires that a patient be assisted during transfer.

**R9-10-311. Patient Outings**

- A. An administrator shall ensure that:
  1. A vehicle owned or lease by a facility to transport a patient:
    - a. Is safe and in good repair,
    - b. Contains a first aid kit,
    - c. Contains drinking water sufficient to meet the needs of each patient present, and
    - d. Contains a working heating and air conditioning system;
  2. Documentation of current vehicle insurance for a vehicle owned or leased by the facility is maintained;
  3. A driver of the vehicle:
    - a. Is 21 years of age or older;
    - b. Has a valid driver license;
    - c. Does not wear headphones or operate any hand-held wireless communication devices or hand-held electronic entertainment devices while operating the vehicle;

- d. Removes the keys from the vehicle and engages the emergency brake before exiting the vehicle or, if the vehicle locks in the park position, places the gear in the park position;
  - e. Does not leave in the vehicle an unattended:
    - i. Child;
    - ii. Patient who may be a threat to the health and safety of the patient or another individual; or
    - iii. Patient who is incapable of independent exit from the vehicle; and
  - f. Ensures the safe and hazard-free loading and unloading of patients;
4. Transportation safety is maintained as follows:
- a. Each individual in the vehicle wears a working seat belt while the vehicle is in motion;
  - b. Each seat in a vehicle is securely fastened to the vehicle and provides sufficient space for a patient's body; and
  - c. Each individual in the vehicle is sitting in a seat while the vehicle is in motion.
- B. An administrator shall ensure that an outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each patient participating in the outing.
- C. An administrator shall ensure that:
- 1. There are at least two personnel members present on an outing;
  - 2. In addition to the personnel members required in subsection (C)(1), there are a sufficient number of personnel members present to ensure each patient's health and safety on an outing;
  - 3. Each personnel member on the outing has documentation of current training in CPR according to R9-10-303(C)(1)(d) and first aid training, as required in R9-10-303(C)(1)(e).
  - 4. Documentation is developed before an outing that includes:
    - a. The name of each patient participating in the outing;
    - b. A description of the outing;
    - c. The date of the outing;
    - d. The anticipated departure and return times;
    - e. The name, address, and, if available, telephone number of the outing destination; and
    - f. If applicable, the license plate number of each vehicle used to transport a patient;
  - 5. The documentation described in subsection (C)(4) is updated to include the actual departure and return times and is maintained for at least 12 months after the date of the outing, and
  - 6. Emergency information for each patient participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to transport the patient on the outing and includes:
    - a. The patient's name;

- b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the patient during the anticipated duration of the outing;
- c. The patient's allergies; and
- d. The name and telephone number of the individual to notify at the facility in case of medical emergency or other emergency.

**R9-10-312. Patient Rights**

- A. An administrator shall ensure that at the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsections (B) and (C) and the patient rights in subsection (D).
- B. An administrator shall ensure that a patient:
  - 1. Is not subjected to:
    - a. Abuse;
    - b. Neglect;
    - c. Exploitation;
    - d. Coercion;
    - e. Manipulation;
    - f. Retaliation for submitting a complaint to the Department or another entity;
    - g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the patient's treatment needs, except as established in a fee agreement signed by the patient or the patient's representative;
    - h. Treatment that involves:
      - i. The denial of:
        - (1) Food,
        - (2) The opportunity to sleep, or
        - (3) The opportunity to use the toilet; or
      - ii. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation; and
  - 2. Except as provided in subsection (C), is allowed to:
    - a. Associate with individuals of the patient's choice, receive visitors, and make telephone calls during the hours established by the facility and conspicuously posted in the facility;
    - b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
    - c. Unless restricted by a court order, to send and receive uncensored and unopened mail.

- C. If a medical director or clinical director determines that a patient's treatment requires the facility to restrict the patient's ability to participate in the activities in subsection (B)(2), the medical director or clinical director shall:
1. Document a specific treatment purpose in the patient's medical record that justifies restricting the patient from the activity,
  2. Inform the patient of the reason why the activity is being restricted, and
  3. Inform the patient of the patient's right to file a grievance and the procedure for filing a grievance.
- D. A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
  2. To receive treatment that:
    - a. Supports and respects the patient's individuality, choices, strengths, and abilities;
    - b. Supports the patient's personal liberty and only restricts the patient's personal liberty according to a court order, by the patient's general consent, or as permitted in this Chapter; and
    - c. Is provided in the least restrictive environment that meets the patient's treatment needs;
  3. Not to be prevented or impeded from exercising the patient's civil rights unless the patient has been adjudicated incompetent or a court of competent jurisdiction has found that the patient is unable to exercise a specific right or category of rights;
  4. To submit grievances to facility personnel members and complaints to outside entities and other individuals without constraint or retaliation;
  5. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights;
  6. To have the patient's information and records kept confidential and released only as permitted under R9-10-313(A)(5) and (A)(6);
  7. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    - a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
    - b. For a patient receiving treatment according to A.R.S. Title 36, Chapter 37;
    - c. For video recordings used for security purposes that are maintained only on a temporary basis; or
    - d. As provided in R9-10-316(7);



