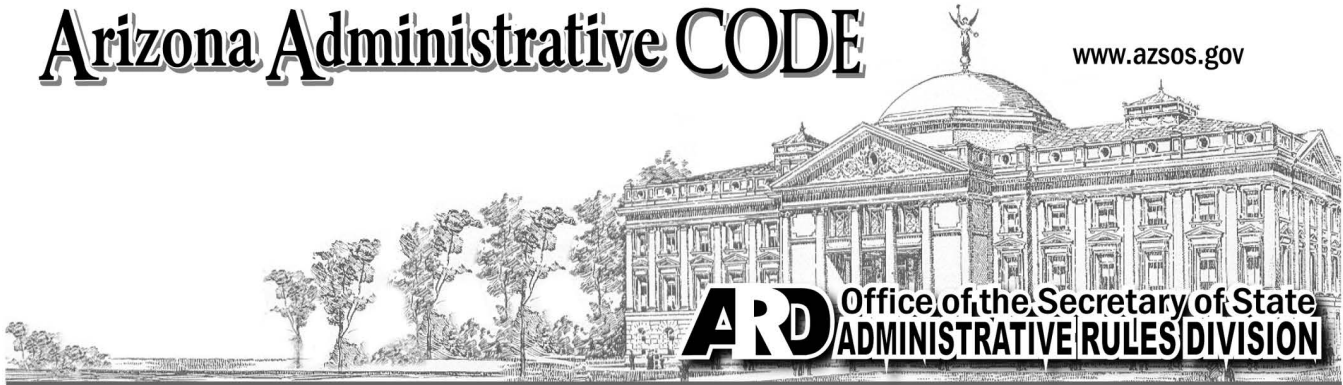


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ARIZONA ADMINISTRATIVE CODE

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

9 A.A.C. 10

Supplement Information

Supp. 26-1

Rules filed between January 1, 2026 through March 31, 2026 are codified in this Chapter.

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The release of this Chapter in Supp. 26-1 replaces Supp. 25-4, 1-341 pages. Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

Rules

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

The Arizona Administrative Code

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then a Section number with a heading. The “R” at the beginning of the Section number stands for “rule.” The rule itself includes sequential letters and numbers in an outline. Each lettered or numbered Section is called a subsection of the rule.

Rules are codified quarterly in the *Code*. For example:

- Rules codified in the first quarter are filed between January 1 through March 31.
- Rules codified in the second quarter are filed between April 1 through June 30.
- Rules codified in the third quarter are filed between July 1 through September 30.
- Rules codified in the fourth quarter are filed between October 1 through December 31.

Supplement release dates are included in the footers of each Chapter. The first supplement for the first quarter of 2026 is cited as Supp. 26-1. Supplements are released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. The Office links to these codified Sections in the Table of Contents of this Chapter.

Rule History

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Arizona Administrative Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

Authentication of PDF Code Chapters

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, espe-

cially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

How to Use the Code

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Register* for recent updates to rule Sections.

Arizona Revised Statutes References

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

Session Law References

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

Exemptions to the APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

Personal and Commercial Use of the Chapter

This Chapter is posted as a public courtesy online, and is for private use only. Those who wish to use the contents for resale or profit should contact the Office about Commercial Use fees. For information on commercial use fees review A.R.S. § 39-121.03 and 1 A.A.C. 1, R1-1-113.

Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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TITLE 9. HEALTH SERVICES**CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING**

Authority: A.R.S. §§ 36-132(A)(1), 36-136, 36-405, and 36-406

Supp. 26-1

Editor's Note: The heading for 9 A.A.C. 10 changed from "Licensure" to "Licensing" per a request from the Department of Health Services (Supp. 03-4).

Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper (Supp. 01-2).

Editor's Note: This Chapter contains rules which were adopted, amended, and repealed under exemptions from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1993, Ch. 163, § 3(B); Laws 1996, Ch. 329, § 5; Laws 1998, Ch. 178 § 17, and Laws 1999, Ch. 311. Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit these rules to the Governor's Regulatory Review Council for review; the Department may not have submitted notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

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Former Article 2, consisting of Sections R9-10-201 through R9-10-250, renumbered as Sections R9-10-301 through R9-10-335 as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days.

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Article 3, consisting of Sections R9-10-301 through R9-10-333, adopted effective February 4, 1981.

Former Article 3, consisting of Sections R9-10-301 through R9-10-335, repealed effective February 4, 1981.

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Article 5, consisting of Sections R9-10-501 through R9-10-514, adopted effective April 4, 1994 (Supp. 94-2).

Article 5, consisting of Sections R9-10-501 through R9-10-518, repealed effective April 4, 1994 (Supp. 94-2).

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES - HEALTH CARE INSTITUTIONS: LICENSING

Article 5, consisting of Sections R9-10-501 through R9-10-518, adopted as permanent rules effective October 30, 1989.

Article 5, consisting of Sections R9-10-501 through R9-10-518, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 5, consisting of Sections R9-10-501 through R9-10-518, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 5, consisting of Sections R9-10-501 through R9-10-518, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 5, consisting of Sections R9-10-501 through R9-10-518, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 5, consisting of Sections R9-10-501 through R9-10-574, repealed effective October 20, 1982.

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Article 6, consisting of Sections R9-10-611 through R9-10-624, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

Article 7, consisting of Sections R9-10-701 through R9-7-710, repealed; New Article 7, consisting of Sections R9-10-701 through R9-7-724 adopted; both actions effective November 1, 1998 under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Article 7, consisting of Sections R9-10-701 through R9-10-710, adopted as permanent rules effective October 30, 1989.

Article 7, consisting of Sections R9-10-701 through R9-10-710, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 7, consisting of Sections R9-10-701 through R9-10-710, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 7, consisting of Sections R9-10-701 through R9-10-710, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 7, consisting of Sections R9-10-701 through R9-10-710, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 7, consisting of Sections R9-10-701 through R9-10-737, repealed effective October 20, 1982.

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ARTICLE 8. ASSISTED LIVING FACILITIES

Article 8 (Sections R9-10-801 through R9-10-812) adopted as permanent rules effective October 30, 1989.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 8, consisting of Sections R9-10-801 through R9-10-812, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 8, consisting of Sections R9-10-801 through R9-10-867, repealed effective October 20, 1982.

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ARTICLE 9. OUTPATIENT SURGICAL CENTERS

Article 9, consisting of Sections R9-10-901 through R9-10-917 adopted effective February 17, 1995 (Supp. 95-1).

Article 9, consisting of Sections R9-10-911 through R9-10-925, repealed effective February 17, 1995 (Supp. 95-1).

Article 9, consisting of Sections R9-10-911 through R9-10-925, adopted effective October 20, 1982 (Supp. 82-5).

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R9-10-923.	Repealed
R9-10-924.	Repealed
R9-10-925.	Repealed
Attachment 1.	Repealed
Attachment 2.	Repealed

ARTICLE 10. OUTPATIENT TREATMENT CENTERS

Article 10, consisting of Sections R9-10-1001 through R9-10-1017, made new by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1).

Article 10, consisting of Sections R9-10-1011 through R9-10-1030, repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1).

Article 10, consisting of R9-10-1011 through R9-10-1030, repealed by summary action, interim effective date of July 21, 1995.

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ARTICLE 11. ADULT DAY HEALTH CARE FACILITIES

Article 11, consisting of Sections R9-10-1101 through R9-10-1109 adopted effective July 22, 1994 (Supp. 94-3).

Article 11, consisting of Sections R9-10-1111 through R9-10-1127 repealed effective July 22, 1994 (Supp. 94-3).

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ARTICLE 12. HOME HEALTH AGENCIES

Article 12, consisting of Sections R9-10-1201 through R9-10-1230, repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

Article 12, consisting of Sections R9-10-1201 through R9-10-1230, adopted effective February 4, 1981.

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ARTICLE 13. BEHAVIORAL HEALTH SPECIALIZED TRANSITIONAL FACILITY

New Article 13, consisting of Sections R9-10-1301 through R9-10-1317, made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted as permanent rules effective November 25, 1992 (Supp. 92-4).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

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Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted as an emergency effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

Article 13, consisting of Sections R9-10-1301 through R9-10-1306, adopted as an emergency effective March 29, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency expired.

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ARTICLE 14. SUBSTANCE ABUSE TRANSITIONAL FACILITIES

Article 14, consisting of Sections R9-10-1401 through R9-10-1412, adopted effective February 1, 1994 (Supp. 94-1).

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ARTICLE 15. ABORTION CLINICS

Article 15, consisting of Sections R9-10-1501 through R9-10-1515, were either amended, renumbered and repealed by final rulemaking which means the public had the opportunity to comment on the rules and they were reviewed and approved by the Governor's Regulatory Review Council. Section editor's notes referring to the adoption under an exemption have been removed in this Article (Supp. 18-4).

Selected Sections in Article 15 were subsequently amended by

final rulemaking in Supp. 10-2 which means the public had the opportunity to comment on the rules and they were reviewed and approved by the Governor's Regulatory Review Council. Refer to the historical notes for more information (Supp. 18-4).

Article 15, consisting of Sections R9-10-1501 through R9-10-1514, adopted under an exemption from the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311, filed in the Office of the Secretary of State December 23, 1999 (Supp. 99-4).

Article 15, consisting of Sections R9-10-1501 through R9-10-1514, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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ARTICLE 16. BEHAVIORAL HEALTH RESPITE HOMES

Article 16, consisting of Sections R9-10-1601 through R9-10-1611, made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

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ARTICLE 17. UNCLASSIFIED HEALTH CARE INSTITUTIONS

Article 17, consisting of Sections R9-10-1701 through R9-10-1713, adopted effective July 6, 1994 (Supp. 94-3).

Article 17, consisting of Sections R9-10-1711 through R9-10-1713, R9-10-1715 through R9-10-1723, and R9-10-1731 through

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ARTICLE 18. ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES

Article 18, consisting of Sections R9-10-1801 through R9-10-1810, made by exempt rulemaking, pursuant to Laws 2013, Ch. 10, § 13 effective July 1, 2014 (Supp. 14-2).

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ARTICLE 19. COUNSELING FACILITIES

Article 19, consisting of Sections R9-10-1901 through R9-10-1911, made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

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ARTICLE 20. PAIN MANAGEMENT CLINICS

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ARTICLE 21. RECOVERY CARE CENTERS

New Article 21, consisting of Sections R9-10-2101 through R9-10-2118, renumbered from R1-10-501 through R1-1-518 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

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ARTICLE 22. NURSING-SUPPORTED GROUP HOMES

Article 22, consisting of Sections R9-10-2201 through R9-10-2226, made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

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ARTICLE 1. GENERAL**R9-10-101. Definitions**

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

1. "Abortion clinic" has the same meaning as in A.R.S. § 36-449.01.
2. "Abuse" means:
 - a. The same:
 - i. For an individual 18 years of age or older, as in A.R.S. § 46-451; and
 - ii. For an individual less than 18 years of age, as in A.R.S. § 8-201;
 - b. A pattern of ridiculing or demeaning a patient;
 - c. Making derogatory remarks or verbally harassing a patient; or
 - d. Threatening to inflict physical harm on a patient.
3. "Accredited" has the same meaning as in A.R.S. § 36-422.
4. "Active malignancy" means a cancer for which:
 - a. A patient is undergoing treatment, such as through:
 - i. One or more surgical procedures to remove the cancer;
 - ii. Chemotherapy, as defined in A.A.C. R9-4-401; or
 - iii. Radiation treatment, as defined in A.A.C. R9-4-401;
 - b. There is no treatment; or
 - c. A patient is refusing treatment.
5. "Activities of daily living" means ambulating, bathing, toileting, grooming, eating, and getting in or out of a bed or a chair.
6. "Acuity" means a patient's need for medical services, nursing services, or behavioral health services based on the patient's medical condition or behavioral health issue.
7. "Acuity plan" means a method for establishing nursing personnel requirements by unit based on a patient's acuity.
8. "Adjacent" means not intersected by:
 - a. Property owned, operated, or controlled by a person other than the applicant or licensee; or
 - b. A public thoroughfare.
9. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
10. "Administrative office" means a location used by personnel for recordkeeping and record retention but not for providing medical services, nursing services, behavioral health services, or health-related services.
11. "Admission" or "admitted" means, after completion of an individual's screening or registration by a health care institution, the individual begins receiving physical health services or behavioral health services and is accepted as a patient of the health care institution.
12. "Adult" has the same meaning as in A.R.S. § 1-215.
13. "Adult behavioral health therapeutic home" means a residence that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to a case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issue and need for behavioral health services and may provide behavioral health services under the clinical oversight of a behavioral health professional.
14. "Adult residential care institution" means a subclass of behavioral health residential facility that only admits residents 18 years of age and older and provides recidivism reduction services.
15. "Adverse reaction" means an unexpected outcome that threatens the health or safety of a patient as a result of a medical service, nursing service, or health-related service provided to the patient.
16. "Affiliated counseling facility" means a counseling facility that shares administrative support with one or more other counseling facilities that operate under the same governing authority.
17. "Affiliated outpatient treatment center" means an outpatient treatment center authorized by the Department to provide behavioral health services that provides administrative support to a counseling facility or counseling facilities that operate under the same governing authority as the outpatient treatment center.
18. "Alternate licensing fee due date" means the last calendar day in a month each year, other than the anniversary date of a facility's health care institution license, by which a licensee is required to pay the applicable fees in R9-10-106.
19. "Ancillary services" means services other than medical services, nursing services, or health-related services provided to a patient.
20. "Anesthesiologist" means a physician granted clinical privileges to administer anesthesia.
21. "Applicant" means a governing authority requesting:
 - a. Approval of a health care institution's architectural plans and specifications for construction or modification,
 - b. Approval of a modification,
 - c. Approval of an alternate licensing fee due date, or
 - d. A health care institution license.
22. "Application packet" means the information, documents, and fees required by the Department for the:
 - a. Approval of a health care institution's architectural plans and specifications for construction or modification,
 - b. Approval of a modification,
 - c. Approval of an alternate licensing fee due date, or
 - d. Licensing of a health care institution.
23. "Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.
24. "Assistance in the self-administration of medication" means restricting a patient's access to the patient's medication and providing support to the patient while the patient takes the medication to ensure that the medication is taken as ordered.
25. "Attending physician" means a physician designated by a patient to participate in or coordinate the medical services provided to the patient.
26. "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.

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27. "Authorized service" means specific medical services, nursing services, behavioral health services, or health-related services provided by a specific health care institution class or subclass for which the health care institution is required to obtain approval from the Department before providing the medical services, nursing services, or health-related services.
28. "Available" means:
- For an individual, the ability to be contacted and to provide an immediate response by any means possible;
 - For equipment and supplies, physically retrievable at a health care institution; and
 - For a document, retrievable by a health care institution or accessible according to the applicable time-frames in this Chapter.
29. "Behavioral care"
- Means limited behavioral health services, provided to a patient whose primary admitting diagnosis is related to the patient's need for physical health services, that include:
 - Assistance with the patient's psychosocial interactions to manage the patient's behavior that can be performed by an individual without a professional license or certificate including:
 - Direction provided by a behavioral health professional, and
 - Medication ordered by a medical practitioner or behavioral health professional; or
 - Behavioral health services provided by a behavioral health professional on an intermittent basis to address the patient's significant psychological or behavioral response to an identifiable stressor or stressors; and
 - Does not include court-ordered behavioral health services.
30. "Behavioral health facility" means a behavioral health inpatient facility, a behavioral health residential facility, a substance abuse transitional facility, a behavioral health specialized transitional facility, an outpatient treatment center that only provides behavioral health services, an adult behavioral health therapeutic home, a behavioral health respite home, or a counseling facility.
31. "Behavioral health inpatient facility" means a health care institution other than a general hospital, rural general hospital, or special hospital that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
- Have a limited or reduced ability to meet the individual's basic physical needs;
 - Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
 - Be a danger to self;
 - Be a danger to others;
 - Be persistently or acutely disabled, as defined in A.R.S. § 36-501; or
 - Be gravely disabled.
32. "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.
33. "Behavioral health observation/stabilization services" means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:
- Requires nursing services,
 - May require medical services, and
 - May be a danger to others or a danger to self.
34. "Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:
- Under supervision by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or
 - Health-related services.
35. "Behavioral health professional" means the following licensed professionals that provide services specifically within the scope of practices defined by their profession:
- An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
 - Independently engage in the practice of behavioral health, as defined in A.R.S. § 32-3251; or
 - Except for a licensed substance abuse technician, engage in the practice of behavioral health, as defined in A.R.S. § 32-3251, under direct supervision as defined in A.A.C. R4-6-101;
 - A psychiatrist as defined in A.R.S. § 36-501;
 - A psychologist as defined in A.R.S. § 32-2061;
 - A physician;
 - A behavior analyst as defined in A.R.S. § 32-2091; or
 - A registered nurse practitioner licensed as an adult psychiatric and mental health nurse;
 - A clinical nurse specialist as described in A.R.S. § 32-1601; or
 - Psychiatric physician assistant.
36. "Behavioral health residential facility" means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
- Limits the individual's ability to be independent, or
 - Causes the individual to require treatment to maintain or enhance independence.
37. "Behavioral health respite home" means a residence where respite care services, which may include assistance in the self-administration of medication, are provided to an individual based on the individual's behavioral health issue and need for behavioral health services.
38. "Behavioral health specialized transitional facility" means a health care institution that provides inpatient behavioral health services and physical health services to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37 and 9 A.A.C. 10 Article 13.
39. "Behavioral health technician" means an individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:
- With clinical oversight by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33; or

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- b. Health-related services.
40. "Benzodiazepine" means any one of a class of sedative-hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven-membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.
 41. "Biohazardous medical waste" has the same meaning as in A.A.C. R18-13-1401.
 42. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
 43. "Case manager" means an individual assigned by an entity other than a health care institution to coordinate the physical health services or behavioral health services provided to a patient at the health care institution.
 44. "Certification" means, in this Article, a written statement that an item or a system complies with the applicable requirements incorporated by reference in R9-10-104.01.
 45. "Certified health physicist" means an individual recognized by the American Board of Health Physics as complying with the health physics criteria and examination requirements established by the American Board of Health Physics.
 46. "Change in ownership" means conveyance of the ability to appoint, elect, or otherwise designate a health care institution's governing authority from an owner of the health care institution to another person.
 47. "Chief administrative officer" or "administrator" means an individual designated by a governing authority to implement the governing authority's direction in a health care institution.
 48. "Clinical laboratory services" means the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of a disease or impairment of a human being, or for the assessment of the health of a human being, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.
 49. "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 and, if applicable, a patient's treatment plan;
 - 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 behavioral health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.
 50. "Clinical privileges" means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.
 51. "Collaborating health care institution" means a health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:
 - a. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and
 - b. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan.
 52. "Common area" means licensed space in health care institution that is:
 - a. Not a resident's bedroom or a residential unit,
 - b. Not restricted to use by employees or volunteers of the health care institution, and
 - c. Available for use by visitors and other individuals on the premises.
 53. "Communicable disease" has the same meaning as in A.R.S. § 36-661.
 54. "Conspicuously posted" means placed:
 - a. At a location that is visible and accessible; and
 - b. Unless otherwise specified in the rules, within the area where the public enters the premises of a health care institution.
 55. "Consultation" means an evaluation of a patient requested by a medical staff member or personnel member.
 56. "Contracted services" means medical services, nursing services, behavioral health services, health-related services, ancillary services, or environmental services provided according to a documented agreement between a health care institution and the person providing the medical services, nursing services, health-related services, ancillary services, or environmental services.
 57. "Contractor" has the same meaning as in A.R.S. § 32-1101.
 58. "Controlled substance" has the same meaning as in A.R.S. § 36-2501.
 59. "Counseling" has the same meaning as "practice of professional counseling" in A.R.S. § 32-3251.
 60. "Counseling facility" means a health care institution that only provides counseling, which may include:
 - a. DUI screening, education, or treatment according to the requirements in 9 A.A.C. 20, Article 1; or
 - b. Misdemeanor domestic violence offender treatment according to the requirements in 9 A.A.C. 20, Article 2.
 61. "Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.
 62. "Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.
 63. "Crisis services" means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.
 64. "Current" means up-to-date, extending to the present time.

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65. "Daily living skills" means activities necessary for an individual to live independently and include meal preparation, laundry, house-cleaning, home maintenance, money management, and appropriate social interactions.
66. "Danger to others" has the same meaning as in A.R.S. § 36-501.
67. "Danger to self" has the same meaning as in A.R.S. § 36-501.
68. "Detoxification services" means behavioral health services and medical services provided to an individual to:
 - a. Treat the individual's signs or symptoms of withdrawal from alcohol or other drugs, and
 - b. Reduce or eliminate the individual's dependence on alcohol or other drugs.
69. "Diagnostic procedure" means a method or process performed to determine whether an individual has a medical condition or behavioral health issue.
70. "Dialysis" means the process of removing dissolved substances from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.
71. "Dialysis services" means medical services, nursing services, and health-related services provided to a patient receiving dialysis.
72. "Dialysis station" means a designated treatment area approved by the Department for use by a patient receiving dialysis or dialysis services.
73. "Dialyzer" means an apparatus containing semi-permeable membranes used as a filter to remove wastes and excess fluid from a patient's blood.
74. "Disaster" means an unexpected occurrence that adversely affects a health care institution's ability to provide services.
75. "Discharge" means a documented termination of services to a patient by a health care institution.
76. "Discharge instructions" means documented information relevant to a patient's medical condition or behavioral health issue provided by a health care institution to the patient or the patient's representative at the time of the patient's discharge.
77. "Discharge planning" means a process of establishing goals and objectives for a patient in preparation for the patient's discharge.
78. "Discharge summary" means a documented brief review of services provided to a patient, current patient status, and reasons for the patient's discharge.
79. "Disinfect" means to clean in order to prevent the growth of or to destroy disease-causing microorganisms.
80. "Documentation" or "documented" means information in written, photographic, electronic, or other permanent form.
81. "Drill" means a response to a planned, simulated event.
82. "Drug" has the same meaning as in A.R.S. § 32-1901.
83. "Electronic" has the same meaning as in A.R.S. § 44-7002.
84. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.
85. "Emergency" means an immediate threat to the life or health of a patient.
86. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
87. "Emergency services" means unscheduled medical services provided in a designated area to an outpatient in an emergency.
88. "End-of-life" means that a patient has a documented life expectancy of six months or less.
89. "Environmental services" means activities such as house-keeping, laundry, facility maintenance, or equipment maintenance.
90. "Equipment" means, in this Article, an apparatus, a device, a machine, or a unit that is required to comply with the specifications incorporated by reference in R9-10-104.01.
91. "Exploitation" has the same meaning as in A.R.S. § 46-451.
92. "Factory-built building" has the same meaning as in A.R.S. § 41-4001.
93. "Family" or "family member" means an individual's spouse, sibling, child, parent, grandparent, or another individual designated by the individual.
94. "Follow-up instructions" means information relevant to a patient's medical condition or behavioral health issue that is provided to the patient, the patient's representative, or a health care institution.
95. "Food services" means the storage, preparation, serving, and cleaning up of food intended for consumption in a health care institution.
96. "Full-time" means 40 hours or more every consecutive seven calendar days.
97. "Garbage" has the same meaning as in A.A.C. R18-13-302.
98. "General consent" means documentation of an agreement from an individual or the individual's representative to receive physical health services to address the individual's medical condition or behavioral health services to address the individual's behavioral health issues.
99. "General hospital" means a subclass of hospital that provides surgical services and emergency services.
100. "Gravely disabled" has the same meaning as "grave disability" in A.R.S. § 36-501.
101. "Habilitation services" means activities provided to an individual to assist the individual with habilitation, as defined in A.R.S. § 36-551.
102. "Hazard" or "hazardous" means a condition or situation where a patient or other individual may suffer physical injury.
103. "Health care directive" has the same meaning as in A.R.S. § 36-3201.
104. "Hemodialysis" means the process for removing wastes and excess fluids from a patient's blood by passing the blood through a dialyzer.
105. "Home health agency" has the same meaning as in A.R.S. § 36-151.
106. "Home health aide" means an individual employed by a home health agency to provide home health services under the direction of a registered nurse or therapist.
107. "Home health aide services" means those tasks that are provided to a patient by a home health aide under the direction of a registered nurse or therapist.
108. "Home health services" has the same meaning as in A.R.S. § 36-151.
109. "Hospice inpatient facility" means a subclass of hospice that provides hospice services to a patient on a continuous basis with the expectation that the patient will remain on the hospice's premises for 24 hours or more.
110. "Hospital" means a class of health care institution that provides, through an organized medical staff, inpatient

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- beds, medical services, continuous nursing services, and diagnosis or treatment to a patient.
111. "Immediate" means without delay.
 112. "Immediate jeopardy" means a situation in which a patient or resident has suffered or is likely to suffer serious injury, serious harm, serious impairment, or death as a result of a licensee's noncompliance with one or more health and safety requirements.
 113. "Incident" means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:
 - a. On the premises of a health care institution, or
 - b. Not on the premises of a health care institution but directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution.
 114. "Infection control" means to identify, prevent, monitor, and minimize infections.
 115. "Infectious tuberculosis" has the same meaning as "infectious active tuberculosis" in A.A.C. R9-6-101.
 116. "Informed consent" means:
 - a. Advising a patient of a proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure; and associated risks and possible complications; and
 - b. Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic medication, opioid, or diagnostic procedure from the patient or the patient's representative.
 117. "In-service education" means organized instruction or information that is related to physical health services or behavioral health services and that is provided to a medical staff member, personnel member, employee, or volunteer.
 118. "Interdisciplinary team" means a group of individuals consisting of a resident's attending physician, a registered nurse responsible for the resident, and other individuals as determined in the resident's comprehensive assessment or, if applicable, placement evaluation.
 119. "Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" has the same meaning as in A.R.S. § 36-551.
 120. "Interval note" means documentation updating a patient's:
 - a. Medical condition after a medical history and physical examination is performed, or
 - b. Behavioral health issue after an assessment is performed.
 121. "Isolation" means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.
 122. "Leased facility" means a facility occupied or used during a set time period in exchange for compensation.
 123. "License" means:
 - a. Written approval issued by the Department to a person to operate a class or subclass of health care institution at a specific location; or
 - b. Written approval issued to an individual to practice a profession in this state.
 124. "Licensed occupancy" means the total number of individuals for whom a health care institution is authorized by the Department to provide crisis services in a unit providing behavioral health observation/stabilization services.
 125. "Licensee" means an owner approved by the Department to operate a health care institution.
 126. "Manage" means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
 127. "Medical condition" means the state of a patient's physical or mental health, including the patient's illness, injury, or disease.
 128. "Medical director" means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.
 129. "Medical history" means an account of a patient's health, including past and present illnesses, diseases, or medical conditions.
 130. "Medical practitioner" means a physician, physician assistant, or registered nurse practitioner.
 131. "Medical record" has the same meaning as "medical records" in A.R.S. § 12-2291.
 132. "Medical staff" means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.
 133. "Medical staff bylaws" means standards, approved by the medical staff and the governing authority, that provide the framework for the organization, responsibilities, and self-governance of the medical staff.
 134. "Medical staff member" means an individual who is part of the medical staff of a health care institution.
 135. "Medication" means one of the following used to maintain health or to prevent or treat a medical condition or behavioral health issue:
 - a. Biologicals as defined in A.A.C. R18-13-1401,
 - b. Prescription medication as defined in A.R.S. § 32-1901, or
 - c. Nonprescription drug as defined in A.R.S. § 32-1901.
 136. "Medication administration" means restricting a patient's access to the patient's medication and providing the medication to the patient or applying the medication to the patient's body, as ordered by a medical practitioner.
 137. "Medication error" means:
 - a. The failure to administer an ordered medication;
 - b. The administration of a medication not ordered; or
 - c. The administration of a medication:
 - i. In an incorrect dosage,
 - ii. More than 60 minutes before or after the ordered time of administration unless ordered to do so, or
 - iii. By an incorrect route of administration.
 138. "Mental disorder" means the same as in A.R.S. § 36-501.
 139. "Mobile clinic" means a movable structure that:
 - a. Is not physically attached to a health care institution's facility;
 - b. Provides medical services, nursing services, behavioral health services, or health related service to an outpatient under the direction of the health care institution's personnel; and
 - c. Is not intended to remain in one location indefinitely.
 140. "Monitor" or "monitoring" means to check systematically on a specific condition or situation.
 141. "Neglect" has the same meaning:

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- a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and
 - b. For an individual 18 years of age or older, as in A.R.S. § 46-451.
142. "Nephrologist" means a physician who is board eligible or board certified in nephrology by a professional credentialing board.
143. "Nurse" has the same meaning as "registered nurse" or "practical nurse" as defined in A.R.S. § 32-1601.
144. "Nursing care institution administrator" means an individual licensed according to A.R.S. Title 36, Chapter 4, Article 6.
145. "Nursing personnel" means individuals authorized according to A.R.S. Title 32, Chapter 15 to provide nursing services.
146. "Observation chair" means a physical piece of equipment that:
- a. Is located in a designated area where behavioral health observation/stabilization services are provided,
 - b. Allows an individual to fully recline, and
 - c. Is used by the individual while receiving crisis services.
147. "Occupational therapist" has the same meaning as in A.R.S. § 32-3401.
148. "Occupational therapy assistant" has the same meaning as in A.R.S. § 32-3401.
149. "Ombudsman" means a resident advocate who performs the duties described in A.R.S. § 46-452.02.
150. "On-call" means a time during which an individual is available and required to come to a health care institution when requested by the health care institution.
151. "Opioid" means a controlled substance, as defined in A.R.S. § 36-2501, that meets the definition of "opiate" in A.R.S. § 36-2501.
152. "Opioid agonist treatment medication" means a prescription medication that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of opioid-related substance use disorder.
153. "Opioid antagonist" means a prescription medication, as defined in A.R.S. § 32-1901, that:
- a. Is approved by the U.S. Department of Health and Human Services, Food and Drug Administration; and
 - b. When administered, reverses, in whole or in part, the pharmacological effects of an opioid in the body.
154. "Opioid treatment" means providing medical services, nursing services, behavioral health services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opioid-related substance use disorder.
155. "Order" means instructions to provide:
- a. Physical health services to a patient from a medical practitioner or as otherwise provided by law; or
 - b. Behavioral health services to a patient from a behavioral health professional.
156. "Orientation" means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.
157. "Outing" means a social or recreational activity that:
- a. Occurs away from the premises,
 - b. Is not part of a behavioral health inpatient facility's or behavioral health residential facility's daily routine, and
 - c. Lasts longer than two hours.
158. "Outpatient surgical center" means a class of health care institution that has the facility, staffing, and equipment to provide surgery and anesthesia services to a patient whose recovery, in the opinions of the patient's surgeon and, if an anesthesiologist would be providing anesthesia services to the patient, the anesthesiologist, does not require inpatient care in a hospital.
159. "Outpatient treatment center" means a class of health care institution without inpatient beds that provides physical health services, or physical health services and behavioral health services, including medication services for the diagnosis and treatment of patients.
160. "Overall time-frame" means the same as in A.R.S. § 41-1072.
161. "Owner" means a person who appoints, elects, or designates a health care institution's governing authority.
162. "Pain management clinic" has the same meaning as in A.R.S. § 36-448.01.
163. "Participant" means a patient receiving physical health services or behavioral health services from an adult day health care facility or a substance abuse transitional facility.
164. "Participant's representative" means the same as "patient's representative" for a participant.
165. "Patient" means an individual receiving physical health services or behavioral health services from a health care institution.
166. "Patient's representative" means:
- a. A patient's legal guardian;
 - b. If a patient is less than 18 years of age and not an emancipated minor, the patient's parent;
 - c. If a patient is 18 years of age or older or an emancipated minor, an individual acting on behalf of the patient with the written consent of the patient or patient's legal guardian; or
 - d. A surrogate as defined in A.R.S. § 36-3201.
167. "Person" means the same as in A.R.S. § 1-215 and includes a governmental agency.
168. "Personnel member" means, except as defined in specific Articles in this Chapter and excluding a medical staff member, a student, or an intern, an individual providing physical health services or behavioral health services to a patient.
169. "Pest control program" means activities that minimize the presence of insects and vermin in a health care institution to ensure that a patient's health and safety is not at risk.
170. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
171. "Physical examination" means to observe, test, or inspect an individual's body to evaluate health or determine the cause of illness, injury, or disease.
172. "Physical health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's medical condition.
173. "Physical therapist" has the same meaning as in A.R.S. § 32-2001.
174. "Physical therapist assistant" has the same meaning as in A.R.S. § 32-2001.
175. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
176. "Placement evaluation" means the same as in A.R.S. § 36-551.

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177. "Pre-petition screening" has the same meaning as "prepetition screening" in A.R.S. § 36-501.
178. "Premises" means property that is designated by an applicant or licensee and licensed by the Department as part of a health care institution where physical health services or behavioral health services are provided to a resident or patient.
179. "Prescribe" means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user's behalf, a specific dose of a specific medication in a specific quantity and route of administration.
180. "Professional credentialing board" means a non-governmental organization that designates individuals who have met or exceeded established standards for experience and competency in a specific field.
181. "Progress note" means documentation by a medical staff member, nurse, or personnel member of:
- An observed patient response to a physical health service or behavioral health service provided to the patient,
 - A patient's significant change in condition, or
 - Observed behavior of a patient related to the patient's medical condition or behavioral health issue.
182. "PRN" means pro re nata or given as needed.
183. "Project" means specific construction or modification of a facility stated on an architectural plans and specifications approval application.
184. "Provider" means an individual to whom the Department issues a license to operate an adult behavioral health therapeutic home or a behavioral health respite home in the individual's place of residence.
185. "Provisional license" means the Department's written approval to operate a health care institution issued to an applicant or licensee that is not in substantial compliance with the applicable laws and rules for the health care institution.
186. "Psychiatric services" means the diagnosis, treatment, and management of a mental disorder under the direction of a licensed psychiatrist or licensed nurse practitioner.
187. "Psychotropic medication" means a chemical substance that:
- Crosses the blood-brain barrier and acts primarily on the central nervous system where it affects brain function, resulting in alterations in perception, mood, consciousness, cognition, and behavior; and
 - Is provided to a patient to address the patient's behavioral health issue.
188. "Quality management program" means ongoing activities designed and implemented by a health care institution to improve the delivery of medical services, nursing services, health-related services, and ancillary services provided by the health care institution.
189. "Recovery care center" has the same meaning as in A.R.S. § 36-448.51.
190. "Referral" means providing an individual with a list of the class or subclass of health care institution or type of health care professional that may be able to provide the behavioral health services or physical health services that the individual may need and may include the name or names of specific health care institutions or health care professionals.
191. "Registered dietitian" means an individual approved to work as a dietitian by the American Dietetic Association's Commission on Dietetic Registration.
192. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
193. "Registered nurse practitioner" has the same meaning as A.R.S. § 32-1601.
194. "Regular basis" means at recurring, fixed, or uniform intervals.
195. "Rehabilitation services" means medical services provided to a patient to restore or to optimize functional capability.
196. "Research" means the use of a human subject in the systematic study, observation, or evaluation of factors related to the prevention, assessment, treatment, or understanding of a medical condition or behavioral health issue.
197. "Resident" means an individual living in and receiving physical health services or behavioral health services, including rehabilitation services or habilitation services if applicable, from a nursing care institution, an intermediate care facility for individuals with intellectual disabilities, a behavioral health residential facility, an assisted living facility, or an adult behavioral health therapeutic home.
198. "Resident's representative" means the same as "patient's representative" for a resident.
199. "Respiratory care services" has the same meaning as "practice of respiratory care" as defined in A.R.S. § 32-3501.
200. "Respiratory therapist" has the same meaning as in A.R.S. § 32-3501.
201. "Respite capacity" means the total number of children who do not stay overnight for whom an outpatient treatment center or a behavioral health residential facility is authorized by the Department to provide respite services on the premises of the outpatient treatment center or behavioral health residential facility.
202. "Respite services" means respite care services provided to an individual who is receiving behavioral health services.
203. "Restraint" means any physical or chemical method of restricting a patient's freedom of movement, physical activity, or access to the patient's own body.
204. "Risk" means potential for an adverse outcome.
205. "Room" means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.
206. "Rural general hospital" means a subclass of hospital:
- Having 50 or fewer inpatient beds,
 - Located more than 20 surface miles from a general hospital or another rural general hospital, and
 - Requesting to be and being licensed as a rural general hospital rather than a general hospital.
207. "Satellite facility" has the same meaning as in A.R.S. § 36-422.
208. "Scope of services" means a list of the behavioral health services or physical health services the governing authority of a health care institution has designated as being available to a patient at the health care institution.
209. "Seclusion" means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.

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210. "Secure behavioral health residential facility" has the same meaning as in A.R.S. § 36.425.06.
211. "Self-injury" means any intentional act of causing harm or injury to oneself and may include, but is not limited to, actions such as cutting, burning, hitting, scratching, or other forms of physical harm which as a result may require care from a health care provider.
212. "Sedative-hypnotic medication" means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.
213. "Self-administration of medication" means a patient having access to and control of the patient's medication and may include the patient receiving limited support while taking the medication.
214. "Sexual abuse" means the same as in A.R.S. § 13-1404(A).
215. "Sexual assault" means the same as in A.R.S. § 13-1406(A).
216. "Shift" means the beginning and ending time of a continuous work period established by a health care institution's policies and procedures.
217. "Short-acting opioid antagonist" means an opioid antagonist that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body.
218. "Signature" means:
- A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or
 - An electronic signature.
219. "Significant change" means an observable deterioration or improvement in a patient's physical, cognitive, behavioral, or functional condition that may require an alteration to the physical health services or behavioral health services provided to the patient.
220. "Single dwelling unit" has the same meaning as "single family residence" in A.R.S. § 33-1310.
221. "Single group license" means a license that includes authorization to operate health care institutions according to A.R.S. § 36-422(F) or (G).
222. "Speech-language pathologist" means an individual licensed according to A.R.S. Title 36, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.
223. "Special hospital" means a subclass of hospital that:
- Is licensed to provide hospital services within a specific branch of medicine; or
 - Limits admission according to age, gender, type of disease, or medical condition.
224. "Student" means an individual attending an educational institution and working under supervision in a health care institution through an arrangement between the health care institution and the educational institution.
225. "Substance abuse" means an individual's misuse of alcohol or other drug or chemical that:
- Alters the individual's behavior or mental functioning;
 - Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
 - Impairs, reduces, or destroys the individual's social or economic functioning.
226. "Substance abuse transitional facility" means a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.
227. "Substance use disorder" means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental, or social effects on an individual.
228. "Substance use risk" means an individual's unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.
229. "Substantial" when used in connection with a modification means:
- An addition or removal of an authorized service;
 - The addition or removal of a colocator;
 - A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;
 - A change in the physical plant, including facilities or equipment, that costs more than \$300,000; or
 - A change in the building where a health care institution is located that affects compliance with:
 - Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or
 - Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.
230. "Substantive review time-frame" means the same as in A.R.S. § 41-1072.
231. "Supportive services" has the same meaning as in A.R.S. § 36-151.
232. "Surgical procedure" means the excision of or incision in a patient's body for the:
- Correction of a deformity or defect;
 - Repair of an injury; or
 - Diagnosis, amelioration, or cure of disease.
233. "Swimming pool" has the same meaning as "semipublic swimming pool" in A.A.C. R18-5-201.
234. "System" means interrelated, interacting, or interdependent elements that form a whole.
235. "Tapering" means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.
236. "Tax ID number" means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
237. "Telehealth" has the same meaning as in A.R.S. § 36-3601.
238. "Therapeutic diet" means foods or the manner in which food is to be prepared that are ordered for a patient.
239. "Therapist" means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.
240. "Time-out" means providing a patient a voluntary opportunity to regain self-control in a designated area from which the patient is not physically prevented from leaving.
241. "Transfer" means a health care institution discharging a patient and sending the patient to another licensed health care institution as an inpatient or resident without intending that the patient be returned to the sending health care institution.
242. "Transport" means a licensed health care institution:

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- a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or
 - b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.
243. "Treatment" means a procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue.
244. "Treatment plan" means a description of the specific physical health services or behavioral health services that a health care institution anticipates providing to a patient.
245. "Unclassified health care institution" means a health care institution not classified or subclassified in statute or in rule.
246. "Vascular access" means the point on a patient's body where blood lines are connected for hemodialysis.
247. "Volunteer" means an individual authorized by a health care institution to work for the health care institution on a regular basis without compensation from the health care institution and does not include a medical staff member who has clinical privileges at the health care institution.
248. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a statewide furlough day.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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

- A. A person may apply for a license as one of the following classes or subclasses of health care institution:
- 1. General hospital;
 - 2. Rural general hospital;
 - 3. Special hospital;
 - 4. Behavioral health inpatient facility;
 - 5. Nursing care institution;
 - 6. Intermediate care facility for individuals with intellectual disabilities;

- 7. Recovery care center;
- 8. Hospice inpatient facility;
- 9. Hospice service agency;
- 10. Behavioral health residential facility;
- 11. Adult residential care institution;
- 12. Assisted living center;
- 13. Assisted living home;
- 14. Adult foster care home;
- 15. Outpatient surgical center;
- 16. Outpatient treatment center; unless exempt pursuant to A.R.S. § 36-402;
- 17. Abortion clinic;
- 18. Adult day health care facility;
- 19. Home health agency;
- 20. Substance abuse transitional facility;
- 21. Behavioral health specialized transitional facility;
- 22. Counseling facility;
- 23. Adult behavioral health therapeutic home;
- 24. Behavioral health respite home;
- 25. Unclassified health care institution;
- 26. Pain management clinic; or
- 27. Secure behavioral health residential facility.

- B. A person shall apply for a license for the class or subclass that authorizes the provision of the highest level of physical health services or behavioral health services the proposed health care institution plans to provide.
- C. The Department shall review a proposed health care institution's scope of services to determine whether the requested health care institution class or subclass is appropriate.
- D. A health care institution shall comply with the requirements in Article 17 of this Chapter if:
 - 1. There are no specific rules in another Article of this Chapter for the health care institution's class or subclass, or
 - 2. The Department determines that the health care institution is an unclassified health care institution.
- E. The Department may conduct on-site monitoring inspections of health care institutions that are found to not be in substantial compliance with the applicable licensure requirements specified in this Chapter, as outlined in Table 1.2.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-103. Licensing Exceptions

- A. A health care institution license is required for each health care institution facility except:

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1. A facility exempt from licensing under A.R.S. § 36-402, or
 2. A health care institution's administrative office.
- B.** Unless required by another Article in this Chapter, the Department does not require a separate health care institution license for:
1. A satellite facility of a hospital under A.R.S. § 36-422(F);
 2. An accredited facility of an accredited hospital under A.R.S. § 36-422(G);
 3. A facility operated by a licensed health care institution that is:
 - a. Adjacent to and contiguous with the licensed health care institution premises; or
 - b. Not adjacent to or contiguous with the licensed health care institution but connected to the licensed health care institution facility by an all-weather enclosure and:
 - i. Owned by the health care institution, or
 - ii. Leased by the health care institution with exclusive rights of possession;
 4. A mobile clinic operated by a licensed health care institution; or
 5. A facility located on grounds that are not adjacent to or contiguous with the health care institution premises where only ancillary services are provided to a patient of the health care institution; or
 6. A home health agency or hospice agency that provides off-site services, as specified as medical services, nursing services, behavioral health services, health-screening services, or health-related services provided by a licensed health care institution in an area that is:
 - a. Not located on the health care institution's premises;
 - b. Used to provide medical services, nursing services, behavioral health services, health-screening services, or health-related services of a limited duration; and
 - c. Used for purposes other than providing medical services, nursing services, behavioral health services, health-screening services, or health-related services when not used by the health care institution.
- C.** A health care institution shall maintain at the health care institution, a current and valid documentation of any certificate or permit issued by a local jurisdiction related to the operation of the health care institution and provide copies to the Department for review upon request.
- Historical Note**
- New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).
- R9-10-104. Architectural Plans and Specifications**
- A.** For the construction or modification of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01, an applicant shall submit as part of the health care institution license application to the Department an application packet including:
1. An application in a Department-provided format that contains:
 - a. For construction of a new health care institution:
 - i. The health care institution's name, street address, city, state, zip code, telephone number, and e-mail address;
 - ii. The name and mailing address of the health care institution's governing authority;
 - iii. The requested health care institution class or subclass; and
 - iv. If applicable, the requested licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations for the health care institution;
 - b. For modification of a licensed health care institution that requires approval of architectural plans and specifications:
 - i. The health care institution's license number,
 - ii. The name and mailing address of the licensee,
 - iii. The health care institution's class or subclass, and
 - iv. The health care institution's existing licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations; and the requested licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations for the health care institution;
 - c. The health care institution's contact person's name, street mailing address, city, state, zip code, telephone number, and email address;
 - d. A notarized attestation from an architect registered pursuant to A.R.S. Title 32, Chapter 1 that verifies the architectural plans and specifications meet or exceed standards adopted by the Department. For a modification of a health care institution, authorities having jurisdiction may grant approval to renovate portions of a structure, space, or system if the facility operations and patient safety in renovated and existing areas are not jeopardized by existing features of areas retained without complete corrective measures which minimize restriction on those improvements where total compliance would create an unreasonable hardship and would not substantially improve safety;
 - e. A narrative description of the project;
 - f. The estimated total project cost including the costs of:
 - i. Site acquisition,
 - ii. General construction,
 - iii. Architect fees,
 - iv. Fixed equipment, and
 - v. Movable equipment;
 - g. If providing or planning to provide medical services, nursing services, or health-related services that require compliance with specific physical plant codes and standards incorporated by reference in R9-10-104.01, the number of rooms or inpatient beds designated for providing the medical services, nursing services, or health-related services;
 - h. If providing or planning to provide behavioral health observation/stabilization services, the number of behavioral health observation/stabilization observation chairs designated for providing the behavioral health observation/stabilization services;
 - i. If construction or modification of a health care institution requires a project engineer, a statement signed

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and sealed by the project engineer, according to the requirements in 4 A.A.C. 30, Article 3, that the project engineer has complied with A.A.C. R4-30-301; and

- j. A statement signed by the governing authority or the licensee that the architectural plans and specifications comply with applicable licensing requirements in A.R.S. Title 36, Chapter 4 and this Chapter;
2. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following:
 - a. A building permit for the construction or modification issued by the local governmental agency; or
 - b. If a building permit issued by the local governmental agency is not required, zoning clearance issued by the local governmental agency that includes:
 - i. The health care institution's name, street address, city, state, zip code, and county;
 - ii. The health care institution's class or subclass and each type of medical services, nursing services, or health-related services to be provided; and
 - iii. A statement signed by a representative of the local governmental agency stating that the address listed is zoned for the health care institution's class or subclass;
3. The following information that is as necessary to demonstrate that the project described on the application complies with applicable codes and standards incorporated by reference in R9-10-104.01:
 - a. A site plan, drawn to scale, of the entire premises showing streets, property lines, facilities, parking areas, outdoor areas, fences, swimming pools, fire access roads, fire hydrants, and access to water mains;
 - b. For each facility, on architectural plans and specifications, a floor plan, drawn to scale, for each level of the facility, showing the layout and dimensions of each room, the name and function of each room, means of egress, and natural and artificial lighting sources;
4. The estimated total project cost including the costs of:
 - a. Site acquisition,
 - b. General construction,
 - c. Architect fees,
 - d. Fixed equipment, and
 - e. Movable equipment;
5. If the health care institution is located on land under the jurisdiction of a local governmental agency, one of the following provided by the local governmental agency:
 - a. A copy of the certificate of occupancy for the facility,
 - b. Documentation that the facility was approved for occupancy, or
 - c. Documentation that a certificate of occupancy for the facility is not available.
- B. The Department may conduct on-site facility reviews during the construction or modification of a health care institution.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13;

effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Publication error corrected in R9-10-104(A)(1) removing "provided by the Department;" publication error corrected in R9-10-104(B) removing "submitting;" with both amendments made at 25 A.A.R. 1583. Publication error corrected in R9-10-104(A), incorporated by reference Section updated as amended at 25 A.A.R. 3481 (Supp. 21-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-104.01. Codes and Standards

- A. For a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in this Section, an applicant shall follow the requirements in subsection (B), except as follows:
 1. Physical plant standards specified in applicable Articles of this Chapter shall govern over the codes and standards incorporated by reference in subsection (B); and
 2. If a conflict occurs among the codes and standards incorporated by reference in subsection (B), the more restrictive codes and standards shall govern over the less restrictive.
- B. The following physical plant health and safety codes and standards are incorporated by reference as modified, are on file with the Department, and include no future editions or amendments:
 1. Guidelines for Design and Construction of Health Care Facilities (2018 ed.), published by the American Society for Healthcare Engineering and available from The Facility Guidelines Institute at www.fgiguidelines.org;
 2. The following National Fire Codes (2012), published by and available from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269, and at www.nfpa.org/catalog:
 - a. NFPA70 National Electrical Code,
 - b. NFPA101 Life Safety Code, and
 - c. 2012 Supplements;
 3. ICC/A117.1-2017, American National Standard: Accessible and Usable Buildings and Facilities (2017), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org;
 4. International Building Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
 - a. Section 101.1 is modified by deleting "of [NAME OF JURISDICTION]";
 - b. Section 101.2 is modified by deleting the "Exception";
 - c. Section 101.4.7 is deleted,
 - d. Sections 103.1 through 103.3 are deleted,
 - e. Sections 104.1 through 104.11.2 are deleted,
 - f. Sections 105.1 through 105.7 are deleted,
 - g. Sections 106.1 through 106.3 are deleted,
 - h. Sections 107.1 through 107.5 are deleted,
 - i. Sections 108.1 through 108.4 are deleted,
 - j. Sections 109.1 through 109.6 are deleted,
 - k. Sections 110.1 through 110.6 are deleted,
 - l. Sections 111.1 through 111.4 are deleted,

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- m. Sections 112.1 through 112.3 are deleted,
 - n. Sections 113.1 through 113.3 are deleted,
 - o. Sections 114.1 through 114.4 are deleted,
 - p. Sections 115.1 through 115.3 are deleted,
 - q. Sections 116.1 through 116.5 are deleted, and
 - r. Appendices A, B, C, D, K, L, and M are deleted;
5. International Mechanical Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
 - a. Section 101.1 is modified by deleting “of [NAME OF JURISDICTION]”,
 - b. Sections 103.1 through 103.4.1 are deleted,
 - c. Sections 104.1 through 104.7 are deleted,
 - d. Sections 105.1 through 105.5 are deleted,
 - e. Sections 106.1 through 106.5.3 are deleted,
 - f. Sections 107.1 through 107.6 are deleted,
 - g. Sections 108.1 through 108.7.3 are deleted,
 - h. Sections 109.1 through 109.7 are deleted,
 - i. Sections 110.1 through 110.4 are deleted, and
 - j. Appendix B is deleted;
 6. International Plumbing Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
 - a. Section 101.1 is modified by deleting “of [NAME OF JURISDICTION]”,
 - b. Sections 103.1 through 103.4.1 are deleted,
 - c. Sections 104.1 through 104.7 are deleted,
 - d. Sections 105.1 through 105.4.1 are deleted,
 - e. Sections 106.1 through 106.6.3 are deleted,
 - f. Sections 107.1 through 107.7 are deleted,
 - g. Sections 108.1 through 108.7.3 are deleted,
 - h. Sections 109.1 through 109.7 are deleted,
 - i. Sections 110.1 through 110.4 are deleted, and
 - j. Appendix A is deleted;
 7. As adopted by the Office of the State Fire Marshal;
 8. International Fuel Gas Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
 - a. Section 101.1 is modified by deleting “of [NAME OF JURISDICTION]”,
 - b. Section 101.2 is modified by deleting the “Exception”,
 - c. Sections 103.1 through 103.4.1 are deleted,
 - d. Sections 104.1 through 104.7 are deleted,
 - e. Sections 105.1 through 105.5 are deleted,
 - f. Sections 106.1 through 106.6.3 are deleted,
 - g. Sections 107.1 through 107.6 are deleted,
 - h. Sections 108.1 through 108.7.3 are deleted,
 - i. Sections 109.1 through 109.7 are deleted, and
 - j. Sections 110.1 through 110.4 are deleted;
 9. International Private Sewage Disposal Code (2018), published by and available from the International Code Council, Inc., Publications, 4051 W. Flossmoor Road, Country Club Hills, IL 60478-5795, and at www.iccsafe.org, with the following modifications:
 - a. Section 101.1 is modified by deleting “of [NAME OF JURISDICTION]”,
 - b. Sections 103.1 through 103.4.1 are deleted,
- c. Sections 104.1 through 104.7 are deleted,
 - d. Sections 105.1 through 105.5 are deleted,
 - e. Sections 106.1 through 106.4.3 are deleted,
 - f. Sections 107.1 through 107.9 are deleted,
 - g. Sections 108.1 through 108.7.2 are deleted,
 - h. Sections 109.1 through 109.7 are deleted, and
 - i. Sections 110.1 through 110.4 are deleted.
- C. The Department shall not assess any penalty or fee specified in the physical plant health and safety codes and standards that are incorporated by reference in this Section.

Historical Note

New Section made by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-105. License Application

- A. A person applying for an initial a health care institution license shall submit to the Department an application packet that contains:
 1. An application in a Department-provided format provided by the Department including:
 - a. The health care institution's:
 - i. Name;
 - ii. Street address, city, state, zip code;
 - iii. Mailing address;
 - iv. Telephone number;
 - v. Email address;
 - vi. Tax ID number; and
 - vii. Class or subclass listed in R9-10-102 for which licensing is requested;
 - b. Except for a home health agency, or hospice service agency, or behavioral health facility, whether the health care institution is located within 1/4 mile of agricultural land;
 - c. Whether the health care institution is located in a leased facility;
 - d. Whether the health care institution is ready for a licensing inspection by the Department;
 - e. If the health care institution is not ready for a licensing inspection by the Department, the date the health care institution will be ready for a licensing inspection;
 - f. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-10-108;
 - g. Owner information including:
 - i. The owner's name, mailing address, telephone number, and email address;
 - ii. Whether the owner is a sole proprietorship, a corporation, a partnership, a limited liability partnership, a limited liability company, or a governmental agency;
 - iii. If the owner is a partnership or a limited liability partnership, the name of each partner;
 - iv. If the owner is a limited liability company, the name of the designated manager or, if no manager is designated, the names of any two members of the limited liability company;
 - v. If the owner is a corporation, the name and title of each corporate officer;
 - vi. If the owner is a governmental agency, the name and title of the individual in charge of the

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- governmental agency or the name of an individual in charge of the health care institution designated in writing by the individual in charge of the governmental agency;
- vii. If the owner is a sole proprietorship, a copy of the applicant's;
 - (1) U.S. Passport, current or expired;
 - (2) Birth certificate;
 - (3) Naturalization documents; or
 - (4) Documentation of legal resident alien status.
 - viii. Whether the owner or any person with 10% or more business interest in the health care institution has had a license to operate a health care institution denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license;
 - ix. Whether the owner or any person with 10% or more business interest in the health care institution has had a health care professional license or certificate denied, revoked, or suspended; the reason for the denial, suspension, or revocation; the date of the denial, suspension, or revocation; and the name and address of the licensing agency that denied, suspended, or revoked the license or certificate; and
 - x. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;
- h. The name and mailing address of the governing authority;
 - i. The chief administrative officer's:
 - i. Name,
 - ii. Title,
 - iii. Highest educational degree, and
 - iv. Work experience related to the health care institution class or subclass for which licensing is requested; and
 - j. Signature required in A.R.S. § 36-422(B);
2. Documentation from the property owner that the property owner approves the health care institution to operate and has exclusive rights of possession on the specified property;
 3. If applicable, a copy of the owner's articles of incorporation, partnership or joint venture documents, or limited liability documents;
 4. If applicable, the name and mailing address of each owner or lessee of any agricultural land regulated under A.R.S. § 3-365 and a copy of the written agreement between the applicant and the owner or lessee of agricultural land as prescribed in A.R.S. § 36-421(D);
 5. Except for a home health agency, a hospice service agency, or a nursing-supported group home, one of the following:
 - a. If the health care institution or a part of the health care institution is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01, an application packet as required in R9-10-104(A); or
 - b. If the health care institution or a part of the health care institution is not required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01:
 - i. One of the following:
 - (1) Documentation from the local jurisdiction of compliance with applicable local building codes and zoning ordinances, specific to the class or subclass of the health care institution;
 - (2) A certificate of occupancy specific to the class or subclass of the health care institution; or
 - (3) If documentation from the local jurisdiction is not available, documentation of the unavailability of the local jurisdiction compliance and documentation of a general contractor's inspection of the facility that states the facility is safe for occupancy as the applicable health care institution class or subclass;
 - ii. The licensed capacity requested by the applicant for the health care institution;
 - iii. If applicable, the licensed occupancy requested by the applicant for the health care institution;
 - iv. If applicable, the respite capacity requested by the applicant for the health care institution;
 - v. A site plan showing each facility, the property lines of the health care institution, each street and walkway adjacent to the health care institution, parking for the health care institution, fencing and each gate on the health care institution premises, and, if applicable, each swimming pool on the health care institution premises; and
 - vi. A floor plan showing, for each story of a facility, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device;
 6. The health care institution's proposed scope of services; and
 7. The applicable application fee required by R9-10-106.
- B.** In addition to the initial license application requirements in this Section, an applicant shall comply with the supplemental application requirements in specific rules in this Chapter for the health care institution class or subclass for which licensing is requested.
- C.** The Department shall approve or deny a license application in this Section according to R9-10-108.
- D.** A health care institution license is valid:
1. Unless, as specified in A.R.S. § 36-425(C):
 - a. The Department revokes or suspends the license according to R9-10-112, or
 - b. The license is considered void because the licensee did not pay the applicable fees in R9-10-106 according to R9-10-107; or
 2. Until a licensee voluntarily surrenders the license to the Department when terminating the operation of the health care institution, according to R9-10-109(B).

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October

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1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-106. Fees

- A.** An applicant submitting an application for a health care institution license shall submit to the Department a nonrefundable application fee of \$50.
- B.** Except as provided in subsection (C), an applicant submitting an application for a health care institution license or a licensee submitting an annual healthcare institution licensing fee shall submit the fees specified in Table 1.3.
- C.** Subsection (B) and Table 1.3 does not apply to a health care institution operated by a state agency according to state or federal law or to an adult foster care home licensed according to Article 8.
- D.** In addition to the applicable fees in subsection (B), a licensee shall submit a late payment fee of \$250 if submitting annual licensing fees according to R9-10-107(E)(1) or (2)(d).
- E.** All fees are nonrefundable except as provided in A.R.S. § 41-1077.

- F.** The Department may charge up to \$1,000 per visit for an onsite monitoring inspection fee, as determined by a provider agreement or notice, according to A.R.S. § 36-405(D).
- G.** If the Department provides in-service training to a health care institution that requests in-service training relating to regulatory compliance outside of the survey process, the Department may charge up to \$500 an hour for the in-service training, according to A.R.S. § 36-405(E).

Historical Note

New Section R9-10-106 renumbered from R9-10-122 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3). Amended by final rulemaking at 31 A.A.R. 4400 (November 21, 2025), effective January 3, 2026 (Supp. 25-4).

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Table 1.3. Fees

Healthcare Institution Class or Subclass	Fees for the following licensed capacities					
	No licensed capacity	1 to 59 beds	60 to 99 beds	100 to 149 beds	150 beds or more	Plus the licensed capacity times
Abortion clinic, according to Article 15	\$482	-	-	-	-	-
Adult behavioral health therapeutic home, according to Article 18	\$495	\$495	-	-	-	\$132
Adult day health care facility, according to Article 11	\$370	-	-	-	-	-
Adult foster care home, according to Article 8	-	-	-	-	-	-
Adult residential care institution, according to Article 8	\$495	\$495	-	-	-	\$132
Assisted living center, according to Article 8	\$370	\$370	\$739	\$1,109	\$1,848	\$98
Assisted living home, according to Article 8	\$370	\$370	-	-	-	\$98
Behavioral health inpatient facility, according to Article 3	\$495	\$495	\$990	\$1,485	\$2,475	\$132
Behavioral health residential facility, according to Article 7	\$495	\$495	\$990	\$1,485	\$2,475	\$132
Behavioral health respite home, according to Article 16	\$495	\$495	-	-	-	\$132
Behavioral health specialized transitional facility, according to Article 13	\$495	\$495	-	-	-	\$132
Counseling facility, according to Article 19	\$495	-	-	-	-	-
Home health agency, according to Article 12	\$482	-	-	-	-	-
Hospice inpatient facility, according to Article 6	\$482	\$482	-	-	-	\$127
Hospice service agency, according to Article 12	\$482	-	-	-	-	-
Hospital license according to Article 2, including a general hospital, a rural hospital, or a special hospital	\$482	\$482	\$964	\$1,445	\$2,409	\$127
	If providing behavioral health observation or stabilization services, in addition to the fee, the licensed occupancy times \$91.					
Intermediate care facility for individuals with intellectual disabilities, according to Article 5	-	\$383	\$766	\$1,148	\$1,914	\$102
Nursing care institution, according to Article 4	-	\$383	\$766	\$1,148	\$1,914	\$102
Nursing-supported group home, according to Article 22	\$383	\$383	-	-	-	\$102
Outpatient surgical center, according to Article 9	\$482	-	-	-	-	-
Outpatient treatment center, according to Article 10	\$482	-	-	-	-	-
	If providing dialysis services, in addition to the licensing fee, the number of dialysis stations times \$91.					
Pain management clinic, according to Article 20	\$482	-	-	-	-	-
Recovery care center, according to Article 21	\$482	\$482	-	-	-	\$127
Single Group Hospital License or Licensee with a Single Group License	\$482	\$482	\$964	\$1,445	\$2,409	\$127
Substance abuse transitional facility, according to Article 14	\$495	-	-	-	-	-
Unclassified health care institution, according to Article 17	\$482	-	-	-	-	-

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Table 1.3 Fees made by final rulemaking at 31 A.A.R. 4400 (November 21, 2025), effective January 3, 2026 (Supp. 25-4).

R9-10-107. Submission of Health Care Institution Licensing Fees

- A.** An applicant for a health care institution license shall submit the applicable licensing fees in R9-10-106 to the Department:
1. Within 60 calendar days after the date of the written notice of approval in R9-10-108(C)(3); or
 2. Within 90 calendar days after the date of the written notice of approval in R9-10-108(C)(3), with the payment of an additional late payment fee of \$250.
- B.** Except as specified in subsection (D), a licensee shall submit to the Department, no earlier than 60 calendar days before the anniversary date of the facility's health care institution license:
1. The following information in a Department-provided format:
 - a. The licensee's name, and
 - b. The facility's name and license number;
 2. The applicable annual licensing fees in R9-10-106.
- C.** If any information in the Department's current records for a health care institution is incorrect, before a licensee submits annual licensing fees according to subsection (B), the licensee shall comply with the applicable requirements in R9-10-109 or R9-10-110 to update the Department's records for the health care institution.
- D.** A licensee may submit to the Department the information in subsection (B)(1) and applicable annual licensing fees in R9-10-106:
1. Within 30 calendar days after the anniversary date of the facility's health care institution license, with the payment of the additional late payment fee in R9-10-106(F); or
 2. If an alternate licensing fee due date has been established for the licensee according to subsections (E) and (F):
 - a. By the anniversary date of the facility's health care institution license, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the alternate licensing fee due date;
 - b. By the alternate licensing fee due date;
 - c. If a new alternate licensing fee due date has been established, by the current alternate licensing fee due date, with the appropriate fee amount to prorate the annual licensing fees in R9-10-106 for a facility to the new alternate licensing fee due date; or
 - d. Within 30 calendar days after the alternate licensing fee due date, with the payment of the additional late payment fee in R9-10-106(F).
- E.** Except as specified in subsection (G), a licensee may request a licensing fee due date for a facility that is different from the anniversary date of a facility's health care institution license by submitting an application for an alternate licensing fee due date to the Department, at least 30 calendar days before the anniversary date of the facility's health care institution license, that includes the following information in a Department-provided format:
1. The licensee's name and email address,
 2. The facility's name and license number,
 3. The current licensing fee due date,
 4. The proposed alternate licensing fee due date,
 5. The reason the licensee is requesting an alternate licensing fee due date, and
 6. The name of the health care institution's administrator or individual representing the health care institution as designated in A.R.S. § 36-422 and the dated signature of the administrator or individual.

- F.** The Department shall review a request made according to subsection (E) according to R9-10-108.

- G.** A licensee may not request an alternate licensing fee due date according to subsection (E):

1. More frequently than once in each three-year period, or
2. For a facility for which the payment of licensing fees is not up-to-date.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-108. Time-frames

- A.** The overall time-frame for each type of approval granted by the Department is listed in Table 1.1. The applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25% of the overall time-frame.
- B.** The administrative completeness review time-frame for each type of approval granted by the Department as prescribed in this Article is listed in Table 1.1. The administrative completeness review time-frame begins on the date the Department receives an application packet or a written request for an alternate licensing fee due date.
1. The application packet for a health care institution license is not complete until the applicant provides the Department with written notice that the health care institution is ready for a licensing inspection by the Department.
 2. If the application packet or written request is incomplete, the Department shall provide a written notice to the applicant specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the missing document or information from the applicant.
 3. When an application packet or written request is complete, the Department shall provide a written notice of administrative completeness to the applicant.
 4. For a health care institution license application packet, an application packet for a modification or a written request for an alternate licensing fee due date, the Department shall consider the application or written request withdrawn if the applicant fails to supply the missing documents or information included in the notice described in subsection (B)(2) within 60 calendar days after the date of the notice described in subsection (B)(2).
 5. If the Department issues a license or grants an approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.
- C.** The substantive review time-frame is listed in Table 1.1 and begins on the date of the notice of administrative completeness.