8. To review, upon written request, the patient's own medical record except as described in R9-10-313(A)(7);
9. To receive a referral to another health care institution if the facility is unable to provide a physical health services or behavioral health service that the patient requests or that is in the patient's treatment plan;
10. To give general consent and, if applicable, informed consent to treatment, refuse treatment, or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the patient's life or physical health, or is provided according to A.R.S. § 36-512;
11. To participate or have the patient's representative participate in the development and periodic review and revision of the patient's treatment plan;
12. To participate or refuse to participate in research or experimental treatment;
13. To be provided locked storage space for the patient's belongings while the patient receives treatment;
14. If stated in the patient's treatment plan, to have opportunities for social contact and daily social, recreational, or rehabilitative activities; and
15. To be informed of the requirements necessary for the patient's discharge or transfer to a less restrictive physical environment.

**R9-10-313. Patient Records**

- A. An administrator shall ensure that:
  1. A medical record is established and maintained for each patient;
  2. An entry in a medical record is:
    - a. Recorded only by a personnel member authorized by facility policies and procedures to make the entry;
    - b. Dated, legible, and authenticated; and
    - c. Not changed to make the initial entry illegible;
  3. An order is:
    - a. Dated when the order is entered in the medical record and includes the time of the order;
    - b. Authenticated by a medical practitioner according to facility policies and procedures; and
    - c. Authenticated in the medical record by the medical practitioner issuing the order if the order is a verbal order;
  4. If a rubber-stamp signature or an electronic signature code is used to authenticate an order, the individual whose signature the stamp or electronic code represents is accountable for the use of the stamp or the electronic code;

5. A medical record is available to personnel members and medical practitioners authorized by facility policies and procedures to access the medical record;
  6. Information in a medical record is disclosed to an individual not authorized under subsection (5) only with the written consent of a patient or the patient's representative or as permitted by law;
  7. A patient's medical record is available for review by the patient or the patient's representative upon written request by the patient or the patient's representative unless the patient's medical practitioner:
    - a. Determines that the patient or patient's representative's review of the medical record is contraindicated, and
    - b. Documents the reason for the determination in the patient's medical record;
  8. A medical record is maintained under the direction of an individual:
    - a. Who is qualified to maintain the medical record according to facility policies and procedures, or
    - b. Who consults with an individual qualified according to facility policies and procedures;
  9. There are facility policies and procedures that include:
    - a. The length of time a medical record is maintained on the facility premises; and
    - b. The maximum time-frame to retrieve a medical record at the request of a medical practitioner or authorized personnel member;
  10. A patient's medical record is provided to the Department:
    - a. Not more than two hours after the Department's request if the patient is a current patient or was discharged within 12 months before the date of the Department's request, or
    - b. Within 24 hours from the time of the Department's request if the patient was discharged 12 or more months before the date of the Department's request; and
  11. A medical record is:
    - a. Protected from loss, damage, or unauthorized use; and
    - b. According to A.R.S. § 12-2297.
- B. If a facility maintains medical records electronically, an administrator shall ensure that:
1. There are safeguards to prevent unauthorized access; and
  2. The date and time of an entry in a medical record is recorded by the computer's internal clock.
- C. An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
    - a. The patient's name;
    - b. The patient's address;
    - c. The patient's date of birth;

- d. The name and contact information of the patient's designated patient representative, if applicable; and
  - e. Any known allergy including medication or biological allergies or sensitivities;
2. Medication information that includes:
    - a. The patient's weight;
    - b. Each medication or biological ordered for the patient; and
    - c. Each medication administered to the patient including:
      - i. The date and time of administration;
      - ii. The name, strength, dosage, amount, and route of administration;
      - iii. The identification and authentication of the individual administering the medication; and
      - iv. Any adverse reaction the patient has to the medication;
3. Documented general and informed consent for treatment by the patient or the patient's representative except in an emergency;
  4. The patient's medical history and results of a physical examination or an interval note;
  5. If the patient provides a health care directive, the health care directive signed by the patient or the patient's representative;
  6. An admitting diagnosis;
  7. The name of the admitting medical practitioner;
  8. Medical practitioner orders;
  9. Assessments and treatment plans;
  10. Documentation of behavioral health services provided to the patient;
  11. Documentation of physical health services provided to the patient;
  12. Progress notes;
  13. Disposition of the patient after discharge;
  14. Discharge plan;
  15. A discharge summary; and
  16. If applicable:
    - a. Laboratory reports;
    - b. Radiologic report;
    - c. Diagnostic reports;
    - d. Documentation of restraint or seclusion; and
    - e. Consultation reports.

**R9-10-314. Physical Health Services**

An administrator shall ensure that:

1. Medical services are provided under the direction of a physician;
2. Nursing services are provided under the direction of a registered nurse; and
3. If a facility provides:
  - a. Surgical services as defined in R9-10-201, the facility complies with:
    - i. The applicable standards for an inpatient surgical services suite and anesthesia services in the codes and standards incorporated by reference in R9-1-412, and
    - ii. The requirements in R9-10-214 and R9-10-215;
  - b. Clinical laboratory services as defined in R9-10-201, the facility complies with the requirements for clinical laboratory services in R9-10-218;
  - c. Radiology services or diagnostic imaging services, the facility complies with the requirements in R9-10-219;
  - d. Intensive care services as defined in R9-10-201, the facility complies with:
    - i. The applicable standards for inpatient intensive care services in the codes and standards incorporated by reference in R9-1-412, and
    - ii. The requirements in R9-10-220; and
  - e. Perinatal services as defined in R9-10-201, the facility complies with:
    - i. The applicable standards for inpatient perinatal services in the codes and standards incorporated by reference in R9-1-412, and
    - ii. The requirements in R9-10-222.

**R9-10-315. Behavioral Health Services**

A. An administrator shall ensure that:

1. Behavioral health services are provided to meet the needs of a patient;
2. When behavioral health services or ancillary services are:
  - a. Listed in the facility's scope of services, the behavioral health services are provided on the facility premises; and
  - b. Provided in a setting or activity with more than one patient participating, the patients participating have similar diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history including any history of physical or sexual abuse to ensure that the:
    - i. Health and safety of each patient is protected, and
    - ii. Treatment needs of each patient participating are being met; and
3. A patient does not share any space, participate in any activity or treatment, or verbally or physically interact with any other patient that may present a threat to the patient's health or safety

based on the other patient's diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history.

- B. An administrator shall ensure that counseling is:
  - 1. Offered as described in the facility's scope of services,
  - 2. Provided according to the frequency and number of hours identified in the patient's treatment plan, and
  - 3. Provided by a behavioral health professional or a behavioral health technician.
- C. An administrator shall ensure that:
  - 1. 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
  - 2. The personnel member's skills and knowledge are verified and documented in the personnel member's personnel record.
- D. An administrator shall ensure that each counseling session is documented in the patient's medical record to include:
  - 1. The date of the counseling session;
  - 2. The amount of time spent in the counseling session;
  - 3. Whether the counseling was individual counseling, family counseling, or group counseling;
  - 4. The treatment goals addressed in the counseling session; and
  - 5. The signature of the personnel member who provided the counseling and the date signed.
- E. An administrator of a facility that provides inpatient services to individuals under 18 years of age:
  - 1. May continue to provide behavioral health services to a patient who is 18 years of age or older:
    - a. If the patient was admitted to the facility before the patient's 18th birthday and is:
      - i. Completing high school or a high school equivalency diploma, or
      - ii. Participating in a job training program; or
    - b. Through the last day of the month of the patient's 18th birthday; and
  - 2. Shall ensure that:
    - a. A patient under 18 years of age:
      - i. Does not share a bedroom, indoor activity area, dining area, outdoor area, or other area where behavioral health services are provided with a patient 18 years of age or older; or
      - ii. Interact with a patient 18 years of age or older;
    - b. A patient does not receive the following from other patients at the facility:
      - i. Threats,

- ii. Ridicule,
    - iii. Verbal harassment,
    - iv. Punishment, or
    - v. Abuse;
  - c. The interior of the facility has furnishings and decorations appropriate to the ages of the patient receiving services at the facility;
  - d. A patient older than three years of age does not sleep in a crib;
  - e. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to patients on the premises in a quantity sufficient to meet each individual's needs and are appropriate to each patient's age, developmental level, and treatment needs;
  - f. A patient's educational needs are met by establishing and providing an educational component, approved in writing by the Arizona Department of Education.
- F. An administrator of a facility that provides pre-petition screening shall ensure pre-petition screening is provided according to the pre-petition screening requirements in A.R.S. Title 36, Chapter 5.
- G. An administrator of a facility that provides court-ordered evaluation shall ensure that court-ordered evaluation is provided according to the court-ordered evaluation requirements in A.R.S. Title 36, Chapter 5.
- H. An administrator is not required to comply with the following provisions in this Article for a patient receiving court-ordered evaluation:
- 1. Admission requirements in R9-10-307,
  - 2. Patient assessment requirements in R9-10-307,
  - 3. Treatment plan requirements in R9-10-308, and
  - 3. Discharge requirements in R9-10-309.
- I. An administrator of a facility that provides court-ordered treatment shall ensure that court-ordered treatment is provided according to the court-ordered treatment requirements in A.R.S. Title 36, Chapter 5.