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1. The Department may conduct an onsite inspection of the facility:
 - a. As part of the substantive review for issuing a health care institution license; or
 - b. As part of the substantive review for approving a modification of a health care institution's license.
2. During the substantive review time-frame, the Department may make one comprehensive written request for additional information or documentation. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation. The time-frame for the Department to complete the substantive review is suspended from the date of a written request for additional information or documentation until the Department receives the additional information or documentation.
3. The Department shall send a written notice of approval to an applicant that is in substantial compliance with applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter.
4. After an applicant for a health care institution license receives the written notice of approval in subsection (C)(3), the applicant shall submit the applicable health care institution license fee in R9-10-106 according to R9-10-107(A).
5. After receiving the applicable health care institution licensing fee from an applicant according to subsection (C)(4) and R9-10-107(A), the Department shall send a health care institution license to the applicant.
6. The Department shall provide a written notice of denial that complies with A.R.S. § 41-1076 to an applicant who does not:
 - a. For a health care institution license application or modification of a health care institution requiring architectural plans and specifications, submit the information or documentation in subsection (C)(2) within 120 calendar days after the Department's written request to the applicant;
 - b. For a modification of a health care institution not requiring architectural plans and specifications or a written request for an alternate licensing fee due date, submit the information or documentation in subsection (C)(2) within 30 calendar days after the Department's written request to the applicant;
 - c. Comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter; or
 - d. If applicable, submit a fee required in R9-10-106 or R9-10-107.
7. An applicant may file a written notice of appeal with the Department within 30 calendar days after receiving the notice described in subsection (C)(6). The appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.
8. If a time-frame's last day falls on a Saturday, a Sunday, or an official state holiday, the Department shall consider the next working day to be the time-frame's last day.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 859, effective April 2, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

Table 1.1 Time-frames

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
Health care institution license R9-10-105	A.R.S. §§ 36-405, 36-407, 36-421, 36-422, 36-424, and 36-425	120 calendar days	30 calendar days	90 calendar days
Approval of an alternate licensing fee due date R9-10-107	A.R.S. § 36-405	30 calendar days	10 calendar days	20 calendar days
Approval of a modification of a health care institution R9-10-110	A.R.S. §§ 36-405, 36-407, and 36-422	75 calendar days	15 calendar days	60 calendar days

Historical Note

New Table 1 made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 859, effective April 2, 2005 (Supp. 05-1). Table 1 number amended to Table 1.1 and contents amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Table 1.1 amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Table 1.1 amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Table 1.1 heading added for clarity by the Division (Supp. 21-2). Table 1.1 amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-109. Changes Affecting a License**A. A licensee shall ensure that:**

1. The Department is notified in writing at least 30 calendar days before the effective date of:
 - a. Except as provided in subsection (H), a change in the name of:
 - i. A health care institution, or
 - ii. The licensee;
 - b. A change in the hours of operation:
 - i. Of an administrative office, or
 - ii. For providing physical health services or behavioral health services to patients of the health care institution;

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- c. A change in the address of a health care institution that does not provide medical services, nursing services, behavioral health services, or health-related services; or
 - d. A change in the geographic region to be served by the hospice service agency or home health agency; and
- 2. Documentation supporting the change is provided to the Department with the notification required in subsection (A)(1).
- B.** If a licensee intends to terminate the operation of a health care institution, the licensee shall ensure that the Department is notified in writing of:
 - 1. The termination of the health care institution's operations, as required in A.R.S. § 36-422(D), at least 30 calendar days before the termination, and
 - 2. The address and contact information for the location where the health care institution's medical records will be retained as required in A.R.S. § 12-2297.
- C.** A licensee shall ensure that the Department is notified in writing, according to A.R.S. § 36-425(I), of a change in the chief administrative officer of the health care institution.
- D.** If a health care institution is accredited by a nationally recognized accrediting organization, a licensee may submit to the Department the health care institution's current accreditation report.
- E.** If a licensee is an adult behavioral health therapeutic home or a behavioral health respite home, the licensee shall ensure that:
 - 1. The Department is notified in writing if the licensee does not have a written agreement with a collaborating health care institution, as required in R9-10-1603(A)(3) or R9-10-1803(A)(3) as applicable; and
 - 2. The adult behavioral health therapeutic home or behavioral health respite home does not accept an individual as a resident or recipient, as applicable, or provide services to a resident or recipient, as applicable, until:
 - a. The adult behavioral health therapeutic home or behavioral health respite home has a written agreement with a collaborating health care institution;
 - b. The collaborating health care institution has approved the adult behavioral health therapeutic home's or behavioral health respite home's:
 - i. Scope of services; and
 - ii. Policies and procedures; and
 - c. The collaborating health care institution has verified the provider's skills and knowledge.
- F.** If a licensee is an affiliated outpatient treatment center, the licensee shall ensure that if the affiliated outpatient treatment center:
 - 1. Plans to begin providing administrative support to a counseling facility at a time other than during the affiliated outpatient treatment center's license application process, the following information for each counseling facility is submitted to the Department before the affiliated outpatient treatment center begins providing administrative support:
 - a. The counseling facility's name,
 - b. The license number assigned to the counseling facility by the Department, and
 - c. The date the affiliated outpatient treatment center will begin providing administrative support to the counseling facility; or
 - 2. No longer provides administrative support to a counseling facility previously identified by the affiliated outpatient treatment center as receiving administrative support from the affiliated outpatient treatment center, the following information for each counseling facility is submitted to the Department within 30 calendar days after the affiliated outpatient treatment center no longer provides administrative support:
 - a. The counseling facility's name,
 - b. The license number assigned to the counseling facility by the Department, and
 - c. The date the affiliated outpatient treatment center stopped providing administrative support to the counseling facility.
- G.** If a licensee is a counseling facility, the licensee shall ensure that if the counseling facility:
 - 1. Plans to begin receiving administrative support from an affiliated outpatient treatment center at a time other than during the counseling facility's license application process, the following information for the affiliated outpatient treatment center is submitted to the Department before the counseling facility begins receiving administrative support:
 - a. The affiliated outpatient treatment center's name,
 - b. The license number assigned to the affiliated outpatient treatment center by the Department, and
 - c. The date the counseling facility will begin receiving administrative support;
 - 2. No longer receives administrative support from an affiliated outpatient treatment center previously identified by the counseling facility as providing administrative support to the counseling facility, the following information for the affiliated outpatient treatment center is submitted to the Department within 30 calendar days after the counseling facility no longer receives administrative support from the affiliated outpatient treatment center:
 - a. The affiliated outpatient treatment center's name,
 - b. The license number assigned to the affiliated outpatient treatment center by the Department, and
 - c. The date the counseling facility stopped receiving administrative support from the affiliated outpatient treatment center;
 - 3. Plans to begin sharing administrative support with an affiliated counseling facility at a time other than during the counseling facility's license application process, the following information for each affiliated counseling facility sharing administrative support with the counseling facility is submitted to the Department before the counseling facility and affiliated counseling facility begin sharing administrative support:
 - a. The affiliated counseling facility's name,
 - b. The license number assigned to the affiliated counseling facility by the Department, and
 - c. The date the counseling facility and the affiliated counseling facility will begin sharing administrative support; or
 - 4. No longer shares administrative support with an affiliated counseling facility previously identified by the counseling facility as sharing administrative support with the counseling facility, the following information is submitted for each affiliated counseling facility within 30 calendar days after the counseling facility and affiliated counseling facility no longer share administrative support:
 - a. The affiliated counseling facility's name,

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- b. The license number assigned to the affiliated counseling facility by the Department, and
 - c. The date the counseling facility and affiliated counseling facility will no longer be sharing administrative support.
- H.** A governing authority shall submit a license application required in R9-10-105 for:
- 1. A change in ownership of a health care institution;
 - 2. A change in the address or location of a health care institution that provides medical services, nursing services, health-related services, or behavioral health services; or
 - 3. A change in a health care institution's class or subclass.
- I.** A governing authority is not required to submit the documentation required in R9-10-105(A)(5) for a license application if:
- 1. The health care institution has not ceased operations for more than 30 calendar days,
 - 2. A modification has not been made to the health care institution,
 - 3. The services the health care institution is authorized by the Department to provide are not changed, and
 - 4. The location of the health care institution's premises is not changed.
- J.** To request a duplicate license, a licensee shall submit a written request to the Department for the duplicate license in a format provided by the Department that includes:
- 1. The licensee's name and address,
 - 2. The licensee's license number and expiration date,
 - 3. The licensee's signature and date of signature, and
 - 4. If applicable, the fee in R9-10-106.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-110. Modification of a Health Care Institution

- A.** A licensee shall submit a request for approval of a modification of a health care institution when planning to make:
- 1. An addition or removal of an authorized service;
 - 2. An addition or removal of a collocator;
 - 3. A change in a health care institution's licensed capacity, licensed occupancy, respite capacity, or the number of dialysis stations;
 - 4. A change in the physical plant, including facilities or equipment, that costs more than \$300,000; or
 - 5. A change in the building where a health care institution is located that affects compliance with:
 - a. Applicable physical plant codes and standards incorporated by reference in R9-10-104.01, or
 - b. Physical plant requirements in the specific Article in this Chapter applicable to the health care institution.
- B.** A licensee of a health care institution that is required by this Chapter to comply with any of the physical plant codes and standards incorporated by reference in R9-10-104.01 shall

submit an application, according to R9-10-104(A), for a modification of the health care institution described in subsections (A)(3) through (5).

- C.** A licensee of a health care institution shall submit an application for a modification of the health care institution in a Department-provided format that contains:
- 1. The following information in a Department-provided format:
 - a. The health care institution's name, mailing address, email address, and license number;
 - b. A narrative description of the modification, including as applicable:
 - i. The services the licensee is requesting be added or removed as an authorized service;
 - ii. The name and license number of an associated licensed provider being added or removed as a collocator;
 - iii. The name and professional license number of an exempt health care provider being added or removed as a collocator;
 - iv. If an associated licensed provider or exempt health care provider is being added as a collocator, the proposed scope of services;
 - v. The current and proposed licensed capacity, licensed occupancy, respite capacity, and number of dialysis stations;
 - vi. The change being made in the physical plant; and
 - vii. The change being made that affects compliance with applicable physical plant codes and standards incorporated by reference in R9-10-104.01; and
 - c. The name and email address of the health care institution's administrator's or individual representing the health care institution as designated in according to A.R.S. § 36-422 and the dated signature of the administrator or individual; and
 - 2. Documentation that demonstrates that the requested modification complies with applicable requirements in this Chapter, including as applicable:
 - a. A floor plan showing the location of each collocator's proposed treatment area and the areas of the collaborating outpatient treatment center's premises shared with a collocator;
 - b. For a change in the licensed capacity, licensed occupancy, respite capacity, or number of dialysis stations or a modification of the physical plant:
 - i. A floor plan showing, for each story of the facility affected by the modification, the room layout, room usage, each door and each window, plumbing fixtures, each exit, and the location of each fire protection device; or
 - ii. For a health care institution or part of the health care institution that is required to comply with the physical plant codes and standards incorporated by reference in R9-10-104.01 or the building, documentation of the Department's approval of the health care institution's architectural plans and specifications in R9-10-104(D); and
 - c. Any other documentation to support the requested modification; and

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3. If applicable, a copy of the written agreement the associated licensed provider or exempt health care provider has with the collaborating outpatient treatment center.
- D. The Department shall approve or deny a request for a modification described in subsection (C) according to R9-10-108.
- E. A licensee shall not implement a modification described in subsection (C) until an approval or amended license is issued by the Department.
- F. A licensee shall submit the applicable fee according to R9-10-106.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-110 renumbered to Section R9-10-111; new Section R9-10-110 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-111. Enforcement Actions

- A. If the Department determines that an applicant or licensee is violating applicable statutes or rules, the Department may take action according to A.R.S. Title 36, Chapter 4, R9-10-112 or, Table 1.2.
- B. The Department may impose civil money penalties on a licensed health care institution that violates Title 36 or this Chapter, with penalties assessed per resident or patient impacted by the violation as determined by the Department based on the following factors:
 1. The civil penalty may be up to \$1,000 per violation, pursuant to A.R.S. § 36-431.01, if one or more of the following aggravating factors apply:
 - a. The violation is repeated;
 - b. Actual harm occurred;
 - c. The violation poses a potential threat for actual harm or to health and safety, including to patients, staff, or residents;
 - d. Immediate jeopardy exists due to the type and severity of the violation;
 - e. The licensee fails to correct the violation in a reasonable timely manner, which may be a threat to health and safety;
 - f. The length of time the violation occurred;
 - g. Patterns of noncompliance; or
 - h. The total number of violations; and
 2. In determining the final penalty, the Department shall consider and reduce the penalty if one or more of the following mitigating factors apply:
 - a. The violation was isolated,
 - b. No actual harm occurred,
 - c. No immediate jeopardy was present,
 - d. The facility reported the violation to the Department,
 - e. The facility promptly corrected the violation,
 - f. The number of persons affected by the violation,
 - g. The size of the facility and the financial impact of the penalty, or
 - h. The length of time the violation occurred.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 97, effective January 1, 2014 (Supp. 13-4). Section R9-10-111 renumbered to Section R9-10-112; new Section R9-10-111 renumbered from R9-10-110 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-112. Denial, Revocation, or Suspension of License

- A. The Department may deny, revoke, or suspend a license to operate a health care institution if an applicant, a licensee, or a controlling person of the health care institution:
 1. Provides false or misleading information to the Department;
 2. Has had in any state or jurisdiction any of the following:
 - a. An application or license to operate a health care institution denied, suspended, or revoked, unless the denial was based on failure to complete the licensing process or to pay a required licensing fee within a required time-frame; or
 - b. A health care professional license or certificate denied, revoked, or suspended;
 3. Does not comply with the applicable requirements in A.R.S. Title 36, Chapter 4 and this Chapter;
 4. Has operated a health care institution, within the preceding ten years, in violation of A.R.S. Title 36, Chapter 4 or this Chapter, that posed a direct risk to the life, health, or safety of a patient; or
 5. Has operated a health care institution without seeing a patient within twelve consecutive months.
- B. The Department shall suspend or revoke a hospital's license if the Department receives, pursuant to A.R.S. § 36-2901.08(H), notice from the Arizona Health Care Cost Containment System that the hospital's provider agreement registration with the Arizona Health Care Cost Containment System has been suspended or revoked.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 9 A.A.R. 526, effective April 1, 2003 (Supp. 03-1). Section R9-10-112 renumbered to R9-10-113; new Section R9-10-112 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-112 renumbered to Section R9-10-113; new Section R9-10-112 renumbered from R9-10-111 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-113. Tuberculosis Screening

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- A. If a health care institution is subject to the requirements of this Section, as specified in an Article in this Chapter, the health care institution's chief administrative officer shall ensure that the health care institution establishes, documents, and implements tuberculosis infection control activities that:
1. Are consistent with recommendations in Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, published by the U.S. Department of Health and Human Services, Atlanta, GA 30333, available at <https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm>, incorporated by reference, on file with the Department, and including no future editions or amendments; and
 2. Include:
 - a. For each individual who is employed by the health care institution, provides volunteer services for the health care institution, or is admitted to the health care institution and who is subject to the requirements of this Section, baseline screening, on or before the date specified in the applicable Article of this Chapter, that consists of:
 - i. Assessing risks of prior exposure to infectious tuberculosis,
 - ii. Determining if the individual has signs or symptoms of tuberculosis, and
 - iii. Obtaining documentation of the individual's freedom from infectious tuberculosis according to subsection (B)(1);
 - b. If an individual may have a latent tuberculosis infection, as defined in A.A.C. R9-6-1201:
 - i. Referring the individual for assessment or treatment; and
 - ii. Annually obtaining documentation of the individual's freedom from symptoms of infectious tuberculosis, signed by a medical practitioner, occupational health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101;
 - c. Annually providing training and education related to recognizing the signs and symptoms of tuberculosis to individuals employed by or providing volunteer services for the health care institution;
 - d. Annually assessing the health care institution's risk of exposure to infectious tuberculosis;
 - e. Reporting, as specified in A.A.C. R9-6-202, an individual who is suspected of exposure to infectious tuberculosis; and
 - f. If an exposure to infectious tuberculosis occurs in the health care institution, coordinating and sharing information with the local health agency, as defined in A.A.C. R9-6-101, for identifying, locating, and investigating contacts, as defined in A.A.C. R9-6-101.
- B. A health care institution's chief administrative officer shall:
1. For an individual for whom baseline screening and documentation of freedom from infectious tuberculosis is required by an Article in this Chapter, as specified in subsection (A)(2)(a), obtain one of the following as evidence of freedom from infectious tuberculosis:
 - a. Documentation of a negative Mantoux skin test or other tuberculosis screening test that:
 - i. Is recommended by the U.S. Centers for Disease Control and Prevention (CDC),
 - ii. Was administered within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution, and
 - iii. Includes the date and the type of tuberculosis screening test;
 - b. If the individual had a history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, compliance with subsection (A)(2)(b); or
 - c. If the individual had a positive Mantoux skin test or other tuberculosis screening test according to subsection (B)(1)(a) and does not have history of tuberculosis or documentation of latent tuberculosis infection, as defined in A.A.C. R9-6-1201, a written statement:
 - i. That the individual is free from infectious tuberculosis, signed by a medical practitioner or local health agency, as defined in A.A.C. R9-6-101; and
 - ii. Dated within 12 months before the date the individual begins providing services at or on behalf of the health care institution or is admitted to the health care institution; and
 2. As part of the annual assessment of the health care institution's risk of exposure to infectious tuberculosis according to subsection (A)(2)(d), ensure that documentation is obtained for each individual required to be screened for infectious tuberculosis that:
 - a. Indicates the individual's freedom from symptoms of infectious tuberculosis; and
 - b. Is signed by a medical practitioner, occupational health provider, as defined in A.A.C. R9-6-801, or local health agency, as defined in A.A.C. R9-6-101.

Historical Note

Former Section R9-10-113 repealed, new Section R9-10-113 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section R9-10-113 renumbered from R9-10-112 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-113 renumbered to Section R9-10-114; new Section R9-10-113 renumbered from R9-10-112 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-114. Clinical Practice Restrictions for Hemodialysis Technician Trainees

- A. The following definitions apply in this Section:
1. "Assess" means collecting data about a patient by:
 - a. Obtaining a history of the patient,
 - b. Listening to the patient's heart and lungs, and
 - c. Checking the patient for edema.
 2. "Blood-flow rate" means the quantity of blood pumped into a dialyzer per minute of hemodialysis.
 3. "Blood lines" means the tubing used during hemodialysis to carry blood between a vascular access and a dialyzer.

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4. "Central line catheter" means a type of vascular access created by surgically implanting a tube into a large vein.
5. "Clinical practice restriction" means a limitation on the hemodialysis tasks that may be performed by a hemodialysis technician trainee.
6. "Conductivity test" means a determination of the electrolytes in a dialysate.
7. "Dialysate" means a mixture of water and chemicals used in hemodialysis to remove wastes and excess fluid from a patient's body.
8. "Dialysate-flow rate" means the quantity of dialysate pumped per minute of hemodialysis.
9. "Directly observing" or "direct observation" means a medical person stands next to an inexperienced hemodialysis technician trainee and watches the inexperienced hemodialysis technician trainee perform a hemodialysis task.
10. "Direct supervision" has the same meaning as "supervision" in A.R.S. § 36-401.
11. "Electrolytes" means chemical compounds that break apart into electrically charged particles, such as sodium, potassium, or calcium, when dissolved in water.
12. "Experienced hemodialysis technician trainee" means an individual who has passed all didactic, skills, and competency examinations provided by a health care institution that measure the individual's knowledge and ability to perform hemodialysis.
13. "Fistula" means a type of vascular access created by a surgical connection between an artery and vein.
14. "Fluid-removal rate" means the quantity of wastes and excess fluid eliminated from a patient's blood per minute of hemodialysis to achieve the patient's prescribed weight, determined by:
 - a. Dialyzer size,
 - b. Blood-flow rate,
 - c. Dialysate-flow rate, and
 - d. Hemodialysis duration.
15. "Germicide-negative test" means a determination that a chemical used to kill microorganisms is not present.
16. "Germicide-positive test" means a determination that a chemical used to kill microorganisms is present.
17. "Graft" means a vascular access created by a surgical connection between an artery and vein using a synthetic tube.
18. "Hemodialysis machine" means a mechanical pump that controls:
 - a. The blood-flow rate,
 - b. The mixing and temperature of dialysate,
 - c. The dialysate-flow rate,
 - d. The addition of anticoagulant, and
 - e. The fluid-removal rate.
19. "Hemodialysis technician" has the same meaning as in A.R.S. § 36-423(A).
20. "Hemodialysis technician trainee" means an individual who is working in a health care institution to assist in providing hemodialysis and who is not certified as a hemodialysis technician according to A.R.S. § 36-423(A).
21. "Inexperienced hemodialysis technician trainee" means an individual who has not passed all didactic, skills, and competency examinations provided by a health care institution that measure the individual's knowledge and ability to perform hemodialysis.
22. "Medical person" means:
 - a. A physician who is experienced in dialysis;
 - b. A registered nurse practitioner who is experienced in dialysis;
 - c. A nurse who is experienced in dialysis;
 - d. A hemodialysis technician who meets the requirements in A.R.S. § 36-423(A) approved by the governing authority; and
 - e. An experienced hemodialysis technician trainee approved by the governing authority.
23. "Not established" means not approved by a patient's nephrologist for use in hemodialysis.
24. "Patient" means an individual who receives hemodialysis.
25. "pH test" means a determination of the acidity of a dialysate.
26. "Preceptor course" means a health care institution's instruction and evaluation provided to a nurse, hemodialysis technician, or hemodialysis technician trainee that enables the nurse, hemodialysis technician, or hemodialysis technician trainee to provide direct observation and education to hemodialysis technician trainees.
27. "Respond" means to mute, shut off, reset, or troubleshoot an alarm.
28. "Safety check" means successful completion of tests recommended by the manufacturer of a hemodialysis machine, a dialyzer, or a water system used for hemodialysis before initiating a patient's hemodialysis.
29. "Water-contaminant test" means a determination of the presence of chlorine or chloramine in a water system used for hemodialysis.
- B.** An experienced hemodialysis technician trainee may:
 1. Perform hemodialysis under direct supervision, and
 2. Provide direct observation to another hemodialysis technician trainee only after completing the health care institution's preceptor course approved by the governing authority.
- C.** An experienced hemodialysis technician trainee shall not access a patient's:
 1. Fistula that is not established, or
 2. Graft that is not established.
- D.** An inexperienced hemodialysis technician trainee may perform the following hemodialysis tasks only under direct observation:
 1. Access a patient's central line catheter;
 2. Respond to a hemodialysis-machine alarm;
 3. Draw blood for laboratory tests;
 4. Perform a water-contaminant test on a water system used for hemodialysis;
 5. Inspect a dialyzer and perform a germicide-positive test before priming a dialyzer;
 6. Set up a hemodialysis machine and blood lines before priming a dialyzer;
 7. Prime a dialyzer;
 8. Test a hemodialysis machine for germicide presence;
 9. Perform a hemodialysis machine safety check;
 10. Prepare a dialysate;
 11. Perform a conductivity test and a pH test on a dialysate;
 12. Assess a patient;
 13. Check and record a patient's vital signs, weight, and temperature;
 14. Determine the amount and rate of fluid removal from a patient;
 15. Administer local anesthetic at an established fistula or graft, administer anticoagulant, or administer replacement saline solution;

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16. Perform a germicide-negative test on a dialyzer before initiating hemodialysis;
 17. Initiate or discontinue a patient's hemodialysis;
 18. Adjust blood-flow rate, dialysate-flow rate, or fluid-removal rate during hemodialysis; or
 19. Prepare a blood, water, or dialysate culture to determine microorganism presence.
- E.** An inexperienced hemodialysis technician trainee shall not:
1. Access a patient's:
 - a. Fistula that is not established, or
 - b. Graft that is not established; or
 2. Provide direct observation.
- F.** When a hemodialysis technician trainee performs hemodialysis tasks for a patient, the patient's medical record shall include:
1. The name of the hemodialysis technician trainee;
 2. The date, time, and hemodialysis task performed;
 3. The name of the medical person directly observing or the nurse or physician directly supervising the hemodialysis technician trainee; and
 4. The initials or signature of the medical person directly observing or the nurse or physician directly supervising the hemodialysis technician trainee.
- G.** If the Department determines that a health care institution is not in substantial compliance with this Section, the Department may take enforcement action according to R9-10-111.

Historical Note

Former Section R9-10-114 repealed, new Section R9-10-114 adopted effective February 4, 1981 (Supp. 81-1).

Amended by adding paragraph (7) as an emergency effective November 17, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Amended by adding paragraph (7) as a permanent amendment effective August 2, 1984 (Supp. 84-4). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section R9-10-114 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-114 renumbered to Section R9-10-115; new Section R9-10-114 renumbered from R9-10-113 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-115. Behavioral Health Paraprofessionals; Behavioral Health Technicians

If a health care institution is a behavioral health facility or is authorized by the Department to provide behavioral health services, an administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented that:
 - a. Delineate the services a behavioral health paraprofessional is allowed to provide at or for the health care institution;
 - b. Cover supervision of a behavioral health paraprofessional, including documentation of supervision;
 - c. Establish the qualifications for a behavioral health professional providing supervision to a behavioral health paraprofessional;
 - d. Delineate the services a behavioral health technician is allowed to provide at or for the health care institution;

- e. Cover clinical oversight for a behavioral health technician, including documentation of clinical oversight;
 - f. Establish the qualifications for a behavioral health professional providing clinical oversight to a behavioral health technician;
 - g. Delineate the methods used to provide clinical oversight, including when clinical oversight is provided on an individual basis or in a group setting; and
 - h. Establish the process by which information pertaining to services provided by a behavioral health technician is provided to the behavioral health professional who is responsible for the clinical oversight of the behavioral health technician;
2. A behavioral health paraprofessional receives supervision according to policies and procedures;
 3. Clinical oversight is 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 receiving services;
 4. A behavioral health technician receives clinical oversight at least once during each two week period, if the behavioral health technician provides services related to patient care at the health care institution during the two week period;
 5. When clinical oversight is provided electronically:
 - a. The clinical oversight is provided verbally with direct and immediate interaction between the behavioral health professional providing and the behavioral health technician receiving the clinical oversight,
 - b. A secure connection is used, and
 - c. The identities of the behavioral health professional providing and the behavioral health technician receiving the clinical oversight are verified before clinical oversight is provided; and
 6. A behavioral health professional provides supervision to a behavioral health paraprofessional or clinical oversight to behavioral health technician within the behavioral health professional's scope of practice established in the applicable licensing requirements under A.R.S. Title 32.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

Amended by final rulemaking 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-115 renumbered to Section R9-10-116; new Section R9-10-115 renumbered from R9-10-114 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-116. Nutrition and Feeding Assistant Training Programs

- A.** For the purposes of this Section, "agency" means an entity other than a nursing care institution that provides the nutrition and feeding assistant training required in A.R.S. § 36-413.
- B.** An agency shall apply for approval to operate a nutrition and feeding assistant training program by submitting:

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1. An application in a Department-provided format that contains:
 - a. The name of the agency;
 - b. The name, telephone number, and e-mail address of the individual in charge of the proposed nutrition and feeding assistant training program;
 - c. The address where the nutrition and feeding assistant training program records are maintained;
 - d. A description of the training course being offered by the nutrition and feeding assistant training program including for each topic in subsection (I):
 - i. The information presented for each topic,
 - ii. The amount of time allotted to each topic,
 - iii. The skills an individual is expected to acquire for each topic, and
 - iv. The testing method used to verify an individual has acquired the stated skills for each topic;
 - e. Whether the agency agrees to allow the Department to submit supplemental requests for information as specified in subsection (F)(2); and
 - f. The signature of the individual in charge of the proposed nutrition and feeding assistant training program and the date signed; and
 2. A copy of the materials used for providing the nutrition and feeding assistant training program.
- C.** For an application for an approval of a nutrition and feeding assistant training program, the administrative review time-frame is 30 calendar days, the substantive review time-frame is 30 calendar days, and the overall time-frame is 60 calendar days.
- D.** Within 30 calendar days after the receipt of an application in subsection (B), the Department shall:
1. Issue an approval of the agency's nutrition and feeding assistant training program;
 2. Provide a notice of administrative completeness to the agency that submitted the application; or
 3. Provide a notice of deficiencies to the agency that submitted the application, including a list of the information or documents needed to complete the application.
- E.** If the Department provides a notice of deficiencies to an agency:
1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the agency;
 2. If the agency does not submit the missing information or documents to the Department within 30 calendar days, the Department shall consider the application withdrawn; and
 3. If the agency submits the missing information or documents to the Department within 30 calendar days, the substantive review time-frame begins on the date the Department receives the missing information or documents.
- F.** Within the substantive review time-frame, the Department:
1. Shall issue or deny an approval of a nutrition and feeding assistant training program; and
 2. May make one written comprehensive request for more information, unless the Department and the agency agree in writing to allow the Department to submit supplemental requests for information.
- G.** If the Department issues a written comprehensive request or a supplemental request for information:
1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives the information requested, and
 2. The agency shall submit to the Department the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
- H.** The Department shall issue:
1. An approval for an agency to operate a nutrition and feeding assistant training program if the Department determines that the agency and the application comply with A.R.S. § 36-413 and this Section; or
 2. A denial for an agency that includes the reason for the denial and the process for appeal of the Department's decision if:
 - a. The Department determines that the agency does not comply with A.R.S. § 36-413 and this Section; or
 - b. The agency does not submit information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
- I.** An individual in charge of a nutrition and feeding assistant training program shall ensure that:
1. The materials and coursework for the nutrition and feeding assistant training program demonstrate the inclusion of the following topics:
 - a. Feeding techniques;
 - b. Assistance with feeding and hydration;
 - c. Communication and interpersonal skills;
 - d. Appropriate responses to resident behavior;
 - e. Safety and emergency procedures, including the Heimlich maneuver;
 - f. Infection control;
 - g. Resident rights;
 - h. Recognizing a change in a resident that is inconsistent with the resident's normal behavior; and
 - i. Reporting a change in subsection (I)(1)(h) to a nurse at a nursing care institution;
 2. An individual providing the training course is:
 - a. A physician,
 - b. A physician assistant,
 - c. A registered nurse practitioner,
 - d. A registered nurse,
 - e. A registered dietitian,
 - f. A licensed practical nurse,
 - g. A speech-language pathologist, or
 - h. An occupational therapist; and
 3. An individual taking the training course completes:
 - a. At least eight hours of classroom time, and
 - b. Demonstrates that the individual has acquired the skills the individual was expected to acquire.
- J.** An individual in charge of a nutrition and feeding assistant training program shall issue a certificate of completion to an individual who completes the training course and demonstrates the skills the individual was expected to acquire as a result of completing the training course that contains:
1. The name of the agency approved to operate the nutrition and feeding assistant training program;

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2. The name of the individual completing the training course;
 3. The date of completion;
 4. The name, signature, and professional license of the individual providing the training course; and
 5. The name and signature of the individual in charge of the nutrition and feeding assistant training program.
- K.** The Department may deny, revoke, or suspend an approval to operate a nutrition and feeding assistant training program if an agency operating or applying to operate a nutrition and feeding assistance training program:
1. Provides false or misleading information to the Department;
 2. Does not comply with the applicable statutes and rules;
 3. Issues a training completion certificate to an individual who did not:
 - a. Complete the nutrition and feeding assistant training program, or
 - b. Demonstrate the skills the individual was expected to acquire; or
 4. Does not implement the nutrition and feeding assistant training program as described in or use the materials submitted with the agency's application.
- L.** In determining which action in subsection (K) is appropriate, the Department shall consider the following:
1. Repeated violations of statutes or rules,
 2. Pattern of non-compliance,
 3. Types of violations,
 4. Severity of violations, and
 5. Number of violations.
- Historical Note**
- Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-116 renumbered to Section R9-10-117; new Section R9-10-116 renumbered from R9-10-115 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).
- R9-10-117. Repealed**
- Historical Note**
- Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-117 renumbered to Section R9-10-118; new Section R9-10-117 renumbered from R9-10-116 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Repealed by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).
- R9-10-118. Collaborating Health Care Institution**
- A.** An administrator of a collaborating health care institution shall ensure that:
1. A list is maintained of adult behavioral health therapeutic homes and behavioral health respite homes for which the collaborating health care institution serves as a collaborating health care institution;
 2. For each adult behavioral health therapeutic home or behavioral health respite home in subsection (A)(1), the collaborating health care institution maintains the following information:
 - a. A copy of the documented agreement that establishes the responsibilities of the adult behavioral health therapeutic home or behavioral health respite home and the collaborating health care institution consistent with the requirements in this Chapter;
 - b. For the adult behavioral health therapeutic home or behavioral health respite home, the following information:
 - i. Provider's name;
 - ii. Street address;
 - iii. License number;
 - iv. Whether the residence is an adult behavioral health therapeutic home or a behavioral health respite home;
 - v. If the residence is a behavioral health respite home, whether the behavioral health respite home provides respite care services to:
 - (1) Individuals 18 years of age or older, or
 - (2) Individuals less than 18 years of age;
 - vi. The beginning and ending dates of the documented agreement in subsection (A)(2)(a); and
 - vii. The name and contact information for the individual assigned by the collaborating health care institution to monitor the adult behavioral health therapeutic home or behavioral health respite home;
 - c. For the adult behavioral health therapeutic home or behavioral health respite home, a copy of the following that have been approved by the collaborating health care institution:
 - i. Scope of services,
 - ii. Policies and procedures, and
 - iii. Documentation of the review and update of policies and procedures;
 - d. A description of the required skills and knowledge for a provider, based on the scope of services of the adult behavioral health therapeutic home or behavioral health respite home, as established by the collaborating health care institution; and
 - e. For a provider in the adult behavioral health therapeutic home or behavioral health respite home, documentation of:
 - i. The provider's skills and knowledge;
 - ii. If applicable, the provider's completion of training in assistance in the self-administration of medication;
 - iii. Verification of the provider's skills and knowledge; and
 - iv. If the provider is required to have clinical oversight according to R9-10-1805(C), the provider's receiving clinical oversight;
 3. A provider's skills and knowledge are verified by a personnel member according to policies and procedures;
 4. A provider who provides behavioral health services receives clinical oversight, required in R9-10-1805(C), from a behavioral health professional; and
 5. A provider, other than a provider who is a medical practitioner or nurse, receives training in assistance in the self-administration of medication:

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- a. From a medical practitioner or registered nurse or from a personnel member of the collaborating health care institution trained by a medical practitioner or registered nurse;
 - b. That includes:
 - i. A demonstration of the provider's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed; and
 - c. That is documented.
- B.** For a patient referred to an adult behavioral health therapeutic home or a behavioral health respite home, an administrator shall ensure that:
1. A resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home does not present a threat to the referred patient, based on the resident's or recipient's developmental levels, social skills, verbal skills, and personal history;
 2. The referred patient does not present a threat to a resident or recipient accepted by and receiving services from the adult behavioral health therapeutic home or behavioral health respite home based on the referred patient's developmental levels, social skills, verbal skills, and personal history;
 3. The referred patient requires services within the adult behavioral health therapeutic home's or behavioral health respite home's scope of services;
 4. A provider of the adult behavioral health therapeutic home or behavioral health respite home has the verified skills and knowledge to provide behavioral health services to the referred patient;
 5. A treatment plan for the referred patient, which includes information necessary for a provider to meet the referred patient's needs for behavioral health services, is completed and forwarded to the provider before the referred patient is accepted as a resident or recipient;
 6. A patient's treatment plan is reviewed and updated at least once every 12 months, and a copy of the patient's updated treatment plan is forwarded to the patient's provider;
 7. If documentation of a significant change in a patient's behavioral, physical, cognitive, or functional condition and the action taken by a provider to address patient's changing needs is received by the collaborating health care institution, a behavioral health professional or behavioral health technician reviews the documentation and:
 - a. Documents the review; and
 - b. If applicable:
 - i. Updates the patient's treatment plan, and
 - ii. Forwards the updated treatment plan to the provider within 10 working days after receipt of the documentation of a significant change;
 8. If the review and updated treatment plan required in subsection (B)(7) is performed by a behavioral health technician, a behavioral health professional reviews and signs the review and updated treatment plan to ensure the patient is receiving the appropriate behavioral health services; and
- 9.** In addition to the requirements for a medical record for a patient in this Chapter, a referred patient's medical record contains:
- a. The provider's name and the street address and license number of the adult behavioral health therapeutic home or behavioral health respite home to which the patient is referred,
 - b. A copy of the treatment plan provided to the adult behavioral health therapeutic home or behavioral health respite home,
 - c. Documentation received according to and required by subsection (B)(7),
 - d. Any information about the patient received from the adult behavioral health therapeutic home or behavioral health respite home, and
 - e. Any follow-up actions taken by the collaborating health care institution related to the patient.
- C.** For a patient referred to an adult behavioral health therapeutic home, an administrator shall ensure that the collaborating health care institution has documentation in the patient's medical record of evidence of freedom from infectious tuberculosis that meets the requirements in R9-10-113.