**R9-10-316. Restraint; Seclusion**

An administrator of a facility that is licensed to use restraint or seclusion shall ensure that:

- 1. Restraint is only used in an emergency situation when needed to ensure a patient's physical safety and less restrictive interventions have not been effective;
- 2. Seclusion is only used for the management of a patient's violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient or other individuals;
- 3. Restraint or seclusion is not used as a means of coercion, discipline, convenience, or retaliation;
- 4. Restraint or seclusion is:

- a. Only ordered by a physician or a registered nurse practitioner, and
  - b. Not written as a standing order or on an as-needed basis;
5. An order for restraint or seclusion includes:
- a. The name of the physician or registered nurse practitioner ordering the restraint or seclusion;
  - b. The date and time that the restraint or seclusion was ordered;
  - c. The specific restraint or seclusion ordered;
  - d. If a drug is ordered as a chemical restraint, the drug's name, strength, dosage, and route of administration;
  - e. The specific criteria for release from restraint or seclusion without an additional order; and
  - f. The maximum duration authorized for the restraint or seclusion;
6. An order for restraint or seclusion is limited to the duration of the emergency situation and does not exceed:
- a. Three continuous hours for a patient who is 18 years of age or older;
  - b. Two continuous hours for a patient who is between the ages of nine and 17; or
  - c. One continuous hour for a patient who is younger than nine;
7. If restraint and seclusion are used on a patient simultaneously, the patient receives continuous:
- a. Face-to-face monitoring by a medical practitioner or personnel member, or
  - b. Video and audio monitoring by a medical practitioner or personnel member who is in close proximity to the patient;
8. If an order for restraint or seclusion of a patient is not provided by the patient's attending physician, the patient's attending physician is notified as soon as possible;
9. A medical practitioner or personnel member does not participate in restraint or seclusion, monitor a patient during restraint or seclusion, or evaluate a patient after restraint or seclusion and a physician or registered nurse practitioner does not order restraint or seclusion until the medical practitioner, or personnel member, completes education and training that:
- a. Includes:
    - i. Techniques to identify medical practitioner, personnel member, and patient behaviors; events; and environmental factors that may trigger circumstances that require restraint or seclusion;
    - ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods;

- iii. Techniques for identifying the least restrictive intervention based on an assessment of the patient's medical or behavioral health condition;
  - iv. The safe use of restraint and the safe use of seclusion, including training in how to recognize and respond to signs of physical and psychological distress in a patient who is restrained or secluded;
  - v. Clinical identification of specific behavioral changes that indicate that the restraint or seclusion is no longer necessary;
  - vi. Monitoring and assessing a patient while the patient is in restraint or seclusion according to facility policies and procedures; and
  - vii. Training exercises in which the medical practitioner or personnel member successfully demonstrates the techniques that the medical practitioner or personnel member has learned for managing emergency situations; and
  - b. Is provided by individuals qualified according the facility policies and procedures;
10. When a patient is placed in restraint or seclusion:
- a. The restraint or seclusion is conducted according to facility policies and procedures;
  - b. The restraint or seclusion is proportionate and appropriate to the severity of the patient's behavior and the patient's:
    - i. Chronological and developmental age;
    - ii. Size;
    - iii. Gender;
    - iv. Physical condition;
    - v. Medical condition;
    - vi. Psychiatric condition; and
    - vii. Personal history, including any history of physical or sexual abuse;
  - c. The physician or registered nurse practitioner who ordered the restraint or seclusion is available for consultation throughout the duration of the restraint or seclusion;
  - d. A patient is monitored and assessed according to facility policies and procedures;
  - e. A physician or other personnel member authorized by facility policies and procedures assesses the patient within one hour after the patient is placed in the restraint or seclusion and determines:
    - i. The patient's current behavior,
    - ii. The patient's reaction to the restraint or seclusion used,
    - iii. The patient's medical and behavioral condition; and
    - iii. Whether to continue or terminate the restraint or seclusion; and



- f. The restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order;
11. If a patient is placed in seclusion, the room used for seclusion:
    - a. Is approved for use as a seclusion room by the Department;
    - b. Is not used as a patient's bedroom or a sleeping area;
    - c. Allows full view of the patient in all areas of the room;
    - d. Is free of hazards, such as unprotected light fixtures or electrical outlets;
    - e. Contains at least 60 square feet of floor space; and
    - f. Contains a metal-framed bed that is bolted to the floor;
  12. A medical practitioner or personnel member documents the following information in a patient's medical record before the end of the shift in which the patient is placed in restraint or seclusion or, if the patient's restraint or seclusion does not end during the shift in which it began, during the shift in which the patient's restraint or seclusion ends:
    - a. The emergency situation that required the patient to be restrained or put in seclusion;
    - b. The times the patient's restraint or seclusion actually began and ended;
    - c. The time of the face-to-face assessment required in subsection (7)(a);
    - d. The monitoring required in subsection (7)(b) or (10)(d), as applicable;
    - e. The names of the medical practitioner and personnel members with direct patient contact while the patient was in the restraint or seclusion; and
    - f. The patient evaluation required in subsection (14);
  13. If an emergency situation continues beyond the time limit of an order for restraint or seclusion, the order is renewed according to facility policies and procedures that include:
    - a. The specific criteria for release from restraint or seclusion without an additional order; and
    - b. The maximum duration authorized for the restraint or seclusion; and
  14. A patient is evaluated after restraint or seclusion is no longer being used for the patient.

**R9-10-317. Observation/stabilization Services**

- A. An administrator of a facility licensed to provide observation/stabilization services shall ensure that observation/stabilization services are available at all times.
- B. An administrator shall ensure that:
  1. Observation/stabilization services are provided in a designated area that:
    - a. Is used exclusively for observation/stabilization services;
    - b. Contains a separate reception area for intake;
    - c. For every 15 observation chairs or less, has one bathroom that contains:

- i. A working sink with running water,
  - ii. A working toilet that flushes and has a seat,
  - iii. Toilet tissue,
  - iv. Soap for hand washing,
  - v. Paper towels,
  - vi. Lighting, and
  - vii. A means of ventilation;
2. If the facility is licensed to provide observation/stabilization services to individuals under 18 years of age:
  - a. There is a separate designated area for providing observation/stabilization services to individuals under 18 years of age that:
    - i. Meets the requirements in subsection (B)(1), and
    - ii. Has floor to ceiling walls that separate the designated area from other areas of the facility;
  - b. A registered nurse is present at all times in the separate designated area; and
  - c. A patient under 18 years of age does not share any space, participate in any activity or treatment, or have verbal or visual interaction with a patient 18 years of age or older;
3. A medical practitioner is present in the facility and available to the designated area at all times;
4. If the medical practitioner present at the facility is a registered nurse practitioner or a physician assistant, a physician is on-call;
5. A registered nurse is present and provides direction for observation/stabilization services in the designated area at all times;
6. A nurse monitors each individual at the interval determined according to subsection (B)(16) and documents the monitoring in the individual's medical record;
7. An individual who arrives at the facility is screened within 30 minutes after entering the facility to determine whether the individual is in need of immediate physical health services;
8. If a screening indicates that an individual needs immediate physical health services, the individual is examined by a medical practitioner within 30 minutes after being screened and is admitted to the facility or transferred to a health care institution capable of meeting the individual's immediate physical health needs;
9. An individual admitted to the facility for observation/stabilization services is provided an observation chair;
10. If an observation chair is not available for an individual's use, the individual is not admitted to the facility for observation/stabilization services;

11. If an individual is not admitted to the facility for observation/stabilization services because there is not an observation chair available for the individual's use, personnel provide support to the individual to access the services or resources necessary for the individual's health and safety which may include:
  - a. Establishing a method to notify the individual when there is an observation chair available;
  - b. Referring or providing transportation to the individual to another health care institution;
  - c. Assisting the individual to contact the individual's support system; and
  - d. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual;
12. Personnel establish a log of individuals who were not admitted because there was not an observation chair available and document the individual's name, actions taken to provide support to the individual to access the services or resources necessary for the individual's health and safety, and date and time the actions were taken;
13. The log required in subsection (B)(12) is maintained for one year after the date of documentation;
14. Each observation chair:
  - a. Has at least three feet of clear floor space:
    - i. On at least two sides of the observation chair, and
    - ii. Between the observation chair and any other observation chair; and
  - b. Is visible to personnel at all times;
15. Within 24 hours after a patient was admitted for observation/stabilization services, a medical practitioner determines whether the patient will be:
  - a. Admitted to an inpatient bed in the facility,
  - b. Transferred to another facility capable of meeting the individual's needs, or
  - c. Provided a referral to another entity capable of meeting the individual's needs;
16. When an individual is admitted to a designated area for observation/stabilization services, an assessment of the individual includes the interval for monitoring the individual based on the individual's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the individual; and
17. An individual is not re-admitted for observation/stabilization services within two hours of the individual discharge from a facility that provided observation/stabilization services to the individual.

#### **R9-10-318. Detoxification Services**

An administrator of a facility licensed to provide detoxification services shall ensure that:

1. Detoxification services are available at all times;
2. A behavioral health professional who provides detoxification services has the skills and knowledge necessary to provide detoxification services and the behavioral health professional's skills and knowledge are verified and documented;
3. The facility policies and procedures state:
  - a. Whether the facility provides involuntary, court-ordered alcohol treatment;
  - b. Whether the facility includes a local alcoholism reception center, as defined in A.R.S. § 36-2021;
  - c. The types of substances for which the facility provides detoxification services, and
  - d. The detoxification process or processes used by the facility;
4. A psychiatrist or physician with skills and knowledge in providing detoxification services is present at the facility or on-call at all times;
5. A registered nurse is present at the facility at all times; and
6. A patient who needs immediate medical services is admitted to the facility or transferred to a facility capable of meeting the patient's immediate medical needs.