Historical Note

New Section R9-10-118 renumbered from R9-10-117 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). The word twelve has been changed to the numeral 12 in subsection (B)(6) for consistency in Chapter style and format (Supp. 21-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-119. Abortion Reporting

- A.** A licensed health care institution where abortions are performed shall submit to the Department, in a Department-provided format and according to A.R.S. § 36-2161(D) and (E), a report that contains the information required in A.R.S. § 36-2161(A) and the following:
1. The final disposition of the fetal tissue from the abortion; and
 2. Except as provided in subsection (B), if custody of the fetal tissue is transferred to another person or persons:
 - a. The name and address of the person or persons accepting custody of the fetal tissue,
 - b. The amount of any compensation received by the licensed health care institution for the transferred fetal tissue, and
 - c. Whether a patient provided informed consent for the transfer of custody of the fetal tissue.
- B.** A licensed health care institution where abortions are performed is not required to include the information specified in subsections (A)(2)(a) through (c) in the report required in subsection (A) if the licensed health care institution where abortions are performed:
1. Transfers custody of the fetal tissue:
 - a. To a funeral establishment, as defined in A.R.S. § 32-1301;
 - b. To a crematory, as defined in A.R.S. § 32-1301; or
 - c. According to requirements in A.A.C. R18-13-1406, A.A.C. R18-13-1407, and A.A.C. R18-13-1408; or
 2. Complies with requirements in A.A.C. R18-13-1405.

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- C. For purposes of this Section, the following definition applies: “Fetal tissue” means cells, or groups of cells with a specific function, obtained from an aborted human embryo or fetus.

Historical Note

New Section made by emergency rulemaking at 21 A.A.R. 1787, effective August 14, 2015 for 180 days (Supp. 15-3). Emergency expired February 10, 2016. Section amended by emergency rulemaking at 22 A.A.R. 420, effective February 11, 2016, for an additional 180 days; filed in the Office February 8, 2016 (Supp. 16-1). New Section made by final rulemaking at 22 A.A.R. 1343, with an immediate effective date upon filing under A.R.S. § 41-1032(A)(1) and (4) of May 5, 2016 (Supp. 16-2). Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

R9-10-120. Opioid Prescribing and Treatment

- A. This Section does not apply to a health care institution licensed under Article 20 of this Chapter.
- B. In addition to the definitions in A.R.S. §§ 32-3248.01 and 36-401(A) and R9-10-101, the following definitions apply in this Section:
1. “Episode of care” means medical services, nursing services, or health-related services provided by a health care institution to a patient for a specific period of time, ending in discharge, the completion of the patient’s treatment plan, or 90 days from the start of service provision to the patient, whichever is later.
 2. “Order” means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.
- C. An administrator of a health care institution where opioids are prescribed or ordered as part of treatment shall:
1. Establish, document, and implement policies and procedures for prescribing or ordering an opioid as part of treatment, to protect the health and safety of a patient, that:
 - a. Cover which personnel members may prescribe or order an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
 - b. As applicable and except when contrary to medical judgment for a patient, are consistent with A.R.S. § 32-3248.01 and the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
 - i. Centers for Disease Control and Prevention, or
 - ii. U.S. Department of Veterans Affairs and the U.S. Department of Defense;
 - c. As applicable, include how, when, and by whom:
 - i. A patient’s profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
 - ii. An assessment is conducted of a patient’s substance use risk;
 - iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient’s representative;
 - iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient’s representative;
 2. Include in the plan for the health care institution’s quality management program a process for:
 - a. Review of known incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
 - b. Surveillance and monitoring of adherence to the policies and procedures in subsection (C)(1);
 3. Except as prohibited by 42 CFR, Chapter I, Subchapter A, Part 2, or as provided in subsection (H)(1), ensure that, if a patient’s death may be related to an opioid prescribed or ordered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient’s death within one working day after the health care institution learns of the patient’s death; and
 4. Ensure that informed consent, if required from a patient or the patient’s representative, includes:
 - a. The patient’s:
 - i. Name,
- v. Informed consent is obtained from a patient or the patient’s representative and, if applicable, in what situations, described in subsection (G), (H), or (I), informed consent would not be obtained before an opioid is prescribed or ordered for a patient;
 - vi. A patient receiving an opioid is monitored; and
 - vii. The actions taken according to subsections (C)(1)(c)(i) through (vi) are documented;
- d. Address conditions that may impose a higher risk to a patient when prescribing or ordering an opioid as part of treatment, including:
- i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
 - ii. History of substance use disorder,
 - iii. Co-occurring behavioral health issue, or
 - iv. Pregnancy;
- e. Cover the criteria for co-prescribing a short-acting opioid antagonist for a patient who is not an inpatient, as defined in R9-10-201;
- f. Include that, if continuing control of a patient’s pain after discharge is medically indicated due to the patient’s medical condition, a method for continuing pain control will be addressed as part of discharge planning;
- g. Include the frequency of the following for a patient being prescribed an opioid for longer than a 30-calendar-day period:
- i. Face-to-face interactions with the patient,
 - ii. Conducting an assessment of a patient’s substance use risk,
 - iii. Renewal of a prescription for an opioid without a face-to-face interaction with the patient, and
 - iv. Monitoring the effectiveness of the treatment;
- h. If applicable according to A.R.S. § 36-2608, include documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
- i. As applicable and consistent with A.R.S. § 32-3248.01, cover the criteria and procedures for tapering opioid prescription or ordering as part of treatment; and
 - j. Cover the criteria and procedures for offering or referring a patient for treatment for substance use disorder;

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- ii. Date of birth or other patient identifier, and
 - iii. Condition for which opioids are being prescribed;
 - b. That an opioid is being prescribed or ordered;
 - c. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
 - d. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;
 - e. Alternatives to a prescribed or ordered opioid;
 - f. The name and signature of the individual explaining the use of an opioid to the patient; and
 - g. The signature of the patient or the patient's representative and the date signed.
- D.** Except as provided in subsection (H) or (I), an administrator of a health care institution where opioids are prescribed as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to prescribe an opioid in treating a patient:
1. Before prescribing an opioid for a patient of the health care institution:
 - a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted during the patient's same episode of care;
 - b. Except as exempted by A.R.S. § 36-2606(H), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted during the same episode of care by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
 - e. Explains alternatives to a prescribed opioid; and
 - f. Obtains informed consent from the patient or the patient's representative that meets the requirements in subsection (C)(4), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:
 - i. Is also prescribed or ordered a sedative-hypnotic medication, or
 - ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;
 2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
 - a. The patient's diagnosis;
 - b. The patient's medical history, including co-morbidities;
 - c. The opioid to be prescribed;
 - d. Other medications or herbal supplements being taken by the patient;
 - e. If applicable:
 - i. The effectiveness of the patient's current treatment,
 - ii. The duration of the current treatment, and
 - iii. Alternative treatments tried by or planned for the patient;
 - f. The expected benefit of the treatment and, if applicable, the benefit of the new treatment compared with continuing the current treatment; and
 - g. Other factors relevant to the patient's being prescribed an opioid; and
- E.** Except as provided in subsection (G) or (H), an administrator of a health care institution where opioids are ordered for administration to a patient in the health care institution as part of treatment shall ensure that a medical practitioner authorized by policies and procedures to order an opioid in treating a patient:
1. Before ordering an opioid for a patient of the health care institution:
 - a. Conducts a physical examination of the patient or reviews the documentation from a physical examination conducted:
 - i. During the patient's same episode of care; or
 - ii. Within the previous 30 calendar days, at a health care institution transferring the patient to the health care institution or by the medical practitioner who referred the patient for admission to the health care institution;
 - b. Except as exempted by A.R.S. § 36-2606(H), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk or reviews the documentation from an assessment of the patient's substance use risk conducted within the previous 30 calendar days by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to conduct an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of opioids, as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of opioids;
 - e. If applicable, explains alternatives to an ordered opioid; and
 - f. Obtains informed consent from the patient or the patient's representative, according to subsection (D)(1)(f); and

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2. Includes the following information in the patient's medical record, an existing treatment plan, or a new treatment plan developed for the patient:
 - a. The patient's diagnosis;
 - b. The patient's medical history, including co-morbidities;
 - c. The opioid being ordered and the reason for the order;
 - d. Other medications or herbal supplements being taken by the patient; and
 - e. If applicable:
 - i. The effectiveness of the patient's current treatment,
 - ii. The duration of the current treatment,
 - iii. Alternative treatments tried by or planned for the patient,
 - iv. The expected benefit of a new treatment compared with continuing the current treatment, and
 - v. Other factors relevant to the patient's being ordered an opioid.
- F. For a health care institution where opioids are administered as part of treatment or where a patient is provided assistance in the self-administration of medication for a prescribed opioid, including a health care institution in which an opioid may be prescribed or ordered as part of treatment, an administrator, a manager as defined in R9-10-801, or a provider, as applicable to the health care institution, shall:
 1. Establish, document, and implement policies and procedures for administering an opioid as part of treatment or providing assistance in the self-administration of medication for a prescribed opioid, to protect the health and safety of a patient, that:
 - a. Cover which personnel members may administer an opioid in treating a patient and the required knowledge and qualifications of these personnel members;
 - b. Cover which personnel members may provide assistance in the self-administration of medication for a prescribed opioid and the required knowledge and qualifications of these personnel members;
 - c. Include how, when, and by whom a patient's need for opioid administration is assessed;
 - d. Include how, when, and by whom a patient receiving an opioid is monitored; and
 - e. Cover how, when, and by whom the actions taken according to subsections (F)(1)(c) and (d) are documented;
 2. Include in the plan for the health care institution's quality management program a process for:
 - a. Review of incidents of opioid-related adverse reactions or other negative outcomes a patient experiences or opioid-related deaths, and
 - b. Surveillance and monitoring of adherence to the policies and procedures in subsection (F)(1);
 3. Except as prohibited by 42 CFR, Chapter I, Subchapter A, Part 2, or as provided in subsection (H)(1), ensure that, if a patient's death may be related to an opioid administered as part of treatment, written notification, in a Department-provided format, is provided to the Department of the patient's death within one working day after the patient's death; and
 4. Except as provided in subsection (H), ensure that an individual authorized by policies and procedures to administer an opioid in treating a patient or to provide assistance in the self-administration of medication for a prescribed opioid:
 - a. Before administering an opioid or providing assistance in the self-administration of medication for a prescribed opioid in compliance with an order as part of the treatment for a patient, identifies the patient's need for the opioid;
 - b. Monitors the patient's response to the opioid; and
 - c. Documents in the patient's medical record:
 - i. An identification of the patient's need for the opioid before the opioid was administered or assistance in the self-administration of medication for a prescribed opioid was provided, and
 - ii. The effect of the opioid administered or for which assistance in the self-administration of medication for a prescribed opioid was provided.
- G. A medical practitioner authorized by a health care institution's policies and procedures to order an opioid in treating a patient is exempt from the requirements in subsection (E), if:
 1. The health care institution's policies and procedures, required in subsection (C)(1) or the applicable Article in 9 A.A.C. 10, contain procedures for:
 - a. Providing treatment without obtaining the consent of a patient or the patient's representative,
 - b. Ordering and administering opioids in an emergency situation, and
 - c. Complying with the requirements in subsection (E) after the emergency is resolved;
 2. The order for the administration of an opioid is:
 - a. Part of the treatment for a patient in an emergency, and
 - b. Issued in accordance with policies and procedures; and
 3. The emergency situation is documented in the patient's medical record.
- H. The requirements in subsections (D), (E), and (F)(4), as applicable, do not apply to a health care institution's:
 1. Prescribing, ordering, or administration of an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy;
 2. Prescribing an opioid as part of treatment for a patient when changing the type or dosage of an opioid, which had previously been prescribed by a medical practitioner of the health care institution for the patient according to the requirements in subsection (D):
 - a. Before a pharmacist dispenses the opioid for the patient; or
 - b. If changing the opioid because of an adverse reaction to the opioid experienced by the patient, within 72 hours after the opioid was dispensed for the patient by a pharmacist;
 3. Ordering an opioid as part of treatment for no longer than three calendar days for a patient remaining in the health care institution and receiving continuous medical services or nursing services from the health care institution; or
 4. Ordering an opioid as part of treatment:
 - a. For a patient receiving a surgical procedure or other invasive procedure; or
 - b. When changing the type, dosage, or route of administration of an opioid, which had previously been ordered by a medical practitioner of the health care institution for a patient according to the requirements in subsection (E), to meet the patient's needs.

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- I. The requirements in subsections (D)(1)(c) through (f) do not apply to a health care institution's prescribing an opioid as part of treatment for a patient with chronic, intractable pain who has had an established health professional-patient relationship with the prescribing medical practitioner for at least 90 days before the opioid is prescribed.

Historical Note

New Section made by emergency rulemaking at 23 A.A.R. 2203, effective July 28, 2017, for 180 days (Supp. 17-3). Emergency expired; new Section renewed by emergency rulemaking at 24 A.A.R. 303, effective January 25, 2018, for 180 days; new Section made by final rulemaking at 24 A.A.R. 657, with an immediate effective date of March 6, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by final expedited rulemaking at 28 A.A.R. 3568 (November 18, 2022), with an immediate effective date November 2, 2022 (Supp. 22-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-121. Disease Prevention and Control

- A. This Section applies:
1. When the Governor has declared a state of emergency, as defined in A.R.S. § 26-301, to address a situation described under A.R.S. § 36-787; and
 2. To health care institutions licensed under Article 4, 5, or 8 of this Chapter.
- B. The following definitions apply in this Section:
1. "Communicable disease" has the same meaning as in A.A.C. R9-6-101.
 2. "Infection" has the same meaning as in A.A.C. R9-6-101.
 3. "Respiratory symptoms" means coughing, shortness of breath, or wheezing not known to be caused by asthma or another chronic lung-related disease.
- C. An administrator or manager, as applicable, shall ensure that policies and procedures are established, documented, and implemented, to protect the health and safety of a resident, that:
1. Cover screening and triage of personnel members, employees, visitors, and, except as provided in subsection (E), any other individuals entering the facility;
 2. Cover the manner and frequency of assessing residents to determine a change in a resident's medical condition;
 3. Establish disinfection protocols and schedules for frequently touched surfaces; and
 4. Specify requirements for distancing residents who exhibit symptoms of a communicable disease from other residents to reduce the chance for infection of another individual.
- D. An administrator or manager, as applicable, shall ensure that:
1. Except as provided in subsection (E), before entering the facility, each individual, including a personnel member, employee, or visitor, is screened for fever or respiratory symptoms indicative of a communicable disease;
 2. If an individual refuses to be screened, the individual is excluded from entry to the facility;
 3. If an individual is determined to have a fever or respiratory symptoms, the individual is excluded from entry to the facility until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner;
 4. If an individual, other than a resident, develops a fever or respiratory symptoms while in the facility, the individual is required to leave the facility and not return until symptoms have resolved or the individual has been evaluated and cleared by a medical practitioner; and
5. If insufficient personnel members are available to meet the needs of all residents in the facility, the administrator or manager, as applicable, implements the disaster plan required in R9-10-424, R9-10-523, or R9-10-819, as applicable, which may include moving a resident to a different facility.
- E. An administrator or manager, as applicable, may allow an emergency medical care technician, as defined in A.R.S. § 36-2201, to enter the facility without screening if the emergency medical care technician is responding to a call for providing emergency medical services, as defined in A.R.S. § 36-2201, to a resident or other individual in the facility.
- F. An administrator or manager, as applicable, shall ensure that:
1. An assessment of a resident includes whether the resident has a fever or respiratory symptoms indicative of a communicable disease and is documented in the resident's medical record; and
 2. If a resident is found to have a fever or respiratory symptoms indicative of a communicable disease:
 - a. The resident is evaluated by a medical practitioner within 24 hours to determine what services need to be provided to the resident and what precautions need to be taken by the facility, and the evaluation is documented in the resident's medical record;
 - b. To reduce the chance for infection of another individual, the resident is:
 - i. Kept at a distance of at least six feet from other residents; or
 - ii. If not possible to keep the resident at a distance from other residents, required to wear a face-mask;
 - c. A personnel member:
 - i. Takes precautions, which may include the use of gloves and a facemask or other personal protection equipment, while providing services to the resident; and
 - ii. Removes and, if applicable, disposes of the personal protection equipment and washes the personnel member's hands with soap and water for at least 20 seconds or, if soap and water are not available, uses a hand sanitizer containing at least 60% alcohol immediately after providing services to the resident and before providing services to another resident;
 - d. Linens, dishes, utensils, and other items used by the resident are:
 - i. Kept separate from similar items used by a resident who does not have a fever or respiratory symptoms indicative of a communicable disease; and
 - ii. Disinfected or disposed of in a manner to reduce the chance for infection of another individual; and
 - e. Surfaces touched by the resident are disinfected before another individual touches the surface.
- G. An administrator or manager, as applicable, shall ensure that door handles, tables, chair backs and arm rests, light switches, and other frequently touched surfaces are cleaned and disinfected, according to policies and procedures, with:
1. An alcohol solution containing at least 70% alcohol;

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2. A bleach solution containing four teaspoons of bleach per quart of water; or
3. An EPA-approved household disinfectant.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by emergency rulemaking at 26 A.A.R. 509, with an immediate effective date of March 16, 2020, for 180 days (Supp. 19-1). Emergency expired. New Section made by final rulemaking at 26 A.A.R. 2793, with an immediate effective date of October 7, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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

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

1. An application in a Department-provided format that contains:
 - a. The name of the entity;
 - b. The name, telephone number, and email address of the individual in charge of the proposed memory care services training program;
 - c. The address where the memory care services training program records are maintained;
 - d. The address and telephone number of each facility from which training services will be provided;
 - e. A description of the minimum eight hours of initial memory care services training for staff and contractors, that includes:
 - i. One of the following:
 - (1) Dementia care training curriculum from a nationally recognized organization; or
 - (2) The evidence-based information presented for each of the following required topics, along with any additional relevant topics:
 - aa. Understanding cognitive impairments and the impact on residents, including the progression of the neurodegenerative disease;
 - bb. Communication techniques with cognitively impaired residents;
 - cc. Managing challenging behaviors such as aggression, wandering, and agitation;
 - dd. Techniques for promoting dignity, comfort, and emotional well-being of residents;
 - ee. Implementation of individualized service planning for residents receiving memory care services;
 - ff. Emergency and safety protocols specific to memory care;
 - gg. Recognizing, preventing, and reporting abuse, neglect, or exploitation;
 - hh. Activities of daily living specific to residents receiving memory care services;
 - ii. Palliative care and end-of-life training; and

- jj. Medication management and administration; and
- ii. In addition to R9-10-122(A)(1)(e)(i):
 - (1) The amount of time allotted to each topic;
 - (2) The skills an individual is expected to acquire for each topic; and
 - (3) The testing method used to verify an individual has acquired the stated skills for each topic;
- f. A description of the minimum four hours of annual memory care services training for staff and contractors, including:
 - i. The evidence-based information presented for each of the following required topics, along with any additional relevant topics:
 - (1) Managing challenging behaviors such as aggression, wandering, and agitation;
 - (2) Techniques for promoting dignity, comfort, and emotional well-being of residents;
 - (3) Recognizing, preventing, reporting abuse, neglect, or exploitation; and
 - (4) Implementation of individualized service planning for residents receiving memory care services;
 - ii. The amount of time allotted to each topic;
 - iii. The skills an individual is expected to acquire for each topic; and
 - iv. The testing method used to verify an individual has acquired the stated skills for each topic;
- g. A description of the minimum four hours of memory care services training for a manager, including:
 - i. The evidence-based information presented for each of the following required topics:
 - (1) Development and implementation of individualized service planning for residents receiving memory care services, and
 - (2) Staffing levels and resource allocation;
 - ii. Any additional relevant topics, which may include evidence-based information or facility-specific information, such as:
 - (1) Supervisory skills for leading interdisciplinary teams;
 - (2) Effective delegation and team-building strategies;
 - (3) Conflict resolution and managing workplace dynamics;
 - (4) In-depth understanding of state regulations specific to memory care services;
 - (5) Monitoring care outcomes and resident satisfaction;
 - (6) Engaging with families during crises or challenging situations;
 - (7) Leading meetings and facilitating collaboration among staff;
 - (8) Advocacy for residents and families;
 - (9) Coaching and mentoring staff for professional growth;
 - (10) Staying updated on advancements in dementia care;
 - (11) Developing emergency protocols;
 - (12) Cultural competency to ensure inclusivity and sensitivity in care;
 - (13) Strategies to improve staff retention and

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- job satisfaction;
 - (14) Supporting mental health and wellness among team members;
 - (15) Room assignments, operations, and environmental standards; or
 - (16) Identification and implementation of control measures for infectious diseases;
 - iii. The amount of time allotted to each topic;
 - iv. The skills an individual is expected to acquire for each topic; and
 - v. The testing method used to verify an individual has acquired the stated skills for each topic;
 - h. Whether the applicant agrees to allow the Department to submit supplemental requests for information as specified in subsection (H)(2); and
 - i. The signature of the individual in charge of the proposed memory care services training program and the date signed; and
 - 2. A copy of the materials used for providing the memory care services training program.
- B.** The memory care services training program shall include in-person components and may incorporate online components. The in-person component shall include a demonstration of the individual's skills and knowledge necessary to provide memory care services.
- C.** The memory care services training program shall review the topics and materials provided in the memory care services training at least once every 12 months to ensure the information is current and evidence-based, and if necessary, update the materials based on the most up-to-date source or sources for evidence-based practice or practices.
- D.** For annual renewal, at least 60 days before the expiration of approval, a memory care services training program shall submit to the Department, in a Department-provided format:
- 1. The memory care services training program's approval number; and
 - 2. The information in subsection (A).
- E.** For an application for an approval of a memory care services training program, the administrative review time-frame is 30 calendar days, the substantive review time-frame is 30 calendar days, and the overall time-frame is 60 calendar days.
- F.** Within 30 calendar days after the receipt of an application in subsection (A), the Department shall:
- 1. Issue an approval of the applicant's memory care services training program;
 - 2. Provide a notice of administrative completeness to the applicant that submitted the application; or
 - 3. Provide a notice of deficiencies to the applicant that submitted the application, including a list of the information or documents needed to complete the application.
- G.** If the Department provides a notice of deficiencies to an applicant:
- 1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant;
 - 2. If the applicant does not submit the missing information or documents to the Department within 30 calendar days, the Department shall consider the application withdrawn; and
 - 3. If the applicant submits the missing information or documents to the Department within 30 calendar days, the substantive review time-frame begins on the date the Department receives the missing information or documents.
- H.** Within the substantive review time-frame, the Department:
- 1. Shall issue or deny an approval of a memory care services training program; and
 - 2. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.
- I.** If the Department issues a written comprehensive request or a supplemental request for information:
- 1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives the information requested, and
 - 2. The applicant shall submit to the Department the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
- J.** The Department shall issue:
- 1. An approval for an applicant to operate a memory care services training program if the Department determines that the applicant and the application comply with A.R.S. § 36-405.03 and this Section, or
 - 2. A denial for an applicant that includes the reason for the denial and the process for appeal of the Department's decision if:
 - a. The Department determines that the applicant does not comply with A.R.S. § 36-405.03 and this Section, or
 - b. The applicant does not submit information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
- K.** The Department may deny, revoke, or suspend an approval to operate a memory care services training program if a memory care services training program provider or an applicant applying to operate a memory care services training program:
- 1. Provides false or misleading information to the Department,
 - 2. Does not comply with the applicable statutes and rules,
 - 3. Issues a training certificate of completion to an individual who did not,
 - a. Complete the memory care services training program, or
 - b. Demonstrate the skills the individual was expected to acquire, or
 - 4. Does not implement the memory care services training program as described in or use the materials submitted with the application.
- L.** In determining which action in subsection (K) is appropriate, the Department shall consider the following:
- 1. Repeated violations of statutes or rules,
 - 2. Pattern of non-compliance,
 - 3. Types of violations,
 - 4. Severity of violations, and
 - 5. Number of violations.

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Historical Note

New Section made by final rulemaking at 7 A.A.R. 2145, effective May 1, 2001 (Supp. 01-2). Amended by final rulemaking at 8 A.A.R. 3578, effective July 26, 2002 (Supp. 02-3). Amended by exempt rulemaking at 14 A.A.R. 3958, effective September 26, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 2100, effective January 1, 2010 (Supp. 09-4). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). New Section made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-123. Notification of Change

- A.** A memory care services training program provider shall notify the Department in writing at least 30 days before the effective date of:
1. Termination of the provision of the memory care services training program, or
 2. A change in the:
 - a. Name under which the memory care services training program provider does business,
 - b. Address or telephone number of a facility where memory care services trainings are provided,
 - c. Administrator, or
 - d. Memory care services training program topics provided, and
- B.** The Department shall review the notification of change for subsection (A) and:
1. If the information complies with the requirements in this Article, the Department shall approve the change, or
 2. If the information does not comply with the requirements in this Article, the Department shall send notification to the memory care services training program provider with reasons for the determination of non-compliance.
- C.** The Department may conduct an on-site inspection as part of the notification of change process.
- D.** The memory care services training program provider retains the existing expiration date of the application approval.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-124. Administration, Monitoring

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

Historical Note

Former Section R9-10-124 repealed, new Section R9-10-124 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3559, effective August 1, 2002 (Supp. 02-3). New Section made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-125. Memory Care Services Trainer Eligibility

- A.** An individual is eligible to be a memory care services trainer if the individual:
1. Is a registered nurse with:
 - a. A Certified Dementia Practitioner (CDP) or an equivalent certification, demonstrating knowledge in dementia care best practices and behavioral management;
 - b. An Alzheimer's Disease and Dementia Care Training (ADCT) certification or an equivalent program recognized by a national or state accrediting body;
 - c. A Gerontological Nurse Certification (RN-BC) issued by the American Nurses Credentialing Center or an equivalent certification specializing in the care of older adults;
 - d. An End-of-Life and Palliative Care Certification from a recognized body, emphasizing care for late-stage dementia and end-of-life situations; or
 - e. Two years of experience providing memory care services; or
 2. Has a current memory care services certificate of completion.
- B.** An individual, who is not a registered nurse, is eligible to become a memory care services trainer,
1. If the individual has a:
 - a. Bachelor's degree or higher in a relevant field, including but not limited to:
 - i. Gerontology,
 - ii. Psychology,
 - iii. Social Work,
 - iv. Education, or
 - v. Nursing-related disciplines; or
 - b. Minimum of three years of direct experience in memory care, dementia care, or a related field, such as:
 - i. Providing care for individuals with Alzheimer's disease or other forms of dementia, or
 - ii. Developing and implementing memory care programs; and
 2. Holds one or more of the following certifications:
 - a. Certified Dementia Practitioner (CDP),
 - b. Certified Alzheimer's Disease and Dementia Care Trainer (CADDCT),
 - c. Certified Activity Director (ADC) with a specialization in memory care, or
 - d. Any equivalent certification recognized by a national accrediting body;
 3. Demonstrates experience in adult education or staff training, including:
 - a. Conducting workshops, seminars, or training sessions in a health care or memory care setting; or
 - b. Developing training materials specific to memory care;
 4. Has completed cultural competency training to ensure inclusivity and sensitivity in care and training approaches;
 5. Possesses strong communication skills and the ability to tailor training to diverse audiences, including care staff and family members; or
 6. Has a valid certificate of completion issued according to R9-10-126.
- C.** An individual is ineligible to become a memory care services trainer if the individual has:

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1. A history of substantiated allegation or allegations of abuse, neglect, or exploitation of a vulnerable individual or individuals; or
2. A record of disciplinary action or actions related to professional misconduct.

Historical Note

New Section made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

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

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

has completed comprehensive training, demonstrated understanding of the topics covered in R9-10-122(A), and achieved a passing score of at least 70% on an examination covering the applicable topics.

- C.** The memory care services training program and an assisted living facility providing memory care services shall maintain a record of the certificate of completion that is kept on file and available with the information specific in subsection (A).
- D.** A memory care services trainer shall comply with:
1. A.R.S. § 36-405.03, and
 2. Applicable requirements in this Article.
- E.** A Department-approved training program shall issue the certificate of completion to the individual who has successfully completed the training program within 10 calendar days of completion.
- F.** An assisted living facility may accept a certificate of completion issued under this Section if:
1. The certificate is issued by a Department-approved training program; and
 2. The certificate holder does not have a lapse of working at an assisted living facility that is licensed to provide directed care services for a period of 12 or more consecutive months, pursuant to A.R.S. § 36-405.03.
- G.** Before the date of issuance of a memory care services certificate of completion, an individual seeking the certificate shall complete the minimum eight hours of initial memory care services training and complete the minimum four hours of annual continuing education training within the preceding 12 consecutive months and achieve a passing score of at least 70% on an examination covering the memory care services training topics specified in R9-10-122(A).

Historical Note

New Section made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

Table 1.2. Violation Severity and Remedy Matrix

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

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Table 1.2. Violation Severity and Remedy Matrix (Continued)

Severity Level	Criteria	Action
Level 5	Immediate jeopardy to health and safety.	Directed plan of correction; Provider agreement; On-site monitoring inspection fee up to \$1,000; Civil money penalties; Suspension; Intermediate sanctions; Revocation; or Other remedies, as applicable, in Title 41, Chapter 6.

Historical Note

Table 1.2 made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

ARTICLE 2. HOSPITALS**R9-10-201. Definitions**

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

1. "Adult" means an individual the hospital designates as an adult based on the hospital's criteria.
2. "Aftercare" means assistance provided to a patient by another individual in the patient's residence, which is not part of a health care institution, following care provided at a hospital, and may include:
 - a. Assisting the patient with activities of daily living, and
 - b. Following the discharge instructions provided by the hospital.
3. "Aftercare provider" means an individual who:
 - a. May be a friend or relative of a patient or be the patient's representative,
 - b. Is designated by the patient or the patient's representative to perform aftercare tasks, and
 - c. Is not compensated for performing aftercare tasks for the patient.
4. "Care plan" means a documented guide for providing nursing services and rehabilitation services to a patient that includes measurable objectives and the methods for meeting the objectives.
5. "Continuing care nursery" means a nursery where medical services and nursing services are provided to a neonate who does not require intensive care services.
6. "Critically ill inpatient" means an inpatient whose severity of medical condition requires the nursing services of specially trained registered nurses for:
 - a. Continuous monitoring and multi-system assessment,
 - b. Complex and specialized rapid intervention, and
 - c. Education of the inpatient or inpatient's representative.
7. "Device" has the same meaning as in A.R.S. § 32-1901.
8. "Diet" means food and drink provided to a patient.
9. "Diet manual" means a written compilation of diets.
10. "Dietary services" means providing food and drink to a patient according to an order.
11. "Diversion" means notification to an emergency medical services provider, as defined in A.R.S. § 36-2201, that a hospital is unable to receive a patient from an emergency medical services provider.
12. "Drug formulary" means a written list of medications available and authorized for use developed according to R9-10-218.
13. "Gynecological services" means medical services for the diagnosis, treatment, and management of conditions or diseases of the female reproductive organs or breasts.
14. "Hospital services" means medical services, nursing services, and health-related services provided in a hospital.
15. "Infection control risk assessment" means determining the probability for transmission of communicable diseases.
16. "Inpatient" means an individual who:
 - a. Is admitted to a hospital as an inpatient according to policies and procedures,
 - b. Is admitted to a hospital with the expectation that the individual will remain and receive hospital services for 24 consecutive hours or more, or
 - c. Receives hospital services for 24 consecutive hours or more.
17. "Intensive care services" means hospital services provided to a critically ill inpatient who requires the services of specially trained nursing and other personnel members as specified in policies and procedures.
18. "Medical staff regulations" means standards, approved by the medical staff, that govern the day-to-day conduct of the medical staff members.
19. "Multi-organized service unit" means an inpatient unit in a hospital where more than one organized service may be provided to a patient in the inpatient unit.
20. "Neonate" means an individual:
 - a. From birth until discharge following birth, or
 - b. Who is designated as a neonate by hospital criteria.
21. "Nurse anesthetist" has the same meaning as "certified registered nurse anesthetist" in A.R.S. § 32-1601.
22. "Nurse executive" means a registered nurse accountable for the direction of nursing services provided in a hospital.
23. "Nursery" means an area in a hospital designated only for neonates.
24. "Nutrition assessment" means a process for determining a patient's dietary needs using information contained in the patient's medical record.
25. "On duty" means that an individual is at work and performing assigned responsibilities.
26. "Organized service" means specific medical services, such as surgical services or emergency services, provided

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in an area of a hospital designated for the provision of those medical services.