#### **R9-10-319. Medication Services**

- A. An administrator shall ensure that policies and procedures for medication services:
  1. Are reviewed and approved by a pharmacist or medical practitioner;
  2. Specify the individuals who may:
    - a. Order medication, and
    - b. Administer medication;
  3. Include:
    - a. A process for providing each patient instruction in the use of the patient's prescribed medication and information regarding:
      - i. The prescribed medication's anticipated results,
      - ii. The prescribed medication's potential adverse reactions,
      - iii. The prescribed medication's potential side effects, and
      - iv. Potential adverse reactions that could result from not taking the medication as prescribed;
    - b. Procedures for preventing, responding to, and reporting a medication error, an adverse response to a medication, or a medication overdose;
    - c. Procedures to ensure that medication is administered to a patient only as prescribed and that a patient's refusal to take prescribed medication is documented in the medical record;

- d. A requirement that verbal orders for medication services be taken only by a nurse, unless otherwise provided by law;
  - e. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner and meets the patient's treatment needs;
  - f. Procedures for documenting medication services;
  - g. Procedures for assisting a patient in obtaining medication; and
  - h. Procedures for providing medication services off the premises, if applicable; and
4. Specify a process for review through the quality management program of:
- a. A medication administration error, and
  - b. An adverse reaction to a medication.

**B.** An administrator shall ensure that:

- 1. A current drug reference guide is available for use by personnel members;
- 2. A current toxicology reference guide is available for use by personnel members;
- 3. If pharmaceutical services are provided:
  - a. The pharmaceutical services are provided under the direction of a pharmacist;
  - b. The pharmaceutical services comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
  - c. A copy of the pharmacy license is provided to the Department upon request;
- 4. A medication administered to a patient:
  - a. Is administered in compliance with an order, and
  - b. Is documented as required in R9-10-313(C)(2); and
- 5. If pain medication is administered to a patient, documentation in the patient's medical record includes:
  - a. An assessment of the patient's pain before administering the medication; and
  - b. The effect of the pain medication administered.

**C.** An administrator shall ensure that there is a separate room used for medication storage that includes:

- 1. A lockable door,
- 2. A window that allows an individual to observe the entire room,
- 3. A locked cabinet or door for medication storage, and
- 4. A refrigerator for storing medications requiring refrigeration.

**R9-10-320. Food Services**

**A.** An administrator shall ensure that:

- 1. Food services are provided in compliance with 9 A.A.C. 8, Article 1;

2. A copy of the facility's food establishment permit required in subsection (A)(1) is provided to the Department for review upon the Department's request;
  3. If a facility contracts with a food establishment as defined in 9 A.A.C. 8, Article 1, to prepare and deliver food to the facility, a copy of the contracted food establishment's permit is:
    - a. Maintained on the facility's premises, and
    - b. Provided to the Department for review upon the Department's request;
  4. A registered dietitian is employed full-time, part-time, or as a consultant; and
  5. If a registered dietitian is not employed full-time, an individual is designated as a director of food services who consults with a registered dietitian as often as necessary to meet the nutritional needs of the patients.
- B. A registered dietitian or director of food services shall ensure that:
1. Food is prepared:
    - a. Using methods that conserve nutritional value, flavor, and appearance; and
    - b. In a form to meet the needs of a patient such as cut, chopped, ground, pureed, or thickened;
  2. A food menu is prepared at least one week in advance and conspicuously posted;
  3. If there is a change to a posted food menu, the change is noted on the posted menu no later than the morning of the day the change occurs;
  3. Meals and snacks provided by the facility are served according to posted menus;
  4. Meals for each day are planned using meal planning guides from (will insert most current document) incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from the U.S. Department of Agriculture, Center for Nutrition Policy and Promotion;
  5. A patient is provided:
    - a. A diet that meets the patient's nutritional needs as specified in the patient's assessment or treatment plan;
    - b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(5)(d);
    - c. The option to have a daily evening snack identified in subsection (B)(5)(d)(ii) or other snack; and
    - d. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
      - i. A patient agrees; and

- ii. The patient is offered an evening snack that includes meat, fish, eggs, cheese, or other protein, and a serving from either the fruit and vegetable food group or the bread and cereal food group;
  - 6. A patient requiring assistance to eat is provided with assistance that recognizes the patient's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
  - 7. Water is available and accessible to patients at all times, unless otherwise stated in a patient's treatment plan.
- C. An administrator shall ensure that food is obtained, prepared, served, and stored as follows:
  - 1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
  - 2. Food is protected from potential contamination;
  - 3. Potentially hazardous food is maintained as follows:
    - a. Foods requiring refrigeration are maintained at 41° F or below;
    - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 140° F, except that:
      - i. Ground beef, poultry, poultry stuffing, stuffed meats and stuffing containing meat are cooked to heat all parts of the food to at least 165° F;
      - ii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      - iii. Rare roast beef is cooked to an internal temperature of at least 140° F and rare beef steak is cooked to a temperature of at least 130° F unless otherwise requested by a resident; and
      - iv. Leftovers are reheated to a temperature of 165° F;
  - 5. A refrigerator contains a thermometer, accurate to plus or minus 3° F at the warmest part of the refrigerator;
  - 6. Frozen foods are stored at a temperature of 0° F or below; and
  - 7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

**R9-10-321. Environmental Standards**

- A. An administrator shall ensure that:
  - 1. The facility premises and equipment are sufficient to accommodate the activities, treatment, and ancillary services stated in the facility's scope of services;
  - 2. The facility premises and equipment are:
    - a. Maintained in good repair;
    - b. Clean,

- c. Free of insects and rodent; and
  - d. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
3. Biohazardous waste and hazardous waste are identified, stored, used, and disposed of according to A.A.C. Title 18, Chapter 13, Article 14 and facility policies and procedures;
4. Equipment used at the facility is:
  - a. Maintained in working order;
  - b. Tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in facility policies and procedures; and
  - c. Used according to the manufacturer's recommendations;
5. Documentation of equipment testing, calibration, and repair is maintained for one year after the date of the testing, calibration, or repair;
6. Garbage and refuse are:
  - a. Stored in plastic bags in covered containers; and
  - b. Removed from the premises at least once a week;
7. Heating and cooling systems maintain the facility at a temperature between 68° F to 85° F at all times;
8. A space heater is not used;
9. Common areas are lighted to assure the safety of patients and sufficient to allow personnel members to monitor patient activity;
10. Hot water temperatures are maintained between 95° F and 120° F in the areas of a facility used by patients;
11. The supply of hot and cold water is sufficient to meet the personal hygiene needs of patients and the cleaning and sanitation requirements in this Article;
12. Soiled linen and soiled clothing stored by the facility are stored in closed containers away from food storage, kitchen, and dining areas;
13. Oxygen containers are secured in an upright position;
14. Poisonous or toxic materials stored by the facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and inaccessible to patients;
15. Combustible or flammable liquids and hazardous materials stored by a facility are stored in the original labeled containers or safety containers in a storage area that is locked and inaccessible to patients;
16. Pets or other animals:



- a. Are controlled to prevent endangering individuals at the facility and to maintain sanitation; and
- b. Other than a service animal as defined in A.R.S. § 11-1024, are:
  - i. Licensed consistent with local ordinances;
  - ii. Vaccinated as follows:
    - (1) A dog is vaccinated against rabies, leptospirosis, distemper, hepatitis, and parvo; and
    - (2) A cat is vaccinated against rabies and feline leukemia;

17. If a non-municipal water source is used:

- a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coli form or *E. coli* bacteria and corrective action is taken to ensure the water is safe to drink, and
- b. Documentation of testing is retained for 24 months after the date of the test; and

18. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

B. An administrator shall ensure that:

- 1. Smoking or tobacco products are not permitted within a facility; and
- 2. Smoking or tobacco products may be permitted on the premises outside a facility if:
  - a. Signs designating smoking areas are conspicuously posted, and
  - b. Smoking is prohibited in areas where combustible materials are stored or in use.

C. An administrator shall ensure that:

- 1. If a patient has a mobility, sensory, or other physical impairment, modifications are made to the premises to ensure that the premises are accessible to and usable by the patient; and
- 2. A facility has:
  - a. A waiting area with seating for patients and visitors; and
  - b. A room that provides privacy for a patient to receive treatment or visitors.

D. An administrator shall ensure that:

- 1. A facility has a bathroom that is available for use by visitors during the facility's hours of operation and:
  - a. Provides privacy; and
  - b. Contains:
    - i. A working sink with running water,
    - ii. A working toilet that flushes and has a seat,
    - iii. Toilet tissue,

- iv. Soap for hand washing,
  - v. Paper towels or a mechanical air hand dryer,
  - vi. Lighting, and
  - vii. A window that opens or another means of ventilation;
2. For every six patients, there is at least one working toilet that flushes and one sink with running water;
3. For every eight patients, there is at least one working bathtub or shower;
4. A patient bathroom complies with the following:
- a. Provides privacy when in use and contains:
    - i. A shatter-proof mirror, unless the patient's treatment plan requires otherwise;
    - ii. A window that opens or another means of ventilation;
    - iii. Nonporous surfaces for shower enclosures, clean usable shower curtains, and slip-resistant surfaces in tubs and showers;
  - b. In the patient bathroom:
    - i. Plumbing, piping, ductwork, or other potentially hazardous elements are concealed above a ceiling;
    - ii. The bathroom door or a door to the shower area swings out to allow for staff emergency access;
    - iii. If a grab bar is provided, the space between the grab bar and the wall is filled to prevent a cord being tied around it;
    - iv. The following are prohibited:
      - (1) A towel bar,
      - (2) A shower curtain rod, or
      - (3) A lever handle that is not a specifically designed anti-ligature lever handle;
      - (4) Each lighting fixture, sprinkler head, and electrical outlet, is tamper-resistant; and
    - v. That is not supervised, a sprinkler head is recessed or designed to minimize patient access; and
  - c. If a patient bathroom door locks from the inside, an employee has a key and access to the bathroom at all times;
5. Each patient is provided a bedroom for sleeping;
6. A patient bedroom complies with the following:
- a. Is not used as a common area;