27. "Outpatient" means an individual who:
 - a. Is admitted to a hospital with the expectation that the individual will receive hospital services for less than 24 consecutive hours; or
 - b. Except as provided in subsection (17) receives, hospital services for less than 24 consecutive hours.
28. "Pathology" means an examination of human tissue for the purpose of diagnosis or treatment of an illness or disease.
29. "Patient care" means hospital services provided to a patient by a personnel member or a medical staff member.
30. "Pediatric" means pertaining to an individual designated by a hospital as a child based on the hospital's criteria.
31. "Perinatal services" means medical services for the treatment and management of obstetrical patients and neonates.
32. "Post-anesthesia care unit" means a designated area for monitoring a patient following a medical procedure for which anesthesia was administered to the patient.
33. "Private duty staff" means an individual, excluding a personnel member, compensated by a patient or the patient's representative.
34. "Social services" means assistance, other than medical services or nursing services, provided by a personnel member to a patient to assist the patient to cope with concerns about the patient's illness or injury while in the hospital or the anticipated needs of the patient after discharge.
35. "Surgical services" means medical services involving a surgical procedure.
36. "Transfusion" means the introduction of blood or blood products from one individual into the body of another individual.
37. "Unit" means a designated area of an organized service.
38. "Well-baby bassinet" means a receptacle used for holding a neonate who does not require treatment and whose anticipated discharge is within 96 hours after birth.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 2797, with an effective date of January 1, 2021 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-202. Supplemental Application, Notification, and Documentation Submission Requirements

- A. In addition to the license application requirements in A.R.S. § 36-422 and Article 1 of this Chapter, an applicant for a hospital license shall include:
 1. On the application the requested licensed capacity for the hospital, including:
 - a. The number of inpatient beds for each organized service, not including well-baby bassinets; and
 - b. If applicable, the number of inpatient beds for each multi-organized service unit;

2. On the application, if applicable, the requested licensed occupancy for providing behavioral health observation/stabilization services to:
 - a. Individuals who are under 18 years of age, and
 - b. Individuals 18 years of age and older; and
3. A list, in a Department-provided format, of medical staff specialties and subspecialties, as in a specific branch of medicine practiced by a licensed individual who has obtained education or qualifications in the specific branch in addition to the education or qualifications required for the individual's license.

- B. For a single group license authorized in A.R.S. § 36-422(F), in addition to the requirements in subsection (A), a governing authority applying for a license shall submit the following to the Department, in a Department-provided format, for each satellite facility under the single group license:
 1. The name, address, email address, and telephone number of the satellite facility;
 2. The class or subclass of the satellite facility, according to R9-10-102;
 3. The name and email address of the administrator;
 4. A list of services to be provided at the satellite facility; and
 5. The hours of operation during which the satellite facility provides medical services, nursing services, behavioral health services, or health-related services.
- C. For a single group license authorized in A.R.S. § 36-422(G), in addition to the requirements in subsection (A), a governing authority applying for a license shall submit the following to the Department in a Department-provided format for each accredited satellite facility under the single group license:
 1. The name, address, email address, and telephone number of the accredited satellite facility;
 2. The class or subclass of the accredited satellite facility, according to R9-10-102;
 3. The name and email address of the administrator;
 4. A list of services to be provided at the accredited satellite facility;
 5. The hours of operation during which the accredited satellite facility provides medical services, nursing services, behavioral health services, or health-related services; and
 6. A copy of the accredited satellite facility's current accreditation report.
- D. A licensee with a single group license shall submit to the Department, with the relevant fees required in R9-10-106(D) and in a Department-provided format, the following, as applicable:
 1. The information required in subsections (B)(1) through (5), or
 2. The information and documentation required in subsections (C)(1) through (6).
- E. A governing authority shall:
 1. Notify the Department:
 - a. At least 30 calendar days before a satellite facility or an accredited satellite facility on a single group license terminates operations;
 - b. Within 30 calendar days after adding a satellite facility or an accredited satellite facility under a single group license and provide, as applicable:

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- i. The information required in subsections (B)(1) through (5), or
- ii. The information and documentation required in subsections (C)(1) through (6); and
- c. At least 60 calendar days before a satellite facility or an accredited satellite facility licensed under a single group license anticipates providing medical services, nursing services, behavioral health services, or health-related services under a license separate from the single group license; and
- 2. Upon notifying the Department according to subsection (E)(1)(c), submit an application, according to the requirements in 9 A.A.C. 10, Article 1, at least 60 calendar days but not more than 120 calendar days before a satellite facility or an accredited satellite facility licensed under a single group license anticipates providing medical services, nursing services, behavioral health services, or health-related services under a license separate from the single group license.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-203. Administration**A. A governing authority shall:**

- 1. Consist of one or more individuals responsible for the organization, operation, and administration of a hospital;
- 2. Establish, in writing:
 - a. A hospital's scope of services,
 - b. Qualifications for an administrator,
 - c. Which organized services are to be provided in the hospital, and
 - d. The organized services that are to be provided in a multi-organized service unit according to R9-10-228(A);
- 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
- 4. Grant, deny, suspend, or revoke a clinical privilege of a medical staff member or delegate authority to an individual to grant or suspend a clinical privilege for a limited time, according to medical staff bylaws;
- 5. Adopt a quality management program according to R9-10-204;
- 6. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
- 7. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on a hospital's premises for more than 30 calendar days, or
 - b. Not present on a hospital's premises for more than 30 calendar days;
- 8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) if there is a

change of administrator and identify the name and qualifications of the new administrator; and

- 9. For a health care institution under a single group license, except for outpatient treatment centers, that are exempt pursuant to A.R.S. § 36-402, ensure that the health care institution complies with the applicable requirements in this Chapter for the class or subclass of the health care institution.
- B. An administrator:**
 - 1. Is directly accountable to the governing authority of a hospital for the daily operation of the hospital and hospital services and environmental services provided by or at the hospital;
 - 2. Has the authority and responsibility to manage the hospital; and
 - 3. Except as provided in subsection (A)(7), shall designate, in writing, an individual who is present on a hospital's premises and available and accountable for hospital services and environmental services when the administrator is not present on the hospital's premises.
- C. An administrator shall ensure that:**
 - 1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills and knowledge for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to patient care;
 - d. Cover the prevention and reporting of abuse, neglect, and exploitation of minors and vulnerable adults in compliance with A.R.S. §§ 13-3620 and 46-454 including:
 - i. Annual training for personnel members who have patient interaction, prescribed in the hospital's policies and procedures on how to recognize the signs and symptoms of minor or vulnerable adult abuse, neglect, and exploitation;
 - ii. Reporting suspected abuse, neglect or exploitation of a minor or vulnerable adult;
 - iii. Submitting to the Department reports of suspected abuse, neglect or exploitation that are filed with law enforcement or the Department of Economic Security; and
 - iv. Maintaining documentation relating to an abuse, neglect, or exploitation investigation for at least 12 months after an initial allegation, including any steps taken to stop or deter substantiated abuse, neglect, or exploitation;
 - e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - f. Cover cardiopulmonary resuscitation training required in R9-10-206(5) including:
 - i. The method and content of cardiopulmonary resuscitation training,
 - ii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
 - iii. The time-frame for renewal of cardiopulmonary resuscitation training, and

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- iv. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
- g. Cover use of private duty staff, if applicable;
- h. Cover diversion, including:
 - i. The criteria for initiating diversion;
 - ii. The categories or levels of personnel or medical staff that may authorize or terminate diversion;
 - iii. The method for notifying emergency medical services providers of initiation of diversion, the type of diversion, and termination of diversion; and
 - iv. When the need for diversion will be reevaluated;
- i. Include a method to identify a patient to ensure the patient receives hospital services as ordered;
- j. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
- k. Cover health care directives;
- l. Cover medical records, including electronic medical records;
- m. Cover quality management, including incident reports and supporting documentation;
- n. Cover contracted services;
- o. Cover tissue and organ procurement and transplant;
- p. Cover when an individual may visit a patient in a hospital, including visiting a neonate in a nursery, if applicable, that comply with A.R.S. § 36-407.03; and
- q. Cover a workplace violence prevention plan according to A.R.S. § 36-420.03;
- 2. Policies and procedures for hospital services are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient screening, admission, transport, and transfer;
 - b. Cover discharge planning and discharge, including the requirements in R9-10-225(B) for an inpatient who was admitted after a suicide attempt or who exhibits suicidal ideation;
 - c. Cover the provision of hospital services;
 - d. Cover acuity, including a process for obtaining sufficient nursing personnel to meet the needs of patients;
 - e. Include when general consent and informed consent are required;
 - f. Include the age criteria for providing hospital services to pediatric patients;
 - g. Cover dispensing, administering, and disposing of medication;
 - h. Cover prescribing a controlled substance to minimize substance abuse by a patient;
 - i. Cover infection control;
 - j. Cover restraints that:
 - i. Require an order, including the frequency of monitoring and assessing the restraint; or
 - ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a patient's sudden, intense, or out-of-control behavior;
 - k. Cover seclusion of a patient including:
 - i. The requirements for an order, and
 - ii. The frequency of monitoring and assessing a patient in seclusion;
 - l. Cover communicating with a midwife when the midwife's client begins labor and ends labor;
 - m. Cover telehealth, if applicable; and
 - n. Cover environmental services that affect patient care;
- 3. Policies and procedures are reviewed at least once every three years and updated as needed;
- 4. Policies and procedures are available to personnel members;
- 5. The licensed capacity in an organized service is not exceeded, except for an emergency admission of a patient;
- 6. A patient is only admitted to an organized service that has exceeded the organized service's licensed capacity after a medical staff member reviews the medical history of the patient and determines that the patient's admission is an emergency; and
- 7. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a hospital, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the hospital.
- D. An administrator of a special hospital shall ensure that:
 - 1. Medical services are available to an inpatient in an emergency based on the inpatient's medical conditions and the scope of services provided by the special hospital; and
 - 2. A physician or nurse, qualified in cardiopulmonary resuscitation, is on the hospital premises.
- E. An administrator shall provide written notification to the Department of a patient's:
 - 1. Death associated with the use of restraints or seclusion by the hospital, within one working day after the patient's death;
 - 2. Death caused by suicide occurring within the hospital, within one working day after the patient's death; and
 - 3. Self-injury, within two working days after the patient inflicts a self-injury on the premises that requires medical treatment by a physician.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4004, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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R9-10-204. Quality Management

- A.** A governing authority shall ensure that an ongoing quality management program is established that:
1. Complies with the requirements in A.R.S. § 36-445; and
 2. Evaluates the quality of hospital services and environmental services related to patient care.
- B.** 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 hospital services and environmental services related to patient care;
 - c. A method to evaluate the data collected to identify a concern about the delivery of hospital services or environmental 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 hospital services or environmental services related to patient care;
 - e. A method to identify and document each occurrence of exceeding licensed capacity, as described in R9-10-203(C)(5), and to evaluate the occurrences of exceeding licensed capacity, including the actions taken for resolving occurrences of exceeding licensed capacity; and
 - f. The frequency of submitting a documented report required in subsection (B)(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 hospital services or environmental 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 hospital services or environmental services related to patient care;
 3. The acuity plan required in R9-10-214(C)(2) is reviewed and evaluated at least once every 12 months and the results are documented and reported to the governing authority;
 4. The reports required in subsections (B)(2) and (3) and the supporting documentation for the reports are maintained for at least 12 months after the date the report is submitted to the governing authority; and
 5. Except for information or documentation that is confidential under federal or state law, a report or documentation required in this Section is provided to the Department for review within two hours after the Department's request.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-205. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. A documented list of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-206. Personnel

An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
3. Sufficient personnel members are present on a hospital's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the hospital's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient;
4. Orientation occurs within the first 30 calendar days after a personnel member begins providing hospital services and includes:
 - a. Informing a personnel member about Department rules for licensing and regulating hospitals and where the rules may be obtained,
 - b. Reviewing the process by which a personnel member may submit a complaint about patient care to a hospital, and

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- c. Providing the information required by policies and procedures;
- 5. Policies and procedures designate the categories of personnel providing medical services or nursing services who are:
 - a. Required to be qualified in cardiopulmonary resuscitation within 30 calendar days after the individual's starting date, and
 - b. Required to maintain current qualifications in cardiopulmonary resuscitation;
- 6. A personnel record for each personnel member is established and maintained and includes:
 - a. The personnel member's name, date of birth, and contact telephone number;
 - b. The personnel member's starting date and, if applicable, ending date;
 - c. Verification of a personnel member's certification, license, or education, if necessary for the position held;
 - d. Documentation of evidence of freedom from infectious tuberculosis required in R9-10-230(5);
 - e. Verification of current cardiopulmonary resuscitation qualifications, if necessary for the position held; and
 - f. Orientation documentation;
- 7. Personnel receive in-service education according to criteria established in policies and procedures;
- 8. In-service education documentation for a personnel member includes:
 - a. The subject matter,
 - b. The date of the in-service education, and
 - c. The signature of the personnel member;
- 9. Personnel records and in-service education documentation are maintained by the hospital for at least 24 months after the last date the personnel member worked; and
- 10. Personnel records and in-service education documentation, for a personnel member who has not worked in the hospital during the previous 12 months, are provided to the Department within 72 hours after the Department's request.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-207. Medical Staff**A.** A governing authority shall ensure that:

- 1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a hospital;
- 2. The medical staff bylaws and medical staff regulations are approved according to the medical staff bylaws and governing authority requirements;
- 3. A medical staff member complies with medical staff bylaws and medical staff regulations;
- 4. The medical staff of a general hospital or a special hospital includes at least two physicians who have clinical

privileges to admit inpatients to the general hospital or special hospital;

- 5. The medical staff of a rural general hospital includes at least one physician who has clinical privileges to admit inpatients to the rural general hospital and one additional physician who serves on a committee according to subsection (A)(7)(c);
- 6. A medical staff member is available to direct patient care;
- 7. Medical staff bylaws or medical staff regulations are established, documented, and implemented for the process of:
 - a. Conducting peer review according to A.R.S. Title 36, Chapter 4, Article 5;
 - b. Appointing members to the medical staff, subject to approval by the governing authority;
 - c. Establishing committees including identifying the purpose and organization of each committee;
 - d. Appointing one or more medical staff members to a committee;
 - e. Obtaining and documenting permission for an autopsy of a patient, performing an autopsy, and notifying, if applicable, the medical practitioner coordinating the patient's medical services when an autopsy is performed;
 - f. Requiring that each inpatient has a medical practitioner who coordinates the inpatient's care;
 - g. Defining the responsibilities of a medical staff member to provide medical services to the medical staff member's patient;
 - h. Defining a medical staff member's responsibilities for the transport or transfer of a patient;
 - i. Specifying requirements for oral, telephone, and electronic orders, including which orders require identification of the time of the order;
 - j. Establishing a time-frame for a medical staff member to complete a patient's medical record;
 - k. Establishing criteria for granting, denying, revoking, and suspending clinical privileges;
 - l. Specifying pre-anesthesia and post-anesthesia responsibilities for medical staff members; and
 - m. Approving the use of medication and devices under investigation by the U.S. Department of Health and Human Services, Food and Drug Administration including:
 - i. Establishing criteria for patient selection;
 - ii. Obtaining informed consent before administering the investigational medication or device; and
 - iii. Documenting the administration of and, if applicable, the adverse reaction to an investigational medication or device; and
- 8. The organized medical staff reviews the medical staff bylaws and the medical staff regulations at least once every three years and updates the bylaws and regulations as needed.

B. An administrator shall ensure that:

- 1. A medical staff member provides evidence of freedom from infectious tuberculosis according to the requirements in R9-10-230(5);
- 2. A record for each medical staff member is established and maintained that includes:
 - a. A completed application for clinical privileges;
 - b. The dates and lengths of appointment and reappointment of clinical privileges;

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- c. The specific clinical privileges granted to the medical staff member, including revision or revocation dates for each clinical privilege; and
 - d. A verification of current Arizona health care professional active license according to A.R.S. Title 32; and
3. Except for documentation of peer review conducted according to A.R.S. § 36-445, a record under subsection (B)(2) is provided to the Department for review:
- a. As soon as possible, but not more than two hours after the time of the Department's request, if the individual is a current medical staff member; and
 - b. Within 72 hours after the time of the Department's request if the individual is no longer a current medical staff member.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-208. Admission

- A.** An administrator shall ensure that:
- 1. A patient is admitted as an inpatient on the order of a medical staff member;
 - 2. An individual, authorized by policies and procedures, is available to accept a patient for admission;
 - 3. Except in an emergency, informed consent is obtained from a patient or the patient's representative before or at the time of admission;
 - 4. The informed consent obtained in subsection (A)(3) or the lack of consent in an emergency is documented in the patient's medical record;
 - 5. A physician or other medical staff member performs a medical history and physical examination on a patient within 30 calendar 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;
 - 6. If a physician or other medical staff member performs a medical history and physical examination on a patient before admission, the physician or the medical staff member enters an interval note into the patient's medical record at the time of admission; and
 - 7. A patient or the patient's representative is given an opportunity to:
 - a. Designate an individual who is willing to participate in discharge planning and act as the patient's aftercare provider;
 - b. Provide contact information for the patient's aftercare provider; and
 - c. Change the patient's designated aftercare provider before discharge.
- B.** If a patient is admitted after a suicide attempt or exhibits suicidal ideation, an administrator shall ensure that the requirements in R9-10-225(B) are met as part of an inpatient assessment.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final

rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-208 renumbered to R9-10-214; new Section R9-10-208 renumbered from R9-10-210 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 26 A.A.R. 2797, with an effective date of January 1, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

R9-10-209. Discharge Planning; Discharge

- A.** For an inpatient, an administrator shall ensure that discharge planning:
- 1. Is completed before discharge occurs;
 - 2. Identifies the specific needs of the patient after discharge, if applicable;
 - 3. Includes the participation of the patient or patient's representative and, if applicable, the patient's aftercare provider;
 - 4. If the patient is being discharged to the patient's residence, which is not part of a health care institution:
 - a. Includes at least one attempt, which is documented in the patient's medical record, to notify the patient's aftercare provider, if designated, before the patient's discharge; and
 - b. Prepares the patient, the patient's representative, or the patient's aftercare provider, as applicable, to carry out the discharge instructions required in subsection (B)(3)(a), including:
 - i. Answering questions about the discharge instructions and aftercare; and
 - ii. Providing a demonstration of the aftercare tasks to the patient, the patient's representative, or the patient's aftercare provider, as applicable;
 - 5. Provides the patient or the patient's representative with written information identifying classes or subclasses of health care institutions and the level of care that the health care institutions provide that may meet the patient's assessed and anticipated needs after discharge, if applicable; and
 - 6. Is documented in the patient's medical record.
- B.** For an inpatient discharge or a transfer of an inpatient, an administrator shall ensure that:
- 1. There is a discharge summary that includes:
 - a. A description of the patient's medical condition and the medical services provided to the patient, and
 - b. The signature of the medical practitioner coordinating the patient's medical services;
 - 2. There is a documented discharge order for the patient by a medical practitioner coordinating the patient's medical services before discharge unless the patient leaves the hospital against a medical staff member's advice;
 - 3. If the patient is not being transferred:
 - a. There are documented discharge instructions; and
 - b. The patient or patient's representative and the patient's aftercare provider, if designated, is provided with a copy of the discharge instructions; and
 - 4. If the patient is being transferred, the transfer complies with R9-10-211.
 - 5. If applicable, the discharge or transfer information required in A.R.S. § 36-420.04.
- C.** For an inpatient discharge or a transfer of an inpatient who was admitted after a suicide attempt or who exhibits suicidal ide-

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ation, an administrator shall ensure that the requirements in R9-10-225(B) are met as part of discharge planning.

- D.** Except as provided in subsection (E), an administrator shall ensure that an outpatient is discharged according to policies and procedures.
- E.** For a discharge of an outpatient receiving emergency services, an administrator shall ensure that:
1. A discharge order is documented by a medical practitioner who provided medical services to the patient before the patient is discharged, unless the patient leaves against a medical staff member's advice; and
 2. Discharge instructions are documented and provided to the patient or patient's representative and the patient's aftercare provider, if designated before the patient is discharged, unless the patient leaves the hospital against a medical staff member's advice.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-209 renumbered to R9-10-212; new Section R9-10-209 renumbered from R9-10-211 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 2797, with an effective date of January 1, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-210. Transport

- A.** For a transport of a patient, the administrator of a sending hospital shall ensure that:
1. Policies and procedures are established, documented, and implemented that:
 - a. Specify the process by which the sending hospital personnel members coordinate the transport and the medical services provided to a patient to protect the health and safety of the patient;
 - b. Require an assessment of the patient by a registered nurse or a medical staff member before transporting the patient and after the patient's return;
 - c. Specify the information in the sending hospital's patient medical record that is required to accompany the patient, which shall include the information related to the medical services to be provided to the patient at the receiving health care institution;
 - d. Specify how the sending hospital personnel members communicate patient medical record information that the sending hospital does not provide at the time of transport but is requested by the receiving health care institution; and
 - e. Specify how a medical staff member explains the risks and benefits of a transport to the patient or the patient's representative based on the:
 - i. Patient's medical 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;

- c. The date and the time of the transport to the receiving health care institution;
- d. The date and time of the patient's return to the sending hospital, if applicable;
- e. The mode of transportation; and
- f. The type of personnel member or medical staff member assisting in the transport if an order requires that a patient be assisted during transport.

- B.** For a transport of a patient to a receiving hospital, the administrator of the receiving hospital shall ensure that:

1. Policies and procedures are established, documented, and implemented that:
 - a. Specify the process by which the receiving hospital personnel members coordinate the transport and the medical services provided to a patient to protect the health and safety of the patient;
 - b. Require an assessment of the patient by a registered nurse or a medical staff member upon arrival of the patient and before the patient is returned to the sending health care institution unless the receiving facility is a satellite facility, as established in A.R.S. § 36-422, and does not have a registered nurse or a medical staff member at the satellite facility;
 - c. Specify the information in the receiving hospital's patient medical record required to accompany the patient when the patient is returned to the sending health care institution, if applicable; and
 - d. Specify how the receiving hospital personnel members communicate patient medical record information to the sending health care institution 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 time the patient arrived at the receiving hospital;
 - b. The medical services provided to the patient at the receiving hospital;
 - c. Any adverse reaction or negative outcome the patient experienced at the receiving hospital, if applicable;
 - d. The date and time the receiving hospital returned the patient to the sending health care institution, if applicable;
 - e. The mode of transportation to return the patient to the sending health care institution, if applicable; and
 - f. The type of personnel member or medical staff member assisting in the transport if an order requires that a patient be assisted during transport.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-210 renumbered to R9-10-208; new Section R9-10-210 renumbered from R9-10-212 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-211. Transfer

For a transfer of a patient, the administrator of a sending hospital shall ensure that:

1. Policies and procedures are established, documented, and implemented that:

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- a. Specify the process by which the sending hospital personnel members coordinate the transfer and the medical services provided to a patient to protect the health and safety of the patient during the transfer;
- b. Require an assessment of the patient by a registered nurse or a medical staff member of the sending hospital before the patient is transferred;
- c. Specify how the sending hospital personnel members communicate medical record information that is not provided at the time of the transfer; and
- d. Specify how a medical staff member explains the risks and benefits of a transfer to the patient or the patient's representative based on the:
 - i. Patient's medical condition, and
 - ii. Mode of transfer;
2. One of the following accompanies the patient during transfer:
 - a. A copy of the patient's medical record for the current inpatient admission; or
 - b. All of the following for the current inpatient admission:
 - i. A medical staff member's summary of medical services provided to the patient,
 - ii. A care plan containing up-to-date information,
 - iii. Consultation reports,
 - iv. Laboratory and radiology reports,
 - v. A record of medications administered to the patient for the seven calendar days before the date of transfer,
 - vi. Medical staff member's orders in effect at the time of transfer, and
 - vii. 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 institution;
 - d. The mode of transportation; and
 - e. The type of personnel member or medical staff member assisting in the transfer if an order requires that a patient be assisted during transfer.
3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
 - b. Where patient rights are posted as required in subsection (A)(1).
- B.** An administrator shall ensure that:
 1. A patient is treated with dignity, respect, and consideration;
 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion, except as allowed under R9-10-217 or R9-10-225;
 - i. Restraint, if not necessary to prevent imminent harm to self or others or as allowed under R9-10-225;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by a hospital's medical staff, personnel members, employees, volunteers, or students; and
 3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse examination or withdraw consent for treatment before treatment is initiated;
 - c. Is informed of:
 - i. Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of the proposed psychotropic medication or surgical procedure;
 - ii. How to obtain a schedule of hospital rates and charges required in A.R.S. § 36-436.01(B);
 - iii. The patient complaint policies and procedures, including the telephone number of hospital personnel to contact about complaints, and the Department's telephone number if the hospital is unable to resolve the patient's complaint; and
 - iv. Except as authorized by the Health Insurance Portability and Accountability Act of 1996, proposed involvement of the patient in research, experimentation, or education, if applicable;
 - d. Except in an emergency, is provided a description of the health care directives policies and procedures:
 - i. If an inpatient, at the time of admission; or
 - ii. If an outpatient:
 - (1) Before any invasive procedure, except phlebotomy for obtaining blood for diagnostic purposes; or
 - (2) If the hospital services include a planned series of treatments, at the start of each series;
 - e. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospital for identification and administrative purposes; and

Historical Note

Former Section R9-10-211 renumbered as R9-10-311 as an emergency effective February 22, 1979, new Section R9-10-211 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-211 renumbered to R9-10-209; new Section R9-10-211 renumbered from R9-10-213 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-212. Patient Rights**A.** An administrator shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the hospital's premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and

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- f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
- Medical record, or
 - Financial records.
- C. A patient has the following rights:
- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 - To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
 - To receive privacy in treatment and care for personal needs;
 - To have access to a telephone;
 - To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 - To receive a referral to another health care institution if the hospital is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
 - To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
 - To participate or refuse to participate in research or experimental treatment;
 - To participate in visitation, in compliance with A.R.S. § 36-407.03; and
 - To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.
- Historical Note**
- Former Section R9-10-212 renumbered as R9-10-312 as an emergency effective February 22, 1979, new Section R9-10-212 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-212 renumbered to R9-10-210; new Section R9-10-212 renumbered from R9-10-209 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).
- R9-10-213. Medical Records**
- A. An administrator shall ensure that:
- A medical record is established and maintained for each patient according to A.R.S. § Title 12, Chapter 13, Article 7.1;
 - An entry in a patient's medical record is:
 - Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - Dated, legible, and authenticated; and
 - Not changed to make the initial entry illegible;
 - An order is:
 - Dated when the order is entered in the patient's medical record and includes the time of the order;
 - Authenticated by a medical staff member according to policies and procedures; and
 - If the order is a verbal order, authenticated by a medical staff member or medical practitioner;
 - If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - A patient's medical record is available to personnel members and medical staff members authorized by policies and procedures to access the medical record;
 - Policies and procedures include the maximum time-frame to retrieve an onsite or off-site patient's medical record at the request of a medical staff member or authorized personnel member; and
 - A patient's medical record is protected from loss, damage, or unauthorized use.
- B. If a hospital maintains patients' medical records electronically, an administrator shall ensure that:
- Safeguards exist to prevent unauthorized access, and
 - The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C. An administrator shall ensure that a medical record for an inpatient contains:
- Patient information that includes:
 - The patient's name;
 - The patient's address;
 - The patient's date of birth; and
 - Any known allergy, including medication allergies or sensitivities;
 - Medication information that includes:
 - A medication ordered for the patient; and
 - A medication administered to the patient including:
 - The date and time of administration;
 - The name, strength, dosage, amount, and route of administration;
 - The identification and authentication of the individual administering the medication; and
 - Any adverse reaction the patient has to the medication;
 - Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
 - A medical history and results of a physical examination or an interval note;
 - If the patient provides a health care directive, the health care directive signed by the patient;
 - An admitting diagnosis;
 - The date of admission and, if applicable, the date of discharge;
 - Names of the admitting medical staff member and medical practitioners coordinating the patient's care;
 - If applicable, the name and contact information of the patient's representative and:
 - If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - If the patient's representative:
 - Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or

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- ii. Is a legal guardian, a copy of the court order establishing guardianship;
- 10. Orders;
- 11. Care plans;
- 12. Documentation of hospital services provided to the patient;
- 13. Progress notes;
- 14. The disposition of the patient after discharge;
- 15. Discharge planning, including discharge instructions required in R9-10-209(B)(3);
- 16. A discharge summary; and
- 17. If applicable:
 - a. A laboratory report,
 - b. A pathology report,
 - c. An autopsy report,
 - d. A radiologic report,
 - e. A diagnostic imaging report,
 - f. Documentation of restraint or seclusion, and
 - g. A consultation report.
- D. An administrator shall ensure that a hospital's medical record for an outpatient 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 representative, if applicable; and
 - e. Any known allergy including medication allergies or sensitivities;
 - 2. If necessary for treatment, medication information that includes:
 - a. A medication ordered for the patient; and
 - b. A 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. Documentation of general and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
 - 4. An admitting diagnosis or reason for outpatient medical services;
 - 5. Orders;
 - 6. Documentation of hospital services provided to the patient; and
 - 7. If applicable:
 - a. A laboratory report,
 - b. A pathology report,
 - c. An autopsy report,
 - d. A radiologic report,
 - e. A diagnostic imaging report,
 - f. Documentation of restraint or seclusion, and
 - g. A consultation report.
- E. In addition to the requirements in subsection (D), an administrator shall ensure that the hospital's record of emergency services provided to a patient contains:
 - 1. Documentation of treatment the patient received before arrival at the hospital, if available;
 - 2. The patient's medical history;
 - 3. An assessment, including the name of the individual performing the assessment;
 - 4. The patient's chief complaint;
 - 5. The name of the individual who treated the patient in the emergency room, if applicable; and
 - 6. The disposition of the patient after discharge.

Historical Note

Former Section R9-10-213 renumbered as R9-10-313 as an emergency effective February 23, 1979, new Section R9-10-213 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-213 renumbered to R9-10-211; new Section R9-10-213 renumbered from R9-10-228 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-214. Nursing Services

- A. An administrator shall ensure that:
 - 1. Nursing services are provided 24 hours a day, and
 - 2. A nurse executive is appointed who is qualified according to policies and procedures.
- B. A nurse executive shall designate a registered nurse who is present on the hospital's premises to be accountable for managing the nursing services when the nurse executive is not present in the hospital.
- C. A nurse executive shall ensure that:
 - 1. Policies and procedures for nursing services are established, documented, and implemented;
 - 2. An acuity plan is established, documented, and implemented that includes:
 - a. A method that establishes the types and numbers of nursing personnel that are required for each unit in the hospital;
 - b. An assessment of a patient's need for nursing services made by a registered nurse providing nursing services directly to the patient; and
 - c. A policy and procedure stating the steps a hospital will take to:
 - i. Obtain the necessary nursing personnel to meet patient acuity, and
 - ii. Make assignments for patient care according to the acuity plan;
 - 3. Registered nurses, including registered nurses providing nursing services directly to a patient, are knowledgeable about the acuity plan and implement the acuity plan established under subsection (C)(2);
 - 4. If licensed capacity in an organized service is exceeded or patients are kept in areas without licensed beds, nursing personnel are assigned according to the specific rules for the organized service in this Chapter;
 - 5. There is at least one registered nurse on the hospital's premises whether or not there is a patient;
 - 6. A general hospital has at least two registered nurses on the general hospital's premises when there is more than one patient;
 - 7. A special hospital offering emergency services or obstetrical services has at least two registered nurses on the special hospital's premises when there is more than one patient;
 - 8. A special hospital not offering emergency services or obstetrical services has at least one registered nurse and

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- one other nurse on the special hospital's premises when there is more than one patient;
9. A rural general hospital with more than one patient has at least one registered nurse and at least one other nursing personnel member on the rural general hospital's premises. If there is only one registered nurse on the rural general hospital's premises, an additional registered nurse is on-call who is able to be present on the rural general hospital's premises within 15 minutes after being called;
 10. If a hospital has a patient in a unit, there is at least one registered nurse present in the unit;
 11. If a hospital has more than one patient in a unit, there is at least one registered nurse and one additional nursing personnel member present in the unit;
 12. At least one registered nurse is present and accountable for the nursing services provided to a patient:
 - a. During the delivery of a neonate,
 - b. In an operating room, and
 - c. In a post-anesthesia care unit;
 13. Nursing personnel work schedules are planned, reviewed, adjusted, and documented to meet patient needs and emergencies;
 14. A registered nurse assesses, plans, directs, and evaluates nursing services provided to a patient;
 15. There is a care plan for each inpatient based on the inpatient's need for nursing services; and
 16. Nursing personnel document nursing services in a patient's medical record.

Historical Note

Former Section R9-10-214 renumbered as R9-10-314 as an emergency effective February 22, 1979, new Section R9-10-214 adopted effective February 23, 1979 (Supp.

79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-214 renumbered to R9-10-215; new Section R9-10-214 renumbered from R9-10-208 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-215. Surgical Services

An administrator of a general hospital shall ensure that:

1. There is an organized service that provides surgical services under the direction of a medical staff member;
2. There is a designated area for providing surgical services as an organized service;
3. The area of the hospital designated for surgical services is managed by a registered nurse or a physician;
4. Documentation is available in the surgical services area that specifies each medical staff member's clinical privileges to perform surgical procedures in the surgical services area;
5. Postoperative orders are documented in the patient's medical record;
6. There is a chronological log of surgical procedures performed in the surgical services area that contains:
 - a. The date of the surgical procedure,
 - b. The patient's name,
 - c. The type of surgical procedure,
 - d. The time in and time out of the operating room,
 - e. The name and title of each individual performing or assisting in the surgical procedure,

- f. The type of anesthesia used,
 - g. An identification of the operating room used, and
 - h. The disposition of the patient after the surgical procedure;
7. The chronological log required in subsection (6) is maintained in the surgical services area for at least 12 months after the date of the surgical procedure and then maintained by the hospital for an additional 12 months;
 8. The medical staff designate in writing the surgical procedures that may be performed in areas other than the surgical services area;
 9. The hospital has the medical staff members, personnel members, and equipment to provide the surgical procedures offered in the surgical services area;
 10. A patient and the surgical procedure to be performed on the patient are identified before initiating the surgical procedure;
 11. Except in an emergency, a medical staff member or a surgeon performs a medical history and physical examination within 30 calendar days before performing a surgical procedure on a patient;
 12. Except as provided in subsection (14), a medical staff member or a surgeon enters an interval note in the patient's medical record before performing a surgical procedure;
 13. Except as provided in subsection (14), the following are documented in a patient's medical record before a surgical procedure:
 - a. A preoperative diagnosis;
 - b. Each diagnostic test performed in the hospital;
 - c. A medical history and physical examination as required in subsection (11) and an interval note as required in subsection (12);
 - d. A consent or refusal for blood or blood products signed by the patient or the patient's representative, if applicable; and
 - e. Informed consent according to policies and procedures;
 14. In an emergency, the documentation required in subsections (12) and (13) is completed within 24 hours after a surgical procedure on a patient is completed;
 15. A physician discharges a patient from the designated area in subsection (2); and
 16. A smoke evacuation system is used in each designated area to prevent exposure to surgical smoke as described in A.R.S. § 36-434.01.

Historical Note

Former Section R9-10-215 renumbered as R9-10-315 as an emergency effective February 22, 1979, new Section R9-10-215 adopted effective February 23, 1979 (Supp.

79-1). Amended subsection (D) effective August 31, 1988 (Supp. 88-3). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-215 renumbered to R9-10-216; new Section R9-10-215 renumbered from R9-10-214 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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R9-10-216. Anesthesia Services

An administrator shall ensure that:

1. Anesthesia services provided in conjunction with surgical services performed in the operating room are provided as an organized service under the direction of a medical staff member;
2. Documentation is available in the surgical services area that specifies the medical staff member's clinical privileges to administer anesthesia;
3. Except in an emergency, an anesthesiologist or a nurse anesthetist performs a pre-anesthesia evaluation within 48 hours before anesthesia is administered in conjunction with surgical services;
4. Anesthesia administration is documented in a patient's medical record and includes:
 - a. A pre-anesthesia evaluation, if applicable;
 - b. An intra-operative anesthesia record;
 - c. The postoperative status of the patient upon leaving the operating room; and
 - d. Post-anesthesia documentation by the individual performing the post-anesthesia evaluation that includes the information required by the medical staff bylaws and medical staff regulations; and
5. A registered nurse or a physician documents resuscitative measures in the patient's medical record.

Historical Note

Adopted as an emergency effective April 2, 1976 (Supp. 76-2). Adopted effective August 25, 1977 (Supp. 77-4). Former Section R9-10-216 renumbered as R9-10-316 as an emergency effective February 22, 1979, new Section R9-10-216 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-216 renumbered to R9-10-217; new Section R9-10-216 renumbered from R9-10-215 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-217. Emergency Services

A. An administrator of a general hospital or a rural general hospital shall ensure that:

1. Emergency services are provided 24 hours a day in a designated area of the hospital;
2. Emergency services are provided as an organized service under the direction of a medical staff member;
3. The scope and extent of emergency services offered are documented in the hospital's scope of services;
4. Emergency services are provided to an individual, including a woman in active labor, requesting emergency services;
5. If emergency services cannot be provided at the hospital to meet the needs of a patient in an emergency, measures and procedures are implemented to minimize risk to the patient until the patient is transported or transferred to another hospital;
6. A roster of on-call medical staff members is available in the emergency services area;
7. There is a chronological log of emergency services provided to patients that includes:
 - a. The patient's name;
 - b. The date, time, and mode of arrival; and
 - c. The disposition of the patient including discharge, transfer, or admission; and

8. The chronological log required in subsection (A)(7) is maintained:
 - a. In the emergency services area for at least 12 months after the date of the emergency services; and
 - b. By the hospital for at least an additional four years.

- B. An administrator of a special hospital that provides emergency services shall comply with subsection (A).
- C. An administrator of a hospital that provides emergency services, but does not provide perinatal organized services, shall ensure that emergency perinatal services are provided within the hospital's capabilities to meet the needs of a patient and a neonate, including the capability to deliver a neonate and to keep the neonate warm until transfer to a hospital providing perinatal organized services.
- D. An administrator of a hospital that provides emergency services shall ensure that a room used for seclusion in a designated area of the hospital used for providing emergency services, complies with applicable physical plant health and safety codes and standards for a secure hold room as described in the American Institute of Architects and Facilities Guidelines Institute, Guidelines for Design and Construction of Health Care Facilities, incorporated by reference in R9-10-104.01.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-217 renumbered to R9-10-218; new Section R9-10-217 renumbered from R9-10-216 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-218. Pharmaceutical Services

An administrator shall ensure that:

1. Pharmaceutical services are provided under the direction of a pharmacist according to A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23;
2. A copy of the pharmacy license is provided to the Department for review upon the Department's request;
3. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - a. Develop a drug formulary,
 - b. Update the drug formulary at least once every 12 months,
 - c. Develop medication usage and medication substitution policies and procedures, and
 - d. Specify which medications and medication classifications are required to be automatically stopped after a specified time period unless the ordering medical staff member specifically orders otherwise;
4. An expired, mislabeled, or unusable medication is disposed of according to policies and procedures;
5. A medication administration error or an adverse reaction is reported to the ordering medical staff member or the medical staff member's designee;
6. A pharmacy medication dispensing error is reported to the pharmacist;

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7. In a pharmacist's absence, personnel members designated by policies and procedures have access to a locked area containing a medication;
8. A medication is maintained at temperatures recommended by the manufacturer;
9. A cart used for an emergency:
 - a. Contains medication, supplies, and equipment as specified in policies and procedures;
 - b. Is available to a unit; and
 - c. Is sealed until opened in an emergency;
10. Emergency cart contents and sealing of the emergency cart are verified and documented according to policies and procedures;
11. Policies and procedures specify individuals who may:
 - a. Order medication, and
 - b. Administer medication;
12. A medication is administered in compliance with an order;
13. A medication administered to a patient is documented as required in R9-10-213;
14. 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; and
15. Policies and procedures specify a process for review through the quality management program of:
 - a. A medication administration error,
 - b. An adverse reaction to a medication, and
 - c. A pharmacy medication dispensing error.
16. If applicable, policies and procedures are established for donated medicine according to A.R.S. § 32-1909.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-218 renumbered to R9-10-219; new Section R9-10-218 renumbered from R9-10-217 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-219. Clinical Laboratory Services and Pathology Services

An administrator shall ensure that:

1. Clinical laboratory services and pathology services are provided by a hospital through a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation or certificate of compliance in subsection (1) is provided to the Department for review upon the Department's request;
3. A general hospital or a rural general hospital provides clinical laboratory services 24 hours a day on the hospital's premises to meet the needs of a patient in an emergency;

4. A special hospital whose patients require clinical laboratory services:
 - a. Is able to provide clinical laboratory services when needed by the patients,
 - b. Obtains specimens for clinical laboratory services without transporting the patients from the special hospital's premises, and
 - c. Has the examination of the specimens performed by a clinical laboratory on the special hospital's premises or by arrangement with a clinical laboratory not on the special hospital's premises;
5. A hospital that provides clinical laboratory services 24 hours a day has on duty or on-call laboratory personnel authorized by policies and procedures to perform testing;
6. A hospital that offers surgical services provides pathology services on the hospital's premises or by contracted service to meet the needs of a patient;
7. Clinical laboratory and pathology test results are:
 - a. Available to the medical staff:
 - i. Within 24 hours after the test is completed if the test is performed at a laboratory on the hospital's premises, or
 - ii. Within 24 hours after the test result is received if the test is performed at a laboratory not on the hospital's premises; and
 - b. Documented in a patient's medical record;
8. If a test result is obtained that indicates a patient may have an emergency medical condition, as established by medical staff, laboratory personnel notify the ordering medical staff member or a registered nurse in the patient's assigned unit;
9. If a clinical laboratory report, a pathology report, or an autopsy report is completed on a patient, a copy of the report is included in the patient's medical record;
10. Policies and procedures are established, documented, and implemented for:
 - a. Procuring, storing, transfusing, and disposing of blood and blood products;
 - b. Blood typing, antibody detection, and blood compatibility testing; and
 - c. Investigating transfusion adverse reactions that specify a process for review through the quality management program;
11. If blood and blood products are provided by contract, the contract includes:
 - a. The availability of blood and blood products through the contract, and
 - b. The process for delivery of blood and blood products through the contract; and
12. Expired laboratory supplies are discarded according to policies and procedures.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-219 renumbered to R9-10-220; new Section R9-10-219 renumbered from R9-10-218 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

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R9-10-220. Radiology Services and Diagnostic Imaging Services

- A.** An administrator shall ensure that:
1. Radiology services and diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
 2. A copy of a certificate documenting compliance with subsection (A)(1) is provided to the Department for review upon the Department's request;
 3. A general hospital or a rural general hospital provides radiology services 24 hours a day on the hospital's premises to meet the emergency needs of a patient;
 4. A hospital that provides surgical services has radiology services and diagnostic imaging services on the hospital's premises to meet the needs of patients;
 5. A general hospital or a rural general hospital has a radiologic technologist on duty or on-call; and
 6. Except as provided in subsection (A)(4), a special hospital whose patients require radiology services and diagnostic imaging services is able to provide the radiology services and diagnostic imaging services when needed by the patients:
 - a. On the special hospital's premises, or
 - b. By arrangement with a radiology and diagnostic imaging facility that is not on the special hospital's premises.
- B.** An administrator of a hospital that provides radiology services or diagnostic imaging services on the hospital's premises shall ensure that:
1. Radiology services and diagnostic imaging services are provided:
 - a. Under the direction of a medical staff member; and
 - b. According to an order that includes:
 - i. The patient's name,
 - ii. The name of the ordering individual,
 - iii. The radiological or diagnostic imaging procedure ordered, and
 - iv. The reason for the procedure;
 2. A medical staff member or radiologist interprets the radiologic or diagnostic image;
 3. A radiologic or diagnostic imaging patient report is prepared that includes:
 - a. The patient's name;
 - b. The date of the procedure;
 - c. A medical staff member's or radiologist's interpretation of the image;
 - d. The type and amount of radiopharmaceutical used, if applicable; and
 - e. The adverse reaction to the radiopharmaceutical, if any; and
 4. A radiologic or diagnostic imaging report is included in the patient's medical record.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-220 renumbered to R9-10-221; new Section R9-10-220 renumbered from R9-10-219 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014

(Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-221. Intensive Care Services

Except for a special hospital that provides only psychiatric services, an administrator of a hospital that provides intensive care services shall ensure that:

1. Intensive care services are provided as an organized service in a designated area under the direction of a medical staff member;
2. An inpatient admitted for intensive care services is personally visited by a physician at least once every 24 hours;
3. Admission and discharge criteria for intensive care services are established;
4. A personnel member's responsibilities for initiation of medical services in an emergency to a patient in an intensive care unit pending the arrival of a medical staff member are established and documented in policies and procedures;
5. In addition to the requirements in R9-10-214(C), an intensive care unit is staffed:
 - a. With at least one registered nurse assigned for every two patients, and
 - b. According to an acuity plan as required in R9-10-214;
6. Each intensive care unit has a policy and procedure that provides for meeting the needs of the patients;
7. If the medical services of an intensive care patient are reduced to a lesser level of care in the hospital, but the patient is not physically relocated, the nurse to patient ratio is based on the needs of the patient;
8. Private duty staff do not provide hospital services in an intensive care unit;
9. At least one registered nurse assigned to a patient in an intensive care unit is certified in advanced cardiac life support specific to the age of the patient;
10. Resuscitation, emergency, and other equipment are available to meet the needs of a patient including:
 - a. Ventilatory assistance equipment,
 - b. Respiratory and cardiac monitoring equipment,
 - c. Suction equipment,
 - d. Portable radiologic equipment, and
 - e. A patient weighing device for patients restricted to a bed; and
11. An intensive care unit has at least one emergency cart that is maintained according to R9-10-218.

Historical Note

Former Section R9-10-221 renumbered as R9-10-317 as an emergency effective February 22, 1979, new Section R9-10-221 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-221 renumbered to R9-10-222; new Section R9-10-221 renumbered from R9-10-220 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-222. Respiratory Care Services

An administrator of a hospital that provides respiratory care services shall ensure that:

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1. Respiratory care services are provided under the direction of a medical staff member;
2. Respiratory care services are provided according to an order that includes:
 - a. The patient's name;
 - b. The name and signature of the ordering individual;
 - c. The type, frequency, and, if applicable, duration of treatment;
 - d. The type and dosage of medication and diluent; and
 - e. The oxygen concentration or oxygen liter flow and method of administration;
3. Respiratory care services provided to a patient are documented in the patient's medical record and include:
 - a. The date and time of administration;
 - b. The type of respiratory care services;
 - c. The effect of respiratory care services;
 - d. If applicable, any adverse reaction to respiratory care services; and
 - e. The authentication of the individual providing the respiratory care services; and
4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-219.

Historical Note

Former Section R9-10-222 renumbered as R9-10-318 as an emergency effective February 22, 1979, new Section R9-10-222 adopted effective February 23, 1979 (Supp. 79-1). Correction, subsection (D)(3) reference to paragraph (E)(2) should read subsection (D)(2). (Supp. 79-6). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-222 renumbered to R9-10-223; new Section R9-10-222 renumbered from R9-10-221 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-223. Perinatal Services

- A.** An administrator of a hospital that provides perinatal organized services shall ensure that:
 1. Perinatal services are provided in a designated area under the direction of a medical staff member;
 2. Only medical and surgical procedures approved by the medical staff are performed in the perinatal services unit;
 3. The perinatal services unit has the capability to initiate an emergency cesarean delivery within the time-frame established by the medical staff and documented in policies and procedures;
 4. Only a patient in need of perinatal services or gynecological services receives perinatal services or gynecological services in the perinatal services unit;
 5. A patient receiving gynecological services does not share a room with a patient receiving perinatal services;
 6. A chronological log of perinatal services provided to patients is maintained that includes:
 - a. The patient's name;
 - b. The date, time, and mode of the patient's arrival;
 - c. The disposition of the patient including discharge, transfer, or admission time;
 - d. The following information for a delivery of a neonate:
 - i. The neonate's name or other identifier;
 - ii. The name of the medical staff member who delivered the neonate;
 - iii. The delivery time and date; and
 - iv. Complications of delivery, if any; and
 - e. If an abortion procedure was performed at or after 20 weeks gestational age, whether the fetus was delivered alive;
7. The chronological log required in subsection (A)(6) is maintained by the hospital in the perinatal services unit for at least 12 months after the date the perinatal services are provided and then maintained by the hospital for at least an additional 12 months;
8. The perinatal services unit provides fetal monitoring;
9. The perinatal services unit has ultrasound capability;
10. Except in an emergency, a neonate is identified as required by policies and procedures before moving the neonate from a delivery area;
11. Policies and procedures specify:
 - a. Security measures to prevent neonatal abduction, and
 - b. How the hospital determines to whom a neonate may be discharged;
12. A neonate is discharged only to an individual who:
 - a. Is authorized according to subsection (A)(11), and
 - b. Provides identification;
13. A neonate's medical record identifies the individual to whom the neonate is discharged;
14. A patient or the individual to whom the neonate is discharged receives perinatal education, discharge instructions, and a referral for follow-up care for a neonate in addition to the discharge planning requirements in R9-10-209;
15. Intensive care services for neonates comply with the requirements in R9-10-221;
16. At least one registered nurse is on duty in a nursery when there is a neonate in the nursery except as provided in subsection (A)(17);
17. A nursery occupied only by a neonate, who is placed in the nursery for the convenience of the neonate's mother and does not require treatment as established in this Article, is staffed by a nurse;
18. Equipment and supplies are available to a nursery, labor-delivery-recovery room, or labor-delivery-recovery-postpartum room to meet the needs of each neonate; and
19. In a nursery, only a neonate's bed or bassinet is used for changing diapers, bathing, or dressing the neonate.
- B.** An administrator of a hospital that does not provide perinatal organized services shall comply with the requirements in R9-10-217(C).
- C.** In addition to applicable requirements in A.R.S. Title 36, Chapter 20, an administrator of a hospital in which an abortion procedure is performed shall ensure that:
 1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that require:
 - a. For an abortion procedure performed at or after 20 weeks gestational age, a personnel member or medical staff member qualified according to policies and procedures to perform neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure is performed before the delivery of the fetus;
 - b. Compliance with A.R.S. § 36-2301.01, if applicable;

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- c. Neonatal resuscitation of a fetus delivered alive, according to A.R.S. § 36-2301(D)(3); and
- d. A medical record to be established and maintained for a fetus delivered alive;
- 2. The medical record of a patient receiving an abortion procedure contains:
 - a. Documentation from the physician providing the abortion procedure and other personnel members present certifying that the fetus was not delivered alive, or
 - b. A link to the medical record of a fetus delivered alive; and
- 3. For a fetus delivered alive, a medical record contains:
 - a. An identification of the fetus, including:
 - i. The name of the patient from whom the fetus was delivered alive, and
 - ii. The date the fetus was delivered alive;
 - b. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 - c. A record of medical services, nursing services, and health-related services provided to the fetus delivered alive;
 - d. If applicable, information about medication administered to the fetus delivered alive; and
 - e. If the fetus had a lethal fetal condition, the results of the confirmation of the lethal fetal condition.

Historical Note

Former Section R9-10-223 renumbered as R9-10-319 as an emergency effective February 22, 1979, new Section R9-10-223 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-223 renumbered to R9-10-224; new Section R9-10-223 renumbered from R9-10-222 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-224. Pediatric Services

- A. An administrator of a hospital that provides pediatric services or pediatric organized services according to the requirements in this Section shall ensure that:
 - 1. Consistent with the health and safety of a pediatric patient, arrangements are made for a parent or a guardian of the pediatric patient to stay overnight;
 - 2. Policies and procedures are established, documented, and implemented for:
 - a. Infection control for shared toys, books, stuffed animals, and other items in a community playroom; and
 - b. Visitation of a pediatric patient, including age limits if applicable;
 - 3. A pediatric inpatient is only admitted if the hospital has the staff, equipment, and supplies available to meet the needs of the pediatric patient based on the pediatric patient's medical condition and the hospital's scope of services; and
 - 4. If the hospital provides pediatric intensive care services, the pediatric intensive care services comply with intensive care services requirements in R9-10-221.
- B. An administrator of a hospital that provides pediatric organized services shall ensure that pediatric services are provided in a designated area under the direction of a medical staff member.
- C. An administrator shall ensure that in a multi-organized service unit or a patient care unit that is providing medical and nursing services to an adult patient and a pediatric patient according to this Section:
 - 1. A pediatric patient is not placed in a patient room with an adult patient, and
 - 2. A medication for a pediatric patient that is stored in the patient care unit is stored separately from a medication for an adult patient.
- D. A hospital may use a bed in a pediatric organized services patient care unit for an adult patient if an administrator establishes, documents, and implements policies and procedures that:
 - 1. Delineate the specific conditions under which an adult patient is placed in a bed in the pediatric organized services unit, and
 - 2. Except as provided in subsections (H) and (I), ensure that an adult patient is:
 - a. Not placed in a pediatric organized services patient care unit if a pediatric patient is admitted to and present in the pediatric organized services patient care unit, and
 - b. Transferred out of the pediatric organized services patient care unit to an appropriate level of care when a pediatric patient is admitted to the pediatric organized services patient care unit.
- E. Except as provided in subsections (F) and (G), an administrator of a hospital that does not provide pediatric organized services may admit a pediatric inpatient only in an emergency.
- F. Subsection (G) only applies to a general hospital or rural general hospital that:
 - 1. Does not provide pediatric organized services;
 - 2. Has designated in the general hospital's or rural general hospital's scope of services, inpatient services that are available to a pediatric patient;
 - 3. Has a licensed capacity of less than 100; and
 - 4. Is located in a county with a population of less than 500,000.
- G. An administrator of a general hospital or rural general hospital that meets the criteria in subsection (F) shall ensure that:
 - 1. There are pediatric appropriate equipment and supplies available, based on the hospital services designated for pediatric patients in the general hospital or rural general hospital's scope of services; and
 - 2. Personnel members that are or may be assigned to provide hospital services to a pediatric patient have the appropriate skills and knowledge for providing hospital services to a pediatric patient, based on the general hospital's or rural general hospital's scope of services.
- H. Subsection (I) only applies to a general hospital or a rural general hospital that:
 - 1. Provides pediatric organized services in a patient care unit;
 - 2. Has designated in the general hospital's or rural general hospital's scope of services, inpatient services that are available to an adult patient in a pediatric organized services patient care unit;
 - 3. Has a licensed capacity of less than 100; and
 - 4. Is located in a county with a population of less than 500,000.

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- I. An administrator of a general hospital or rural general hospital that meets the criteria in subsection (H) shall comply with the requirements in subsection (D)(1).

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

Amended by exempt rulemaking at 18 A.A.R. 1719, effective June 30, 2012 (Supp. 12-2). Section R9-10-224 renumbered to R9-10-225; new Section R9-10-224 renumbered from R9-10-223 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-225. Psychiatric Services

- A. An administrator of a hospital that contains an organized psychiatric services unit or a special hospital licensed to provide psychiatric services shall ensure that in the organized psychiatric unit or special hospital:
1. Psychiatric services are provided under the direction of a medical staff member;
 2. An inpatient admitted to the organized psychiatric services unit or special hospital has a principal diagnosis of a mental disorder, a personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor;
 3. Except in an emergency, a patient receives a nursing assessment before treatment for the patient is initiated;
 4. An individual whose medical needs cannot be met while the individual is an inpatient in an organized psychiatric services unit or a special hospital is not admitted to or is transferred out of the organized psychiatric services unit or special hospital;
 5. Policies and procedures for the organized psychiatric services unit or special hospital are established, documented, and implemented that:
 - a. Establish qualifications for medical staff members and personnel members who provide clinical oversight to behavioral health technicians;
 - b. Establish the process for patient assessment, including identification of a patient's medical conditions and criteria for the on-going monitoring of any identified medical condition;
 - c. Establish the process for developing and implementing a patient's care plan including:
 - i. Obtaining the patient's or the patient's representative's participation in the development of the patient's care plan;
 - ii. Ensuring that the patient is informed of the modality, frequency, and duration of any treatments that are included in the patient's care plan;
 - iii. Informing the patient that the patient has the right to refuse any treatment;
 - iv. Updating the patient's care plan and informing the patient of any changes to the patient's care plan; and
 - v. Documenting the actions in subsection (A)(5)(c)(i) through (iv) in the patient's medical record;
- d. Establish the process for warning an identified or identifiable individual, as described in A.R.S. § 36-517.02 (B) through (C), if a patient communicates to a medical staff member or personnel member a threat of imminent serious physical harm or death to the individual and the patient has the apparent intent and ability to carry out the threat;
 - e. Establish the criteria for determining when an inpatient's absence is unauthorized, including whether the inpatient:
 - i. Was admitted under A.R.S. Title 36, Chapter 5, Articles 1, 2, or 3;
 - ii. Is absent against medical advice; or
 - iii. Is under 18 years of age;
 - f. Identify each type of restraint and seclusion used in the organized psychiatric services unit or special hospital and include for each type of restraint and seclusion used:
 - i. The qualifications of a medical staff member or personnel member who can:
 - (1) Order the restraint or seclusion,
 - (2) Place a patient in the restraint or seclusion,
 - (3) Monitor a patient in the restraint or seclusion,
 - (4) Evaluate a patient's physical and psychological well-being after being placed in the restraint or seclusion and when released from the restraint or seclusion, or
 - (5) Renew the order for restraint or seclusion;
 - ii. On-going training requirements for a medical staff member or personnel member who has direct patient contact while the patient is in a restraint or in seclusion; and
 - iii. Criteria for monitoring and assessing a patient including:
 - (1) Frequencies of monitoring and assessment based on a patient's condition, cognitive status, situational factors, and risks associated with the specific restraint or seclusion;
 - (2) For the renewal of an order for restraint or seclusion, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
 - (3) Assessment content, which may include, depending on a patient's condition, the patient's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
 - (4) If a mechanical restraint is used, how often the mechanical restraint is monitored or loosened; and
 - (5) A process for meeting a patient's nutritional needs and elimination needs;
 - g. Establish the criteria and procedures for renewing an order for restraint or seclusion;
 - h. Establish procedures for internal review of the use of restraint or seclusion;
 - i. Establish requirements for notifying the parent or guardian of a patient who is under 18 years of age and who is restrained or secluded; and

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- j. Establish medical record and personnel record documentation requirements for restraint and seclusion, if applicable;
- 6. If time-out is used in the organized psychiatric services unit or special hospital, a time-out:
 - a. Takes place in an area that is unlocked, lighted, quiet, and private;
 - b. Does not take place in the room approved for seclusion by the Department under R9-10-104;
 - c. Is time-limited and does not exceed two hours per incident or four hours per day;
 - d. Does not result in a patient's missing a meal if the patient is in time-out at mealtime;
 - e. Includes monitoring of the patient by a medical staff member or personnel member at least once every 15 minutes to ensure the patient's health, safety, and welfare and to determine if the patient is ready to leave time-out; and
 - f. Is documented in the patient's medical record, to include:
 - i. The date of the time-out,
 - ii. The reason for the time-out,
 - iii. The duration of the time-out, and
 - iv. The action planned and taken to address the reason for the time-out;
- 7. Restraint or seclusion is:
 - a. Not used as a means of coercion, discipline, convenience, or retaliation;
 - b. Only used when all of the following conditions are met:
 - i. Except as provided in subsection (A)(8), after obtaining an order for the restraint or seclusion;
 - ii. For the management of a patient's aggressive, violent, or self-destructive behavior;
 - iii. When less restrictive interventions have been determined to be ineffective; and
 - iv. To ensure the immediate physical safety of the patient, to prevent imminent harm to the patient or another individual, or to stop physical harm to another individual; and
 - c. Discontinued at the earliest possible time;
- 8. If as a result of a patient's aggressive, violent, or self-destructive behavior, harm to the patient or another individual is imminent or the patient or another individual is being physically harmed, a personnel member:
 - a. May initiate an emergency application of restraint or seclusion for the patient before obtaining an order for the restraint or seclusion, and
 - b. Obtains an order for the restraint or seclusion of the patient during the emergency application of the restraint or seclusion;
- 9. 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;
- 10. An order for restraint or seclusion includes:
 - a. The name of the individual 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;
- 11. An order for restraint or seclusion is limited to the duration of the emergency situation and does not exceed:
 - a. Four 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 years of age, or
 - c. One continuous hour for a patient who is younger than nine years of age;
- 12. If restraint and seclusion are used on a patient simultaneously, the patient receives continuous:
 - a. Face-to-face monitoring by a medical staff member or personnel member, or
 - b. Video and audio monitoring by a medical staff member or personnel member who is in close proximity to the patient;
- 13. If an order for restraint or seclusion of a patient is not provided by a medical practitioner coordinating the patient's medical services, the medical practitioner is notified as soon as possible;
- 14. A medical staff member 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 until the medical staff member or personnel member completes education and training that:
 - a. Includes:
 - i. Techniques to identify medical staff member, 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 policies and procedures; and
 - vii. Training exercises in which medical staff members and personnel members successfully demonstrate the techniques that the medical staff members and personnel members have learned for managing emergency situations; and
 - b. Is provided by individuals qualified according to policies and procedures;

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15. When a patient is placed in restraint or seclusion:
 - a. The restraint or seclusion is conducted according to 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 policies and procedures;
 - e. A physician or other health professional authorized by 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
 - iv. Whether to continue or terminate the restraint or seclusion;
 - f. The patient is given the opportunity:
 - i. To eat during mealtime, and
 - ii. To use the toilet; and
 - g. The restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order;
16. If a patient is placed in seclusion, the room used for seclusion:
 - a. Is approved for use as a seclusion room by the Department under R9-10-104;
 - 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. Except as provided in subsection (A)(17), contains a non-adjustable bed that:
 - i. Consists of a mattress on a solid platform that is:
 - (1) Constructed of a durable, non-hazardous material; and
 - (2) Raised off of the floor;
 - ii. Does not have wire springs or a storage drawer; and
 - iii. Is securely anchored in place;
17. If a room used for seclusion does not contain a non-adjustable bed required in subsection (A)(16)(f):
 - a. A piece of equipment is available for use in the room used for seclusion that:
 - i. Is commercially manufactured to safely and humanely restrain a patient's body;
 - ii. Provides support to the trunk and head of a patient's body;
 - iii. Provides restraint to the trunk of a patient's body;
 - iv. Is able to restrict movement of a patient's arms, legs, trunk, and head;
 - v. Allows a patient's body to recline; and
 - vi. Does not inflict harm on a patient's body; and
 - b. Documentation of the manufacturer's specifications for the piece of equipment in subsection (A)(17)(a) is maintained;
18. A seclusion room may be used for services or activities other than seclusion if:
 - a. A sign stating the service or activity scheduled or being provided in the room is conspicuously posted outside the room;
 - b. No permanent equipment other than the bed required in subsection (A)(16)(f) is in the room;
 - c. Policies and procedures are established, documented, and implemented that:
 - i. Delineate which services or activities other than seclusion may be provided in the room,
 - ii. List what types of equipment or supplies may be placed in the room for the delineated services, and
 - iii. Provide for the prompt removal of equipment and supplies from the room before the room is used for seclusion; and
 - d. The sign required in subsection (A)(18)(a) and equipment and supplies in the room, other than the bed required in subsection (A)(16)(f), are removed before a patient is placed in seclusion in the room;
19. A medical staff member 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 (A)(12)(a);
 - d. The monitoring required in subsection (A)(12)(b) or (15)(d), as applicable;
 - e. The times the patient was given the opportunity to eat or use the toilet according to subsection (A)(15)(f); and
 - f. The names of the medical staff members and personnel members with direct patient contact while the patient was in the restraint or seclusion; and
20. If an emergency situation continues beyond the time limit of an order for restraint or seclusion, the order is renewed according to policies and procedures.
- B.** For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, in addition to the admission requirements in R9-10-208 and discharge planning requirements in R9-10-209, an administrator shall ensure that:
 1. The patient receives a suicide assessment; and
 2. The patient or the patient's representative receives:
 - a. The results of the suicide assessment in subsection (B)(1);

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- b. Information about the availability of age-appropriate, suicide crisis services, including contact information;
 - c. Specific information about or a referral to one of the following for ongoing or follow-up treatment related to suicide, including scheduling an appointment for the patient when practicable:
 - i. Another health care institution;
 - ii. A medical practitioner or, for a patient going to another state after discharge, a similarly licensed individual in the other state; or
 - iii. A behavioral health professional certified or licensed under A.R.S. Title 32 to provide treatment related to suicide or, for a patient going to another state after discharge, a similarly certified or licensed individual in the other state; and
 - d. Information about and instructions on how to access the Department of Insurance and Financial Institution's website, available through difi.az.gov, developed in compliance with A.R.S. § 20-3503(B), including how to file an appeal of an insurance determination.
- C. An administrator of a hospital that provides opioid treatment services to an outpatient shall comply with the requirements in R9-10-1020.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-225 renumbered to R9-10-227; new Section R9-10-225 renumbered from R9-10-224 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

R9-10-226. Behavioral Health Observation/Stabilization Services

An administrator of a hospital that is authorized to provide behavioral health observation/stabilization services shall ensure that:

- 1. Behavioral health observation/stabilization services are provided according to the requirements in R9-10-1012, and
- 2. Restraint and seclusion are provided according to the requirements for restraint and seclusion in R9-10-225.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-226 renumbered to R9-10-229; new Section R9-10-226 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-227. Rehabilitation Services

An administrator shall ensure that:

- 1. If rehabilitation services are provided as an organized service, the rehabilitation services are provided under the direction of an individual qualified according to policies and procedures;
- 2. Rehabilitation services are provided according to an order; and
- 3. The medical record of a patient receiving rehabilitation services includes:
 - a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis,
 - b. A documented care plan that is developed in coordination with the ordering individual and the individual providing the rehabilitation services,
 - c. The rehabilitation services provided,
 - d. The patient's response to the rehabilitation services, and
 - e. The authentication of the individual providing the rehabilitation services.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-227 renumbered to R9-10-231; new Section R9-10-227 renumbered from R9-10-225 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-228. Multi-organized Service Unit

- A. A governing authority may designate the following as a multi-organized service unit:
 - 1. An adult unit that provides both intensive care services and medical and nursing services other than intensive care services,
 - 2. A pediatric unit that provides both intensive care services and medical and nursing services other than intensive care services,
 - 3. A unit that provides both perinatal services and intensive care services for obstetrical patients,
 - 4. A unit that provides both intensive care services for neonates and a continuing care nursery, or
 - 5. A unit that provides medical and nursing services to adult and pediatric patients.
- B. An administrator shall ensure that:
 - 1. For a patient in a multi-organized service unit, a medical staff member designates in the patient's medical record which organized service is to be provided to the patient;
 - 2. A multi-organized service unit is in compliance with the requirements in this Article that would apply if each organized service were offered as a single organized service unit; and
 - 3. A multi-organized service unit and each bed in the unit are in compliance with physical plant health and safety codes and standards incorporated by reference in R9-10-104.01 for all organized services provided in the multi-organized service unit.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 536, effective March 5, 2005 (Supp. 05-1). Section R9-10-228 renumbered to R9-10-213; new Section R9-10-228 renumbered from R9-10-234 and amended by exempt rulemaking at

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19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).
Amended by final expedited rulemaking, at 25 A.A.R.
3481 with an immediate effective date of November 5,
2019 (Supp. 19-4).