- b. Contains a door that opens into a hallway, common area, or outdoors;
  - c. In addition to the door in subsection (D)(6)(b), contains another means of egress;
  - d. Is constructed and furnished to provide unimpeded access to the door;
  - e. Has window or door covers that provide patient privacy
  - f. Is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of an individual occupying the bedroom;
  - g. Has floor to ceiling walls:
  - h. Is a:
    - i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
    - ii. Shared bedroom that:
      - (1) Is shared by no more than four patients;
      - (2) Contains at least 60 square feet of floor space, not including a closet, for each individual occupying the bedroom; and
      - (3) Provides at least three feet of floor space between beds;
  - i. Contains for each patient occupying the bedroom:
    - i. A bed that is at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and linens; and
    - ii. Individual storage space for personal effects and clothing such as a dresser or chest;
  - j. Has sufficient lighting for patient occupying the bedroom to read;
  - k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a patient to cause self-injury, and
  - l. If applicable, A drawer pull is recessed to eliminate the possibility of use as a tie-off point;
7. In a patient bathroom or a patient bedroom:
- a. A ceiling is secured from access or at least 9 feet in height; and
  - b. A ventilation grille is:
    - i. Secured and has perforations that are too small to use as a tie-off point; or
    - ii. Of sufficient height to prevent patient access;
8. For a door located in an area of the facility that is accessible to patients:
- a. A door closing device, if used on a patient bedroom door, is mounted on the public side of the door;
  - b. A door's hinges are designed to minimize points for hanging;

- c. Except for a door lever handle that contains specifically designed anti-ligature hardware, a door lever handle points downward when in the latched or unlatched position; and
    - d. Hardware has tamper-resistant fasteners; and
  - 9. A window located in an area of the facility that is accessible to patients is fabricated with laminated safety glass or protected by polycarbonate, laminate, or safety screens;
- E. An administrator shall ensure that if a swimming pool is located on the premises:
  - 1. The pool is enclosed by a wall or fence that:
    - a. Is at least five feet in height;
    - b. Has no vertical openings greater than four inches across;
    - c. Has no horizontal openings, except as described in subsection (E)(1)(e);
    - d. Is not chain-link;
    - e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height; and
    - f. Has a self-closing, self-latching gate that:
      - i. Opens away from the pool,
      - ii. Has a latch located at least five feet from the ground, and
      - iii. Is locked when the pool is not in use;
  - 2. At least one personnel member with cardiopulmonary resuscitation training, as required in R9-10-303(C)(1)(d) is present in the pool area when a patient is in the pool area;
  - 3. At least two personnel members are present in the pool area if two or more patients are in the pool area; and
  - 4. A life preserver is available and accessible in the pool area.
- F. An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (E)(1) is covered and locked when not in use.

**R9-10-322. Fire and Safety Requirements**

An administrator shall ensure that:

- 1. A fire drill for employees and patients on the premises is conducted at least once every three months on each shift;
- 2. Documentation of each fire drill is created and includes:
  - a. The date and time of the drill;
  - b. The amount of time taken for all employees and patients to evacuate the facility;
  - c. Any problems encountered in conducting the drill; and
  - d. Recommendations for improvement, if applicable;

3. Records of employee and patient fire drills are maintained on the premises for 12 months after the date of the drill and include the date and time of the drill, names of employees participating in the drill, and identification of patients needing assistance for evacuation;
4. A written evacuation plan is developed and maintained on the premises;
5. An evacuation path is conspicuously posted on each hallway of each floor of the facility; and
6. A written disaster preparedness plan is developed and maintained on the premises that includes:
  - a. When, how, and where patients will be relocated;
  - b. How each patient's medical record will be available to personnel providing services to the patient during a disaster;
  - c. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
  - d. A plan for obtaining food and water for individuals present in the facility or the facility's relocation site during a disaster.

#### **R9-10-323. Physical Plant Requirements**

- A. An administrator shall ensure that facility:
  1. Has a fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm Code, Chapter 3, Section 3-4.1.1(a), incorporated by reference in A.A.C. R9-1-412, and a sprinkler system installed according to the National Fire Protection Association 13 standards incorporated by reference in A.A.C. R9-1-412; or
  2. Has an alternative method to ensure patient safety documented and approved by the local jurisdiction.
- B. An administrator shall obtain the following inspections of a facility, according to the following schedules, and make any repairs or corrections stated on an inspection report:
  1. Sanitation inspections, conducted a minimum of every 12 months by a local health department; and
  2. Fire inspections, conducted according the timeframe established by the local fire department or the State Fire Marshal.
- C. An administrator shall maintain current reports of sanitation and fire inspections on the facility premises.