R9-10-229. Social Services

An administrator of a hospital that provides social services shall ensure that:

1. A registered nurse or another personnel member designated according to policies and procedures coordinates social services;
2. If a personnel member provides social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, the personnel member is licensed under A.R.S. Title 32, Chapter 33, Article 5;
3. A medical staff member, nurse, patient, patient's representative, or member of the patient's family may request social services;
4. A personnel member providing social services participates in discharge planning as necessary to meet the needs of a patient;
5. The patient has privacy when communicating with a personnel member providing social services; and
6. Social services provided to a patient are documented in the patient's medical record and the entries are authenticated by the individual providing the social services.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-229 renumbered to R9-10-230; new Section R9-10-229 renumbered from R9-10-226 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-230. Infection Control

An administrator shall ensure that:

1. An infection control program that meets the requirements of this Section is established under the direction of an individual qualified according to policies and procedures;
2. An infection control program has a procedure for documenting:
 - a. The collection and analysis of infection control data;
 - b. The actions taken relating to infections and communicable diseases; and
 - c. Reports of communicable diseases to the governing authority and state and county health departments;
3. Infection control documents are maintained for at least 12 months after the date of the document;
4. Policies and procedures are established, documented, and implemented:
 - a. To prevent or minimize, identify, report, and investigate infections and communicable diseases that include:
 - i. Isolating a patient;
 - ii. Sterilizing equipment and supplies;
 - iii. Maintaining and storing sterile equipment and supplies;
 - iv. Using personal protective equipment such as gowns, masks, or face protection;
 - v. Disposing of biohazardous medical waste; and
 - vi. Moving and processing soiled linens and clothing;

- b. That specify communicable diseases, medical conditions, or criteria that prevent an individual, a personnel member, or a medical staff member from:
 - i. Working in the hospital;
 - ii. Providing patient care, or
 - iii. Providing environmental services;
 - c. That establish criteria for determining whether a medical staff member is at an increased risk of exposure to infectious tuberculosis based on:
 - i. The level of risk in the area of the hospital premises where the medical staff member practices; and
 - ii. The work that the medical staff member performs; and
 - d. That establish the frequency of tuberculosis screening for an individual determined to be at an increased risk of exposure;
5. Tuberculosis screening is performed for a personnel member or medical staff member:
 - a. On or before the date the personnel member or medical staff member begins providing services at or on behalf of the hospital; and
 - b. As part of a tuberculosis infection control program according to R9-10-113;
6. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
7. A personnel member washes hands or uses a hand disinfection product after each patient contact and after handling soiled linen, soiled clothing, or potentially infectious material;
8. An infection control committee is established according to policies and procedures and consists of:
 - a. At least one medical staff member;
 - b. The individual directing the infection control program; and
 - c. Other personnel identified in policies and procedures; and
9. The infection control committee:
 - a. Develops a plan for preventing, tracking, and controlling infections;
 - b. Reviews the type and frequency of infections and develops recommendations for improvement;
 - c. Meets and provides a quarterly written report for inclusion by the quality management program; and
 - d. Maintains a record of actions taken and minutes of meetings.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-230 renumbered to R9-10-233; new Section R9-10-230 renumbered from R9-10-229 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

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R9-10-231. Dietary Services

An administrator shall ensure that:

1. Dietary services are provided according to 9 A.A.C. 8, Article 1;
2. A copy of the hospital's food establishment license or permit under 9 A.A.C. 8, Article 1, is maintained;
3. For a hospital that contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the hospital, a copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1, is maintained;
4. If a hospital contracts with a food establishment to prepare and deliver food to the hospital, the hospital is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;
5. Dietary services are provided under the direction of an individual qualified to direct the provision of dietary services according to policies and procedures;
6. There are personnel members on duty to meet the dietary needs of patients;
7. Personnel members providing dietary services are qualified to provide dietary services according to policies and procedures;
8. A nutrition assessment of a patient is:
 - a. Performed according to policies and procedures, and
 - b. Communicated to the medical practitioner coordinating the patient's medical services if the nutrition assessment reveals a specific dietary need;
9. A medical staff member documents an order for a diet for each patient in the patient's medical record;
10. A current diet manual approved by a registered dietitian is available to personnel members and medical staff members; and
11. A patient's dietary needs are met 24 hours a day.

Historical Note

Former Section R9-10-231 renumbered as R9-10-320 as an emergency effective February 22, 1979, new Section R9-10-231 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-231 renumbered to R9-10-232; new Section R9-10-231 renumbered from R9-10-227 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-232. Disaster Management

An administrator shall ensure that:

1. A disaster plan is developed and documented that includes:
 - a. Procedures for protecting the health and safety of patients and other individuals;
 - b. Assigned personnel responsibilities; and
 - c. Instructions for the evacuation, transport, or transfer of patients, maintenance of medical records, and arrangements to provide any other hospital services to meet the patients' needs;
2. A plan exists for back-up power and water supply;
3. A fire drill is performed on each shift at least once every three months;
4. A disaster drill is performed on each shift at least once every 12 months;

5. Documentation of a fire drill required in subsection (3) and a disaster drill required in subsection (4) includes:
 - a. The date and time of the drill;
 - b. A critique of the drill; and
 - c. Recommendations for improvement, if applicable; and
6. Documentation of a fire drill or a disaster drill is maintained by the hospital for at least 12 months after the date of the drill.

Historical Note

Former Section R9-10-232 renumbered as R9-10-321 as an emergency effective February 22, 1979, new Section R9-10-232 adopted effective February 23, 1979 (Supp. 79-1). Section amended by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section R9-10-232 renumbered to R9-10-234; new Section R9-10-232 renumbered from R9-10-231 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-233. Environmental Standards

An administrator shall ensure that:

1. An individual providing environmental services who has the potential to transmit infectious tuberculosis to patients, as determined by the infection control risk assessment criteria in R9-10-230(4)(c), provides evidence of freedom from infectious tuberculosis:
 - a. On or before the date the individual begins providing environmental services at or on behalf of the hospital, and
 - b. According to R9-10-113;
2. The hospital premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control infection or illness; and
 - b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. The hospital maintains a tobacco smoke-free environment;
5. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14, and policies and procedures;
6. Equipment used to provide hospital services 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations; and
7. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair.

Historical Note

Former Section R9-10-233 renumbered as R9-10-322 as an emergency effective February 22, 1979, new Section R9-10-233 adopted effective February 23, 1979 (Supp. 79-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). Section expired under A.R.S. § 41-1056(E)

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at 14 A.A.R. 2374, effective February 29, 2008 (Supp. 08-2). New Section R9-10-233 renumbered from R9-10-230 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-10-234. Physical Plant Standards

- A.** An administrator shall ensure that:
1. A hospital complies with the applicable physical plant health and safety codes and standards incorporated by reference in R9-10-104.01 in effect on the date the hospital submitted the application packet including the notarized attestation of architectural plans according to R9-10-104;
 2. A hospital's premises or any part of the hospital premises is not leased to or used by another person;
 3. A unit with inpatient beds is not used as a passageway to another health care institution; and
 4. A hospital's premises are not licensed as more than one health care institution.
- B.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the inspection report, and
 3. Maintain documentation of a current fire inspection report.

Historical Note

New Section made by final rulemaking 14 A.A.R. 4646, effective December 2, 2008 (Supp. 08-4). Section R9-10-234 renumbered to R9-10-228; new Section R9-10-234 renumbered from R9-10-232 and amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Duplicate language in subsection (A)(1) corrected (Supp. 22-2).

R9-10-235. Administrative Separation

- A.** In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-201, the following definition applies in this Section: "Administrative separation" means the temporary isolation of a patient for the purpose of preserving the integrity of evidence during the course of a criminal investigation or for a situation where not isolating the patient presents a risk of serious harm to other individuals or a serious risk to the safety or security of a hospital.
- B.** Only a hospital established according to A.R.S. § 36-202 may use administrative separation.
- C.** An administrator appointed according to A.R.S. § 36-205 shall ensure that:
1. Administrative separation:
 - a. Is only used for a patient admitted to the hospital pursuant to a criminal court order; and
 - b. Is not used:
 - i. In conjunction with a restraint,
 - ii. As a method to manage behaviors, or
 - iii. If prohibited by law; and

2. Policies and procedures are established, documented, and implemented for administrative separation that:
 - a. Include the process and criteria for requesting an administrative separation;
 - b. Include the process and deadlines for approving a request for an administrative separation;
 - c. Cover patient notification of the right to appeal the administrative separation and to file a complaint;
 - d. Include the process for providing a patient access to:
 - i. Incoming mail, and
 - ii. An advocate or legal representative;
 - e. Include the process for providing treatment to a patient while in administrative separation;
 - f. Include the process for establishing investigative goals; and
 - g. Include the process for determining when administrative separation will no longer be used for a patient.

Historical Note

New Section R9-10-235 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES

Article 3, consisting of Sections R9-10-311 through R9-10-333, repealed at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-301. Definitions

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

"Child and adolescent residential treatment services" means behavioral health services and physical health services provided in or by a behavioral health inpatient facility to a patient who is:

- Under 18 years of age, or
- Under 21 years of age and meets the criteria in R9-10-318(B).

Historical Note

New Section R9-10-301 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-302. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a behavioral health inpatient facility shall include in a Department-provided format whether the applicant is requesting authorization to provide:

1. Inpatient services to individuals 18 years of age and older, including the licensed capacity requested;
2. Pre-petition screening;
3. Court-ordered evaluation;
4. Court-ordered treatment;
5. Behavioral health observation/stabilization services, including the licensed occupancy requested for providing behavioral health observation/stabilization services to individuals:
 - a. Under 18 years of age, and
 - b. 18 years of age and older;

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6. Child and adolescent residential treatment services, including the licensed capacity requested;
7. Detoxification services;
8. Seclusion;
9. Clinical laboratory services;
10. Radiology services; or
11. Diagnostic imaging services.

Historical Note

New Section R9-10-302 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-303. Administration**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of a behavioral health in-patient facility;
2. Establish, in writing:
 - a. A behavioral health inpatient facility's scope of services, and
 - b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-304;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
 - a. Expected not to be present on the behavioral health inpatient facility's premises for more than 30 calendar days, or
 - b. Not present on the behavioral health inpatient facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

B. An administrator:

1. Is directly accountable to the governing authority of a behavioral health inpatient facility for the daily operation of the behavioral health inpatient facility and for all services provided by or at the behavioral health inpatient facility;
2. Has the authority and responsibility to manage the behavioral health inpatient facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the behavioral health inpatient facility's premises and accountable for the behavioral health inpatient facility when the administrator is not present on the behavioral health inpatient facility's premises.

C. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;

- b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a patient;
 - d. Include methods to prevent abuse or neglect of a patient, including:
 - i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
 - ii. Reporting of abuse or neglect of a patient;
 - e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - f. Cover cardiopulmonary resuscitation training including:
 - i. The method and content of cardiopulmonary resuscitation training,
 - 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 that the individual has received cardiopulmonary resuscitation training;
 - g. Cover first aid training;
 - h. Cover the requirements in subsection (J), if applicable;
 - i. Include a method to identify a patient to ensure the patient receives physical health and behavioral health services as ordered;
 - j. 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;
 - k. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The behavioral health inpatient facility to respond to a patient's complaint;
 - l. Cover health care directives;
 - m. Cover medical records, including electronic medical records;
 - n. Cover quality management, including incident reports and supporting documentation;
 - o. Cover contracted services; and
 - p. Cover when an individual may visit a patient in the behavioral health inpatient facility;
2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient screening, admission, assessment, treatment plan, transport, and transfer;
 - b. Cover discharge planning and discharge, including the requirements in R9-10-309(B) for a patient who was admitted after a suicide attempt or who exhibits suicidal ideation;
 - c. Cover the provision of behavioral health services and physical health services;
 - d. Include when general consent and informed consent are required;
 - e. Cover restraint and, if applicable, seclusion;
 - f. Cover dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;

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- g. Cover prescribing a controlled substance to minimize substance abuse by a patient;
- h. Cover infection control;
- i. Cover telehealth, if applicable;
- j. Cover environmental services that affect patient care;
- k. Cover patient outings;
- l. Cover whether pets and 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. If the behavioral health inpatient facility is involved in research, cover the establishment or use of a Human Subject Review Committee;
- n. Cover the process for receiving a fee from a patient and refunding a fee to a patient;
- 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; and
- q. Cover smoking and the use of tobacco products on the premises;
- 3. Policies and procedures are reviewed at least once every three years and updated as needed;
- 4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
- 5. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health inpatient facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health inpatient facility.
- D.** An administrator shall designate a:
 - 1. Medical director who:
 - a. Provides direction for physical health services provided by or at the behavioral health inpatient facility;
 - b. Is a physician or registered nurse practitioner; and
 - c. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(2)(b) and (D)(1)(a) and (b);
 - 2. Clinical director who:
 - a. Provides direction for the behavioral health services provided by or at the behavioral health inpatient 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)(2)(b) and (D)(2)(a) and (b); and
 - 3. Registered nurse to provide direction for nursing services provided by or at the behavioral health inpatient facility.
- E.** An administrator shall provide written notification to the Department of a patient's:
 - 1. Death, if the patient's death is required to be reported according to A.R.S. § 11-593, within one working day after the patient's death; and
 - 2. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- F.** Except as specified in R9-10-318(A)(1), if abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from a behavioral health inpatient facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 46-454.
- G.** If an administrator has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from a behavioral health inpatient facility's employee or personnel member, the administrator shall:
 - 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 46-454;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (G)(1); and
 - c. The report in subsection (G)(2);
 - 4. Maintain the documentation in subsection (G)(3) for at least 12 months after the date of the report in subsection (G)(2);
 - 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (G)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 - 6. Maintain a copy of the documented information required in subsection (G)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- H.** An administrator shall establish and document the criteria for determining when a patient's absence is unauthorized, including the criteria for a patient who:
 - 1. Was admitted under A.R.S. Title 36, Chapter 5, Articles 1, 2, or 3;
 - 2. Is absent against medical advice; or
 - 3. Is under the age of 18.
- I.** An administrator shall:
 - 1. For a patient who is under a court's jurisdiction, within an hour after determining that the patient's absence is unauthorized according to the criteria in subsection (H), notify the appropriate court or a person designated by the appropriate court;
 - 2. Document the notification in subsection (I)(1) and the written log required in subsection (I)(3);

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3. Maintain a written log of unauthorized absences for at least 12 months after the date of a patient's absence that includes the:
 - a. Name of a patient absent without authorization;
 - b. If applicable, name of the person notified as required in subsection (I)(1); and
 - c. Date of the notification; and
4. Evaluate and take action related to unauthorized absences under the quality management program in R9-10-304.
- J.** If a behavioral health inpatient facility has a physician or registered nurse practitioner on-call to comply with R9-10-306(J)(1), an administrator shall ensure that:
 1. The on-call schedule is documented;
 2. Personnel members are aware of:
 - a. The location at which the on-call schedule is available to personnel members of the behavioral health inpatient facility,
 - b. The process through which the on-call physician or registered nurse practitioner is contacted,
 - c. The circumstances that would require the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility, and
 - d. The process through which a request is made for the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility;
 3. A request for the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility is documented, including:
 - a. The time that a request for the on-call physician or registered nurse practitioner to come to the behavioral health inpatient facility is made,
 - b. The name of the individual making the request,
 - c. The reason for the request,
 - d. The name of the physician or registered nurse practitioner contacted and requested to come to the behavioral health inpatient facility, and
 - e. The time the on-call physician or registered nurse practitioner arrives at the behavioral health inpatient facility in response to a request;
 4. The documentation in subsections (J)(1) and (3) is maintained for at least 12 months after the last date on the documentation; and
 5. Documentation related to the request is included in the medical record of the applicable patient.
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 for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section R9-10-304 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-305. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section R9-10-305 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-306. Personnel

A. An administrator shall ensure that:

1. A personnel member, an employee, or a student is at least 18 years old; and
2. A volunteer is at least 21 years old.

B. An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health

Historical Note

New Section R9-10-303 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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;

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- services listed in the established job description,
- ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
- C.** An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.
- D.** An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as 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 A.A.C. R4-6-101.
- E.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have direct interaction with a participant for more than eight hours in a week, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the behavioral health inpatient facility, and
 2. As specified in R9-10-113.
- F.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the employee's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. The individual's qualifications and on-going training for each type of restraint or seclusion used, as required in R9-10-316;
 - f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - g. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-303(C)(1)(e);
 - h. First aid training, if required for the individual according to this Article or policies and procedures; and
 - i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (D).
- G.** An administrator shall ensure that personnel records are:
1. Maintained:
 - a. Throughout an individual's period of providing services in or for the behavioral health inpatient facility, and
 - b. For at least 24 months after the last date the individual provided services in or for the behavioral health inpatient facility; and
 2. For a personnel member who has not provided physical health services or behavioral health services at or for the behavioral health inpatient facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- H.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
 2. A personnel member completes orientation before providing behavioral health services or physical health services;
 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 4. A clinical director develops, documents, and implements a plan to provide in-service education specific to the duties of a personnel member; and
 5. A personnel member's in-service education 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.
- I.** An administrator shall ensure that a behavioral health inpatient 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 work each calendar day and the hours worked by each employee; and
 3. Is maintained for at least 12 months after the last date on the daily staffing schedule.
- J.** An administrator shall ensure that:
1. A physician or registered nurse practitioner is present on the behavioral health inpatient facility's premises or on-call,
 2. A registered nurse is present on the behavioral health inpatient facility's premises, and
 3. A registered nurse who provides direction for the nursing services provided at the behavioral health inpatient facility is present at the behavioral health inpatient facility at least 40 hours every week.

Historical Note

New Section R9-10-306 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R.

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1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R9-10-307. Admission; Assessment

A. Except as provided in R9-10-315(E) or (F), an administrator shall ensure that:

1. A patient is admitted based upon the patient's presenting behavioral health issue and treatment needs and the behavioral health inpatient 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 or clinical director;
3. A medical practitioner or clinical director, authorized by policies and procedures to accept a patient for admission, is available;
4. Except in an emergency or as provided in subsections (A)(6) and (7), general consent is obtained from a patient or, if applicable, 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 calendar days before admission or within 24 hours after admission and documents the medical history and physical examination in the patient's medical record within 24 hours after admission;
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 within seven calendar days after admission;
10. Except when a patient needs crisis services, a behavioral health assessment of a patient is completed to determine the acuity of the patient's behavioral health issue and to identify the behavioral health services needed by the patient before treatment for the patient is initiated and whenever the patient has a significant change in condition or experiences an event that affects treatment;
11. If the patient was admitted after a suicide attempt or exhibits suicidal ideation, the behavioral health assessment in subsection (A)(10) includes a suicide assessment;
12. If a behavioral health assessment in subsection (A)(10), including a suicide assessment in subsection (A)(11) if applicable, is conducted by a:
 - a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed under A.R.S. Title 32 to provide the behavioral health services needed by the patient, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by and the acuity of the patient; or
 - b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed under A.R.S. Title 32 to provide the behavioral health services needed by the patient, supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by and the acuity of the patient;
13. When a patient is admitted, a registered nurse:
 - a. Conducts a nursing assessment of a patient's medical condition and history;
 - b. Determines whether the:
 - i. Patient requires immediate physical health services, and
 - ii. Patient's behavioral health issue may be related to the patient's medical condition and history;
 - c. Determines the acuity of the patient's medical condition;
 - d. Documents the patient's nursing assessment and the determinations required in subsection (A)(13)(b) and (c) in the patient's medical record; and
 - e. Signs the patient's medical record;
14. A behavioral health assessment:
 - a. Documents the patient's:
 - i. Presenting issue, including the acuity of the patient's presenting issue;
 - ii. Substance abuse history;
 - iii. Co-morbidity;
 - iv. Legal history, including:
 - (1) Custody,
 - (2) Guardianship, and
 - (3) Pending litigation;
 - v. Court-ordered evaluation;
 - vi. Court-ordered treatment;
 - vii. Criminal justice record;
 - viii. Family history;
 - ix. Behavioral health treatment history;
 - x. Symptoms reported by the patient; and
 - xi. Referrals needed by the patient, if any; and
 - b. Includes:
 - i. Recommendations for further assessment or examination of the patient's needs;
 - ii. Recommendations for staffing levels or personnel member qualifications related to the patient's treatment to ensure patient health and safety;
 - iii. For a patient who:
 - (1) Is admitted to receive crisis services, the behavioral health services and physical health services that will be provided to the patient; or
 - (2) Does not need crisis services, the behavioral health services or physical health 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 behavioral health assessment;
15. 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;

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16. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
 17. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;
 18. The request in subsection (A)(16) and the opportunity in subsection (A)(17) are documented in the patient's medical record;
 19. For a patient who is admitted to receive crisis services, the patient's behavioral health assessment is documented in the patient's medical record within eight hours after admission;
 20. Except as provided in subsection (A)(19), a patient's behavioral health assessment is documented in the patient's medical record within 24 hours after completing the assessment; and
 21. If the information listed in subsection (A)(14) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained.
- B.** If the results of a suicide assessment required in subsection (A)(11) indicate that the patient could be a danger to self upon discharge, an administrator shall ensure that the information in R9-10-309(B)(2) is made available to the patient or the patient's representative as part of the opportunity for participation in the patient's behavioral health assessment required in subsection (A)(17).

Historical Note

New Section R9-10-307 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-308. Treatment Plan

- A.** Except for a patient admitted to receive crisis services or as provided in R9-10-315(E) or (F), an administrator shall ensure that a treatment plan is developed and implemented for a patient that:
1. Is based on the behavioral health assessment and ongoing changes to the behavioral health assessment of the patient;
 2. Is completed:
 - a. By a behavioral health professional or by a behavioral health technician under the clinical oversight of a behavioral health professional, and
 - b. Before the patient receives treatment;
 3. Is documented in the patient's medical record within 24 hours after the patient first receives treatment;
 4. Includes:
 - a. The patient's presenting issue, including the acuity of the patient's presenting issue;
 - b. The behavioral health services and physical health services to be provided to the patient;
 - c. If the patient was admitted after a suicide attempt or who exhibits suicidal ideation:

- i. The results of the suicide assessment required in R9-10-307(11), and
 - ii. Information specific to helping prevent a recurrence;
- d. The signature of the patient or the patient's representative and date signed, or documentation of the refusal to sign;
 - e. The date when the patient's treatment plan will be reviewed;
 - f. If a discharge date has been determined, the treatment needed after discharge; and
 - g. 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, is reviewed and signed by a behavioral health professional within 24 hours after the completion of the treatment plan to ensure that the treatment plan identifies the acuity of the patient 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 behavioral health 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. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the patient's medical record.
- C.** If a patient who is admitted to receive crisis services remains admitted as a patient after the patient no longer needs crisis services, an administrator shall ensure that a treatment plan for the patient is:
1. Except for subsection (A)(3), completed according to the requirements in subsection (A); and
 2. Documented in the patient's medical record within 24 hours after the patient no longer needs crisis services.

Historical Note

New Section R9-10-308 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

R9-10-309. Discharge

- A.** Except as provided in R9-10-315(E) or (F), 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. If the discharge date has been determined, includes the discharge date;

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- c. Is completed before discharge occurs; and
 - d. Includes a description of the level of care that may meet the patient's assessed and anticipated needs after discharge;
- 2. Documented in the patient's medical record within 48 hours after the discharge plan is completed; and
- 3. Provided to the patient or the patient's representative before the discharge occurs.
- B.** For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, in addition to the discharge planning requirements in subsection (A), an administrator shall ensure that:
 - 1. The patient receives a suicide assessment; and
 - 2. The patient or the patient's representative receives:
 - a. The results of the suicide assessment;
 - b. Information about the availability of age-appropriate, suicide crisis services, including contact information; and
 - c. Information about and instructions on how to access the Department of Insurance and Financial Institution's website, available through difi.az.gov, developed in compliance with A.R.S. § 20-3503(B), including how to file an appeal of an insurance determination.
- C.** 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. The request in subsection (C)(1) and the opportunity in subsection (C)(2) are documented in the patient's medical record.
- D.** An administrator shall ensure that a patient is discharged from a behavioral health inpatient facility when the patient's treatment needs are not consistent with the services that the behavioral health inpatient facility is authorized and able to provide.
- E.** An administrator shall ensure that there is a documented discharge order by a medical practitioner or behavioral health professional before a patient is discharged unless the patient leaves the behavioral health inpatient facility against a medical practitioner's or behavioral health professional's advice.
- F.** An administrator shall ensure that, at the time of discharge, a patient receives:
 - 1. A referral for treatment or ancillary services that the patient may need after discharge, if applicable; and
 - 2. For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, specific information about or a referral to one of the following for ongoing or follow-up treatment related to suicide, including scheduling an appointment for the patient when practicable:
 - a. Another health care institution;
 - b. A medical practitioner or, for a patient going to another state after discharge, a similarly licensed individual in the other state; or
 - c. A behavioral health professional certified or licensed under A.R.S. Title 32 to provide treatment related to suicide or, for a patient going to another state after discharge, a similarly certified or licensed individual in the other state.
- G.** If a patient is discharged to any location other than a health care institution, an administrator shall ensure that:
 - 1. Discharge instructions are documented, and
 - 2. The patient or the patient's representative is provided with a copy of the discharge instructions.
- H.** An administrator shall ensure that a discharge summary:
 - 1. Is entered into the patient's medical record within 10 working days after a patient's discharge; and
 - 2. Includes:
 - a. The following information authenticated by a medical practitioner or behavioral health professional:
 - i. The patient's presenting issue and other physical health and behavioral health issues identified in the patient's nursing assessment, behavioral health assessment, or 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 ordered for the patient by a medical practitioner at the behavioral health inpatient facility at the time of the patient's discharge;
 - b. For a patient who was admitted after a suicide attempt or who exhibits suicidal ideation, the following information:
 - i. A description of the specific information about ongoing or follow-up treatment related to suicide provided to the patient or the patient's representative;
 - ii. Whether a referral was made for the patient according to subsection (F)(2) for ongoing or follow-up treatment related to suicide and, if so, information about the referral; and
 - iii. Whether an appointment was scheduled for the patient according to subsection (F)(2) for ongoing or follow-up treatment related to suicide and, if so, the date and time of the appointment; and
 - c. A description of the disposition of the patient's possessions, funds, or medications brought to the behavioral health inpatient facility by the patient.
- I.** 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 behavioral health inpatient facility if a medical practitioner for the behavioral health inpatient facility will not be prescribing the medication for the patient at or after discharge.

Historical Note

New Section R9-10-309 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

R9-10-310. Transport; Transfer

- A.** Except as provided in subsection (B), an administrator shall ensure that:
 - 1. A personnel member coordinates the transport and the services provided to the patient;
 - 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before and after the transport,

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- b. Information from the patient's medical record is provided to a receiving health care institution,
 - c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative, and
 - d. A personnel member communicates or documents why the personnel member did not communicate with an individual at a receiving health care institution; and
 - 3. The patient's medical record includes documentation of:
 - a. Communication or lack of communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transport.
 - B.** Subsection (A) does not apply to:
 - 1. Transportation to a location other than a licensed health care institution,
 - 2. Transportation provided for a patient by the patient or the patient's representative,
 - 3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative, or
 - 4. A transport to another licensed health care institution in an emergency.
 - C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
 - 1. A personnel member coordinates the transfer and the services provided to the patient;
 - 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
 - 3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.
- Historical Note**
- Adopted as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 4, 1979 (Supp. 79-3). Amended effective January 28, 1980 (Supp. 80-1). Repealed effective February 4, 1981 (Supp. 81-1). New Section R9-10-310 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).
- R9-10-311. Patient Rights**
- A.** An administrator shall ensure that:
 - 1. The requirements in subsection (B) and the patient rights in subsection (D) are conspicuously posted on the premises;
 - 2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (D); and
 - 3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (D), and
 - b. Where patient rights are posted as required in subsection (A)(1).
 - B.** An administrator shall ensure that:
 - 1. A patient is treated with dignity, respect, and consideration;
 - 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Except as allowed under R9-10-316, restraint or seclusion;
 - i. Retaliation for submitting a complaint to the Department or another entity;
 - j. Misappropriation of personal and private property by the behavioral health inpatient facility's personnel members, employees, volunteers, or students;
 - k. 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; or
 - l. Treatment that involves the denial of:
 - i. Food,
 - ii. The opportunity to sleep, or
 - iii. The opportunity to use the toilet;
 - 3. Except as provided in subsection (C), a patient is allowed to:
 - a. Associate with individuals of the patient's choice, receive visitors, and make telephone calls during the hours established by the behavioral health inpatient facility;
 - b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
 - c. Unless restricted by a court order, send and receive uncensored and unopened mail; and
 - 4. Except as provided in R9-10-318, a patient or, if applicable, the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated, 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;
 - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication and the associated risks and possible complications of the proposed psychotropic medication;
 - d. Is informed of the following:
 - i. The policy on health care directives, and
 - ii. The patient complaint process; and

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- e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.
- C. If a medical director or clinical director determines that a patient's treatment requires the behavioral health inpatient facility to restrict the patient's ability to participate in an activity in subsection (B)(3), 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 complaint and the procedure for filing a complaint.
- 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, or diagnosis;
 - 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 or the patient's representative'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. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
 - a. A patient may be photographed when admitted to a behavioral health inpatient facility for identification and administrative purposes;
 - b. For a patient receiving treatment according to A.R.S. Title 36, Chapter 37; or
 - c. For video recordings used for security purposes that are maintained only on a temporary basis;
 - 4. 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 not able to exercise a specific right or category of rights;
 - 5. To review, upon written request, the patient's own medical record according to A.R.S. §§12-2293, 12-2294, and 12-2294.01;
 - 6. To receive a referral to another health care institution if the behavioral health inpatient facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
 - 7. To participate or have the patient's representative participate in the development of a treatment plan or decisions concerning treatment;
 - 8. To participate or refuse to participate in research or experimental treatment; and
 - 9. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

Section R9-10-311, formerly numbered as R9-10-211, renumbered as an emergency effective February 22,

1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-311 repealed, new Section R9-10-311 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-311 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-312. Medical Records

- A. An administrator shall ensure that:
 - 1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
 - 2. An entry in a patient's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 - 3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative, or
 - c. As permitted by law; and
 - 6. A patient's medical record is protected from loss, damage, or unauthorized use.
- B. If a behavioral health inpatient facility maintains patients' medical records electronically, an administrator shall ensure that:
 - 1. Safeguards exist to prevent unauthorized access, and
 - 2. The date and time of an entry in a 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; and
 - d. Any known allergy, including medication allergies;
 - 2. Medication information that includes:
 - a. Documentation of medication ordered for the patient; and
 - b. Documentation of medication administered to the patient that includes:
 - i. The date and time of administration;

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- ii. The name, strength, dosage, amount, and route of administration;
 - iii. For a medication administered for pain on a PRN basis:
 - (1) An assessment of the patient's pain before administering the medication, and
 - (2) The effect of the medication administered;
 - iv. For a psychotropic medication administered on a PRN basis:
 - (1) An assessment of the patient's behavior before administering the psychotropic medication, and
 - (2) The effect of the psychotropic medication administered;
 - v. The identification and authentication of the individual administering the medication or providing assistance in the self-administration of the medication; and
 - vi. Any adverse reaction the patient has to the medication;
3. If applicable, documented general consent and informed consent by the patient or the patient's representative;
 4. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 5. The patient's medical history and results of a physical examination or an interval note;
 6. If the patient provides a health care directive, the health care directive signed by the patient or the patient's representative;
 7. An admitting diagnosis or presenting symptoms;
 8. The date of admission and, if applicable, the date of discharge;
 9. The name of the admitting medical practitioner or behavioral health professional;
 10. Orders;
 11. The patient's nursing assessment and behavioral health assessment and any interval notes;
 12. Treatment plans;
 13. Documentation of behavioral health services and physical health services provided to the patient;
 14. Progress notes;
 15. If applicable, documentation of restraint or seclusion;
 16. If applicable, documentation that evacuation from the behavioral health inpatient facility would cause harm to the patient;
 17. The disposition of the patient after discharge;
 18. The discharge plan;
 19. The discharge summary; and
 20. If applicable:
 - a. A laboratory report,
 - b. A radiologic report,
 - c. A diagnostic report, and

- d. A consultation report.

Historical Note

Section R9-10-312, formerly numbered as R9-10-212, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-312 repealed, new Section R9-10-312 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-312 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-313. Transportation; Patient Outings

- A.** An administrator of a behavioral health inpatient facility that uses a vehicle owned or leased by the behavioral health inpatient facility to provide transportation to a patient shall ensure that:
 1. The vehicle:
 - 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 in the vehicle, and
 - d. Contains a working heating and air conditioning system;
 2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
 3. A driver of the vehicle:
 - a. Is 21 years of age or older;
 - b. Has a valid driver license;
 - c. Operates the vehicle in a manner that does not endanger a patient in the vehicle;
 - d. Does not leave in the vehicle an unattended:
 - i. Child;
 - ii. Patient who may be a threat to the health, safety, or welfare of the patient or another individual; or
 - iii. Patient who is incapable of independent exit from the vehicle; and
 - e. Ensures the safe and hazard-free loading and unloading of patients; and
 4. Transportation safety is maintained as follows:
 - a. An individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
 - b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a patient's body.
- 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. At least two personnel members are present on an outing;
 2. In addition to the personnel members required in subsection (C)(1), a sufficient number of personnel members are present on an outing to ensure the health and safety of a patient on the outing;

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3. Each personnel member on the outing has documentation of current training in cardiopulmonary resuscitation according to R9-10-303(C)(1)(e) and first aid training;
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 a vehicle used to provide transportation for the outing;
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 a patient participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for 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 a designated individual, to notify in case of an emergency, who is present on the behavioral health inpatient facility's premises.

Historical Note

Section R9-10-313, formerly numbered as R9-10-213, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-313 repealed, new Section R9-10-313 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-313 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-314. Physical Health Services

- A.** An administrator shall ensure that:
1. Medical services are provided under the direction of a physician or registered nurse practitioner;
 2. Nursing services are provided:
 - a. Under the direction of a registered nurse,
 - b. According to an acuity plan developed for the behavioral health inpatient facility, and
 - c. To meet the needs of a patient based on the patient's acuity; and
 3. If a behavioral health inpatient facility is authorized to provide:
 - a. Clinical laboratory services, as defined in R9-10-101, the behavioral health inpatient facility complies with the requirements for clinical laboratory services in R9-10-219; or

- b. Radiology services or diagnostic imaging services, the behavioral health inpatient facility complies with the requirements in R9-10-220.

- B.** An administrator shall ensure that, if a patient requires immediate medical services to ensure the patient's health and safety that the behavioral health inpatient facility is not authorized or not able to provide, a personnel member arranges for the patient to be transported to a hospital, another health care institution, or a health care provider where the medical services can be provided.

Historical Note

Section R9-10-314, formerly numbered as R9-10-214, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-314 repealed, new Section R9-10-314 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-314 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-315. Behavioral Health Services

- A.** An administrator shall ensure that:
1. Behavioral health services listed in the behavioral health inpatient facility's scope of services are provided to meet the needs of a patient;
 2. When behavioral health services are:
 - a. Listed in the behavioral health inpatient facility's scope of services, the behavioral health services are provided on the behavioral health inpatient facility's premises; and
 - b. Provided in a setting or activity with more than one patient participating, before a patient participates, the diagnoses, treatment needs, developmental levels, social skills, verbal skills, and personal histories, including any history of physical abuse or sexual abuse, of the patients participating are reviewed to ensure that the:
 - i. Health and safety of each patient is protected, and
 - ii. Treatment needs of each patient participating in the setting or activity are being met;
 3. An acuity plan is developed, documented, and implemented for each unit in the behavioral health inpatient facility that:
 - a. Includes:
 - i. A method that establishes the types and numbers of personnel members that are required for each unit in the behavioral health inpatient facility to ensure patient health and safety, and
 - ii. A policy and procedure stating the steps the behavioral health inpatient facility will take to obtain or assign the necessary personnel members to address patient acuity;
 - b. Is used when making assignments for patient treatment; and
 - c. Is reviewed and updated, as necessary, at least once every 12 months;

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4. A patient is assigned to a unit in the behavioral health inpatient facility based, as applicable, on the patient's:
 - a. Presenting issue,
 - b. Substance abuse history,
 - c. Behavioral health treatment history,
 - d. Acuity, and
 - e. Treatment needs; and
 5. A patient does not share any space, participate in any activity or treatment, or verbally or physically interact with any other patient that, based on the other patient's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, and personal history, may present a threat to the patient's health and safety.
- B.** An administrator shall ensure that counseling is:
1. Offered as described in the behavioral health inpatient 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 each counseling session is documented in a 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.
- D.** An administrator of a behavioral health inpatient facility authorized to provide 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.
- E.** An administrator of a behavioral health inpatient facility authorized to provide court-ordered evaluation shall ensure that court-ordered evaluation is provided according to the court-evaluation requirements in A.R.S. Title 36, Chapter 5.
- F.** Except as specified in subsection (G), an administrator is not required to comply with the following provisions in this Chapter 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
 4. Discharge requirements in R9-10-309.
- G.** For a patient receiving court-ordered evaluation who attempts suicide or exhibits suicidal ideation, an administrator shall ensure that the following requirements are met:
1. Patient assessment requirements in R9-10-307(10), (11), and (12);
 2. Treatment plan requirements in R9-10-308(A)(4)(c); and
 3. Discharge requirements in R9-10-309(B), (F)(2), and (H)(2)(b).
- H.** An administrator of a behavioral health inpatient facility authorized to provide 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.

Historical Note

Section R9-10-315, formerly numbered as R9-10-215, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-315 repealed, new Section R9-10-315 adopted effective February 4, 1981

(Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-315 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 661, effective May 1, 2021 (Supp. 21-2).

R9-10-316. Seclusion; Restraint

- A.** An administrator shall ensure that restraint is provided according to the requirements in subsection (C).
- B.** An administrator of a behavioral health inpatient facility authorized to provide seclusion shall ensure that:
1. Seclusion is provided according to the requirements in subsection (C);
 2. 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. Except as provided in subsection (B)(3), contains a non-adjustable bed that:
 - i. Consists of a mattress on a solid platform that is:
 - (1) Constructed of a durable, non-hazardous material; and
 - (2) Raised off of the floor;
 - ii. Does not have wire springs or a storage drawer; and
 - iii. Is securely anchored in place;
 3. If a room used for seclusion does not contain a non-adjustable bed required in subsection (B)(2)(f):
 - a. A piece of equipment is available that:
 - i. Is commercially manufactured to safely and humanely restrain a patient's body;
 - ii. Provides support to the trunk and head of a patient's body;
 - iii. Provides restraint to the trunk of a patient's body;
 - iv. Is able to restrict movement of a patient's arms, legs, body, and head;
 - v. Allows a patient's body to recline; and
 - vi. Does not inflict harm on a patient's body; and
 - b. Documentation of the manufacturer's specifications for the piece of equipment in subsection (B)(3)(a) is maintained; and
 4. A seclusion room may be used for services or activities other than seclusion if:
 - a. A sign stating the service or activity scheduled or being provided in the room is conspicuously posted outside the room;
 - b. No permanent equipment other than the bed required in subsection (B)(2)(f) is in the room;
 - c. Policies and procedures:
 - i. Delineate which services or activities other than seclusion may be provided in the room,

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- ii. List what types of equipment or supplies may be placed in the room for the delineated services, and
 - iii. Provide for the prompt removal of equipment and supplies from the room before the room is used for seclusion; and
 - d. The sign required in subsection (B)(4)(a) and equipment and supplies in the room, other than the bed required in subsection (B)(2)(f), are removed before being used for seclusion.
- C. An administrator shall ensure that:
 - 1. Policies and procedures for providing restraint or seclusion are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Establish the process for patient assessment, including identification of a patient's medical conditions and criteria for the on-going monitoring of any identified medical condition;
 - b. Identify each type of restraint or seclusion used and include for each type of restraint or seclusion used:
 - i. The qualifications of a personnel member who can:
 - (1) Order the restraint or seclusion,
 - (2) Place a patient in the restraint or seclusion,
 - (3) Monitor a patient in the restraint or seclusion,
 - (4) Evaluate a patient's physical and psychological well-being after being placed in the restraint or seclusion and when released from the restraint or seclusion, or
 - (5) Renew the order for restraint or seclusion;
 - ii. On-going training requirements for a personnel member who has direct patient contact while the patient is in a restraint or seclusion; and
 - iii. Criteria for monitoring and assessing a patient including:
 - (1) Frequencies of monitoring and assessment based on a patient's medical condition and risks associated with the specific restraint or seclusion;
 - (2) For the renewal of an order for restraint or seclusion, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
 - (3) Assessment content, which may include, depending on a patient's condition, the patient's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
 - (4) If a mechanical restraint is used, how often the mechanical restraint is loosened; and
 - (5) A process for meeting a patient's nutritional needs and elimination needs;
 - c. Establish the criteria and procedures for renewing an order for restraint or seclusion;
 - d. Establish procedures for internal review of the use of restraint or seclusion; and
 - e. Establish medical record and personnel record documentation requirements for restraint and seclusion, if applicable;
 - 2. An order for restraint or seclusion is:
 - a. Obtained from a physician or registered nurse practitioner, and
 - b. Not written as a standing order or on an as-needed basis;
 - 3. Restraint or seclusion is:
 - a. Not used as a means of coercion, discipline, convenience, or retaliation;
 - b. Only used when all of the following conditions are met:
 - i. Except as provided in subsection (C)(4), after obtaining an order for the restraint or seclusion;
 - ii. For the management of a patient's aggressive, violent, or self-destructive behavior;
 - iii. When less restrictive interventions have been determined to be ineffective; and
 - iv. To ensure the immediate physical safety of the patient, to prevent imminent harm to the patient or another individual, or to stop physical harm to another individual; and
 - c. Discontinued at the earliest possible time;
 - 4. If as a result of a patient's aggressive, violent, or self-destructive behavior, harm to the patient or another individual is imminent or the patient or another individual is being physically harmed, a personnel member:
 - a. May initiate an emergency application of restraint or seclusion for the patient before obtaining an order for the restraint or seclusion, and
 - b. Obtains an order for the restraint or seclusion of the patient during the emergency application of the restraint or seclusion;
 - 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 three continuous hours;
 - 7. 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;
 - 8. A medical practitioner or personnel member does not participate in restraint or seclusion, assess or 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

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- 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 policies and procedures; and
- vii. Except for the medical practitioner, training exercises in which the 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 to policies and procedures;
- 9. When a patient is placed in restraint or seclusion:
 - a. The restraint or seclusion is conducted according to 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. The patient is monitored and assessed according to policies and procedures;
 - e. A physician or registered nurse 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
 - iv. Whether to continue or terminate the restraint or seclusion;
 - f. The patient is given the opportunity:
 - i. To eat during mealtime, and
 - ii. To use the toilet; and
 - g. The restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order;
- 10. 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 assessment required in subsection (C)(9)(e);
 - d. The monitoring required in subsection (C)(9)(d);
 - e. The names of the medical practitioners and personnel members with direct patient contact while the patient was in the restraint or seclusion;
 - f. The times the patient was given the opportunity to eat or use the toilet according to subsection (C)(9)(f); and
 - g. The patient evaluation required in subsection (C)(12);
- 11. If an emergency situation continues beyond the time limit of an order for restraint or seclusion, the order is renewed according to 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
- 12. A patient is evaluated after restraint or seclusion is no longer being used for the patient.

Historical Note

Section R9-10-316, formerly numbered as R9-10-216, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-316 repealed, new Section R9-10-316 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-316 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-317. Behavioral Health Observation/Stabilization Services

- A. An administrator of a behavioral health inpatient facility authorized to provide behavioral health observation/stabilization services shall comply with the requirements for behavioral health observation/stabilization services in R9-10-1012.
- B. If a behavioral health inpatient facility is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age, an administrator shall ensure that, in addition to complying with the requirements in R9-10-1012, the behavioral health inpatient facility complies with the requirements for a patient under 18 years of age, personnel records, and physical plant in R9-10-318.

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Historical Note

Section R9-10-317, formerly numbered as R9-10-221, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-317 repealed, new Section R9-10-317 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-317 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-318. Child and Adolescent Residential Treatment Services

A. An administrator of a behavioral health inpatient facility authorized to provide child and adolescent residential treatment services shall:

1. If abuse, neglect, or exploitation of a patient under 18 years of age is alleged or suspected to have occurred before the patient was accepted or while the patient is not on the premises and not receiving services from an employee or personnel member of the behavioral health inpatient facility, report the alleged or suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 13-3620;
2. If the administrator has a reasonable basis, according to A.R.S. § 13-3620, to believe that abuse, neglect, or exploitation of a patient under 18 years of age has occurred on the premises or while the patient is receiving services from an employee or a personnel member:
 - a. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - b. Report the suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 13-3620;
 - c. Document:
 - i. The suspected abuse, neglect, or exploitation;
 - ii. Any action taken according to subsection (A)(2)(a); and
 - iii. The report in subsection (A)(2)(b);
 - d. Maintain the documentation in subsection (A)(2)(c) for at least 12 months after the date of the report in subsection (A)(2)(b);
 - e. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (A)(2)(b):
 - i. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - ii. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - iii. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - iv. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 - f. Maintain a copy of the documented information required in subsection (A)(2)(e) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated;
3. If a patient who is under 18 years of age is absent and the absence is unauthorized as determined according to the criteria in R9-10-303(H), within an hour after determining that the patient's absence is unauthorized, notify:
 - a. Except as provided in subsection (A)(3)(b), the patient's parent or legal guardian; and
 - b. For a patient who is under a court's jurisdiction, the appropriate court or a person designated by the appropriate court;
4. Document the notification in subsection (A)(3) in the patient's medical record and the written log required in R9-10-303(I)(3);
5. In addition to the personnel records requirements in R9-10-306(F), ensure that a personnel record for each employee, volunteer, and student contains documentation of the individual's compliance with the finger-printing requirements in A.R.S. § 36-425.03;
6. Ensure that the patient's representative for a patient who is under 18 years of age:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent to treatment before treatment is initiated, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01; is necessary to save the patient's life or physical health; or is provided according to A.R.S. § 36-512;
 - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication and the associated risks and possible complications of the proposed psychotropic medication;
 - d. Is informed of the following:
 - i. The policy on health care directives, and
 - ii. The patient complaint process; and
 - e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records;
7. In addition to the restrictions provided in R9-10-311(C), ensure that a parent of a patient under 18 years of age is allowed to restrict the patient from:
 - a. Associating with individuals of the patient's choice, receiving visitors, and making telephone calls during the hours established by the behavioral health inpatient facility;
 - b. Having privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
 - c. Sending and receiving uncensored and unopened mail;
8. Establish, document, and implement policies and procedures to ensure that a patient is protected from the following from other patients at the behavioral health inpatient facility:
 - a. Threats,
 - b. Ridicule,
 - c. Verbal harassment,
 - d. Punishment, or
 - e. Abuse;
9. Ensure that:
 - a. The interior of the behavioral health inpatient facility has furnishings and decorations appropriate to

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- the ages of the patients receiving services at the behavioral health inpatient facility;
- b. A patient older than three years of age does not sleep in a crib;
- c. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to patients in a quantity sufficient to meet each patient's needs and are appropriate to each patient's age, developmental level, and treatment needs; and
- d. A patient's educational needs are addressed according to A.R.S. Title 15, Chapter 7, Article 4;
- 10. In addition to the requirements for seclusion or restraint in R9-10-316, ensure that:
 - a. An order for restraint or seclusion is limited to the duration of the emergency situation and does not exceed:
 - i. Two continuous hours for a patient who is between the ages of nine and 17, or
 - ii. One continuous hour for a patient who is younger than nine; and
 - b. Requirements are established for notifying the parent or guardian of a patient who is under 18 years of age and who is restrained or secluded; and
- 11. Prohibit a patient under 18 years of age from possessing or using tobacco products on the premises.
- B.** An administrator of a behavioral health inpatient facility authorized to provide child and adolescent residential treatment services may continue to provide behavioral health services to a patient who is 18 years of age or older:
 - 1. If the patient:
 - a. Was admitted to the behavioral health inpatient facility before the patient's 18th birthday,
 - b. Is not 21 years of age or older, and
 - c. Is completing high school or a high school equivalency diploma or participating in a job training program; or
 - 2. Through the last calendar day of the month of the patient's 18th birthday.

Historical Note

Section R9-10-318, formerly numbered as R9-10-222, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-318 repealed, new Section R9-10-318 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-318 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-318 renumbered to R9-10-319; new Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-319. Detoxification Services

An administrator of a behavioral health inpatient facility authorized to provide detoxification services shall ensure that:

- 1. Detoxification services are available;
- 2. Policies and procedures state:

- a. Whether the behavioral health inpatient facility is authorized to provide involuntary, court-ordered alcohol treatment;
- b. Whether the behavioral health inpatient facility includes a local alcoholism reception center, as defined in A.R.S. § 36-2021;
- c. The types of substances for which the behavioral health inpatient facility provides detoxification services;
- d. The detoxification process or processes used by the behavioral health inpatient facility; and
- e. When an adjustable bed can be used by a patient and what actions are necessary, including supervision, to protect the patient's health and safety when the patient is in an adjustable bed; and
- 3. A physician or registered nurse practitioner with skills and knowledge in providing detoxification services is present at the behavioral health inpatient facility or on-call.

Historical Note

Section R9-10-319, formerly numbered as R9-10-223, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-319 repealed, new Section R9-10-319 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-319 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-319 renumbered to R9-10-320; new Section R9-10-319 renumbered from R9-10-318 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-320. Medication Services

A. An administrator shall ensure that policies and procedures for medication services:

- 1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient including:
 - 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:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs;
 - d. Procedures for documenting medication administration and assistance in the self-administration of medication;
 - e. Procedures for assisting a patient in obtaining medication; and

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- f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 - g. If applicable, donated medicine according to A.R.S. § 32-1909.
- 2. 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.** If a behavioral health inpatient facility provides medication administration, an administrator shall ensure that:
 - 1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
 - 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
 - 3. A medication administered to a patient is:
 - a. Administered in compliance with an order, and
 - b. Documented in the patient's medical record.
- C.** If a behavioral health inpatient facility provides assistance in the self-administration of medication, an administrator shall ensure that:
 - 1. A patient's medication is stored by the behavioral health inpatient facility;
 - 2. The following assistance is provided to a patient:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the patient;
 - c. Observing the patient while the patient removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
 - i. The patient taking the medication is the individual stated on the medication container label,
 - ii. The patient is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
 - iii. The patient is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
 - e. Observing the patient while the patient takes the medication;
 - 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 - 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
- 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
- 6. Assistance in the self-administration of medication provided to a patient:
 - a. Is in compliance with an order, and
 - b. Is documented in the patient's medical record.
- D.** 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; and
 - 3. If pharmaceutical services are provided on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - i. Develop a drug formulary,
 - ii. Update the drug formulary at least once every 12 months,
 - iii. Develop medication usage and medication substitution policies and procedures, and
 - iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
 - b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. 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
 - d. A copy of the pharmacy license is provided to the Department upon request.
- E.** When medication is stored at a behavioral health inpatient facility, an administrator shall ensure that:
 - 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and
 - 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.

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- F. An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the behavioral health inpatient facility's clinical director.

Historical Note

Section R9-10-320, formerly numbered as R9-10-231, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-320 repealed, new Section R9-10-320 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-320 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-320 renumbered to R9-10-321; new Section R9-10-320 renumbered from R9-10-319 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-321. Food Services

- A. An administrator shall ensure that:
1. The behavioral health inpatient facility obtains a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
 2. A copy of the behavioral health inpatient facility's food establishment license or permit is maintained;
 3. If a behavioral health inpatient facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health inpatient facility:
 - a. A copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health inpatient facility; and
 - b. The behavioral health inpatient facility is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;
 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. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 2. Meals and snacks provided by the behavioral health inpatient facility are served according to posted menus;
 3. Meals and snacks for each day are planned using:
 - a. The applicable guidelines in the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture, and
 - b. Preferences for meals and snacks obtained from patients;
 4. 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)(4)(d);
 - c. The option to have a daily evening snack identified in subsection (B)(4)(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 group 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;
 5. 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
 6. Water is available and accessible to patients.
- 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. 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;
 4. Potentially hazardous food is maintained as follows:
 - a. Foods requiring refrigeration are maintained at 41° F or below; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 165° F;
 5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
 6. Frozen foods are stored at a temperature of 0° F or below; and

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7. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

Historical Note

Section R9-10-321, formerly numbered as R9-10-232, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-321 repealed, new Section R9-10-321 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-321 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-321 renumbered to R9-10-322; new Section R9-10-321 renumbered from R9-10-320 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-322. Emergency and Safety Standards

- A.** An administrator shall ensure that a behavioral health inpatient facility has:
1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and a sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that are in working order; or
 2. An alternative method to ensure a patient's safety, documented and approved by the local jurisdiction.
- B.** An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where patients will be relocated;
 - b. How a patient's medical record will be available to individuals 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 behavioral health inpatient facility or the behavioral health inpatient facility's relocation site during a disaster;
 2. The disaster plan required in subsection (B)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (B)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, volunteer, or student participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 5. An evacuation drill for employees and patients:

- a. Is conducted at least once every six months; and
 - b. Includes all individuals on the premises except for:
 - i. A patient whose medical record contains documentation that evacuation from the behavioral health inpatient facility would cause harm to the patient, and
 - ii. Sufficient personnel members to ensure the health and safety of patients not evacuated according to subsection (B)(5)(b)(i);
6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
- a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and patients to evacuate to a designated area;
 - c. If applicable:
 - i. An identification of patients needing assistance for evacuation, and
 - ii. An identification of patients who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health inpatient facility.
- C.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the fire inspection report, and
 3. Maintain documentation of a current fire inspection.

Historical Note

Section R9-10-322, formerly numbered as R9-10-233, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-322 repealed, new Section R9-10-322 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-322 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-322 renumbered to R9-10-323; new Section R9-10-322 renumbered from R9-10-321 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-323. Environmental Standards

- A.** An administrator shall ensure that:
1. The premises and equipment are:
 - a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
 - b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
 2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;

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3. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 4. Equipment used at the behavioral health inpatient 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 6. Garbage and refuse are:
 - a. In areas used for food storage, food preparation, or food service, stored in covered containers lined with plastic bags;
 - b. In areas not used for food storage, food preparation, or food service, stored:
 - i. According to the requirements in subsection (6)(a), or
 - ii. In a paper-lined container that is cleaned and sanitized as often as necessary to ensure that the container is clean; and
 - c. Removed from the premises at least once a week;
 7. Heating and cooling systems maintain the behavioral health inpatient facility at a temperature between 70° F and 84° F;
 8. Common areas:
 - a. Are lighted to assure the safety of patients, and
 - b. Have lighting sufficient to allow personnel members to monitor patient activity;
 9. Hot water temperatures are maintained between 95° F and 120° F in the areas of a behavioral health inpatient facility used by patients;
 10. 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;
 11. Soiled linen and soiled clothing stored by the behavioral health inpatient facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
 12. Oxygen containers are secured in an upright position;
 13. Poisonous or toxic materials stored by the behavioral health inpatient facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
 14. Combustible or flammable liquids and hazardous materials stored by a behavioral health inpatient facility are stored in the original labeled containers or safety containers in a locked area inaccessible to patients;
 15. If pets or animals are allowed in the behavioral health inpatient facility, pets or animals are:
 - a. Controlled to prevent endangering the patients and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
 16. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is maintained for at least 12 months after the date of the test; and
 17. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to applicable state laws and rules.
- B.** An administrator shall ensure that:
1. Smoking tobacco products is not permitted within a behavioral health inpatient facility; and
 2. Except as provided in R9-10-318(A)(11), smoking tobacco products may be permitted on the premises outside a behavioral health inpatient 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.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. At least one personnel member with cardiopulmonary resuscitation training that meets the requirements in R9-10-303(C)(1)(e) is present in the pool area when a patient is in the pool area, and
 2. At least two personnel members are present in the pool area when two or more patients are in the pool area.

Historical Note

Section R9-10-323, formerly numbered as R9-10-234, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-323 repealed, new Section R9-10-323 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-323 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-323 renumbered to R9-10-324; new Section R9-10-323 renumbered from R9-10-322 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

R9-10-324. Physical Plant Standards

- A.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the behavioral health inpatient facility's scope of services, and
 2. An individual accepted as a patient by the behavioral health inpatient facility.
- B.** An administrator shall ensure that:
1. A behavioral health inpatient facility has a:
 - a. Waiting area with seating for patients and visitors;
 - b. Room that provides privacy for a patient to receive treatment or visitors; and
 - c. Common area and a dining area that:
 - i. Are not converted, partitioned, or otherwise used as a sleeping area; and
 - ii. Contain furniture and materials to accommodate the recreational and socialization needs of

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- the patients and other individuals in the behavioral health inpatient facility;
2. A bathroom is available for use by visitors during the behavioral health inpatient 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;
 3. For every six patients, there is at least one working toilet that flushes and has a seat and one sink with running water;
 4. For every eight patients, there is at least one working bathtub or shower with a slip-resistant surface;
 5. A patient bathroom complies with the following:
 - a. Provides privacy when in use;
 - b. Contains:
 - i. A shatterproof mirror, unless the patient's treatment plan requires otherwise;
 - ii. A window that opens or another means of ventilation; and
 - iii. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
 - c. Has plumbing, piping, ductwork, or other potentially hazardous elements concealed above a ceiling;
 - d. If the bathroom or shower area has a door, the door swings outward to allow for staff emergency access;
 - e. If grab bars for the toilet and tub or shower or other assistive devices are identified in the patient's treatment plan, has grab bars or other assistive devices to provide for patient safety;
 - f. If a grab bar is provided, has the space between the grab bar and the wall filled to prevent a cord being tied around the grab bar;
 - g. Does not contain a towel bar, a shower curtain rod, or a lever handle that is not a specifically designed anti-ligature lever handle;
 - h. Has tamper-resistant lighting fixtures, sprinkler heads, and electrical outlets; and
 - i. For a bathroom with a sprinkler head where a patient is not supervised while the patient is in the bathroom, has a sprinkler head that is recessed or designed to minimize patient access;
 6. If a patient bathroom door locks from the inside, an employee has a key and access to the bathroom;
 7. Each patient is provided a bedroom for sleeping;
 8. A patient bedroom complies with the following:
 - a. Is not used as a common area;
 - b. Is not used as a passageway to another bedroom or bathroom unless the bathroom is for the exclusive use of a patient occupying the bedroom;
 - c. Contains a door that opens into a hallway, common area, or outdoors and, except as provided in subsection (E), 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. Has floor to ceiling walls;
 - g. 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, except as provided in subsection (B)(9), at least 60 square feet of floor space, not including a closet, for each patient occupying the bedroom; and
 - (3) Provides sufficient space between beds to ensure that a patient has unobstructed access to the bedroom door;
 - h. 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 that is not a threat to health and safety; and
 - ii. Individual storage space for personnel effects and clothing such as shelves, a dresser, or chest of drawers;
 - i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each patient;
 - j. Has sufficient lighting for a patient occupying the bedroom to read; and
 - k. If applicable, has a drawer pull that is recessed to eliminate the possibility of use as a tie-off point;
 9. If a behavioral health inpatient facility licensed before November 1, 2003 was approved for 50 square feet of floor space for each patient in a bedroom, ensure that the bedroom contains at least 50 square feet for each patient not including the closet;
 10. In a patient bathroom or a patient bedroom:
 - a. The 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;
 11. For a door located in an area of the behavioral health inpatient 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
 12. A window located in an area of the behavioral health inpatient facility that is accessible to patients is fabricated with laminated safety glass or protected by polycarbonate, laminate, or safety screens.
- C. An administrator of a licensed behavioral health inpatient facility may submit a request, in a Department-provided format, for additional time to comply with a physical plant requirement in subsection (B)(5)(c) through (B)(5)(i), (B)(10), (B)(11), or (B)(12) that includes:
1. The rule citation for the specific plant requirement,

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2. The current physical plant condition that does not comply with the physical plant requirement,
 3. How the current physical plant condition will be changed to comply with the physical plant requirement,
 4. Estimated completion date of the identified physical plant change, and
 5. Specific actions taken to ensure the health and safety of a patient until the physical plant requirement is met.
- D.** When the Department receives a request for additional time to comply with a physical plant requirement in subsection (B)(5)(c) through (B)(5)(i), (B)(10), (B)(11), or (B)(12) submitted according to subsection (C), the Department may approve the request for up to 24 months after the effective date of these rules based on:
1. The behavioral health inpatient facility's scope of services,
 2. The expected patient acuity based on the behavioral health inpatient facility's scope of services,
 3. The specific physical plant requirement in the request, and
 4. The threat to patients' health and safety.
- E.** A bedroom in a behavioral health inpatient facility is not required to have a second means of egress if:
1. An administrator ensures that policies and procedures are established, documented, and implemented that provide for the safe evacuation of a patient in the bedroom based on the patient's physical and mental limitations and the location of the bedroom; or
 2. The building where the bedroom is located has a fire alarm system and a sprinkler system required in R9-10-322(A)(1).
- F.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (F)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and
 2. A life preserver or shepherd's crook is available and accessible in the pool area.
- G.** An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (F)(1) is covered and locked when not in use.

Historical Note

Section R9-10-324, formerly numbered as R9-10-235, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-324 repealed, new Section R9-10-324 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

New Section R9-10-324 renumbered from R9-10-323 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-325. Repealed**Historical Note**

Section R9-10-325, formerly numbered as R9-10-236, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-325 repealed, new Section R9-10-325 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-326. Repealed**Historical Note**

Section R9-10-326, formerly numbered as R9-10-237, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-326 repealed, new Section R9-10-326 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-327. Repealed**Historical Note**

Section R9-10-327, formerly numbered as R9-10-241, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-327 repealed, new Section R9-10-327 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-328. Repealed**Historical Note**

Section R9-10-328, formerly numbered as R9-10-242, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-328 repealed, new Section R9-10-328 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-329. Repealed**Historical Note**

Section R9-10-329, formerly numbered as R9-10-243, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-329 repealed, new Section R9-10-329 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-330. Repealed

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Historical Note

Section R9-10-330, formerly numbered as R9-10-244, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-330 repealed, new Section R9-10-330 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-331. Repealed**Historical Note**

Section R9-10-331, formerly numbered as R9-10-245, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-331 repealed, new Section R9-10-331 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-332. Repealed**Historical Note**

Section R9-10-332, formerly numbered as R9-10-246, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-332 repealed, new Section R9-10-332 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-333. Repealed**Historical Note**

Section R9-10-333, formerly numbered as R9-10-247, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-333 repealed, new Section R9-10-333 adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-334. Repealed**Historical Note**

Section R9-10-334, formerly numbered as R9-10-249, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Repealed effective February 4, 1981 (Supp. 81-1).

R9-10-335. Repealed**Historical Note**

Section R9-10-335, formerly numbered as R9-10-250, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Repealed effective February 4, 1981 (Supp. 81-1).

ARTICLE 4. NURSING CARE INSTITUTIONS

Article 4, consisting of Sections R9-10-411 through R9-10-438, repealed at 8 A.A.R. 2785, effective October 1, 2002 (Supp.

02-2).

R9-10-401. Definitions

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

1. "Administrator" has the same meaning as in A.R.S. § 36-446.
2. "Care plan" means a documented description of physical health services and behavioral health services expected to be provided to a resident, based on the resident's comprehensive assessment, that includes measurable objectives and the methods for meeting the objectives.
3. "Direct care" means medical services, nursing services, or social services provided to a resident.
4. "Director of nursing" means an individual who is responsible for the nursing services provided in a nursing care institution.
5. "Highest practicable" means a resident's optimal level of functioning and well-being based on the resident's current functional status and potential for improvement as determined by the resident's comprehensive assessment.
6. "Intermittent" means not on a regular basis.
7. "Nursing care institution services" means medical services, nursing services, behavioral care, health-related services, ancillary services, social services, and environmental services provided to a resident.
8. "Resident group" means residents or residents' family members who:
 - a. Plan and participate in resident activities, or
 - b. Meet to discuss nursing care institution issues and policies.
9. "Secured" means the use of a method, device, or structure that:
 - a. Prevents a resident from leaving an area of the nursing care institution's premises, or
 - b. Alerts a personnel member of a resident's departure from the nursing care institution.
10. "Social services" means assistance provided to or activities provided for a resident to maintain or improve the resident's physical, mental, and psychosocial capabilities.
11. "Total health condition" means a resident's overall physical and psychosocial well-being as determined by the resident's comprehensive assessment.
12. "Unnecessary drug" means a medication that is not required because:
 - a. There is no documented indication for a resident's use of the medication;
 - b. The medication is duplicative;
 - c. The medication is administered before determining whether the resident requires the medication; or
 - d. The resident has experienced an adverse reaction from the medication, indicating that the medication should be reduced or discontinued.
13. "Ventilator" means a device designed to provide, to a resident who is physically unable to breathe or who is breathing insufficiently, the mechanism of breathing by mechanically moving breathable air into and out of the resident's lungs.

Historical Note

New Section R9-10-401 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by

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exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-402. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a nursing care institution shall include:

1. In a Department-provided format whether the applicant:
 - a. Has:
 - i. A secured area for a resident with Alzheimer's disease or other dementia, or
 - ii. An area for a resident on a ventilator;
 - b. Is requesting authorization to provide to a resident:
 - i. Behavioral health services,
 - ii. Clinical laboratory services,
 - iii. Dialysis services, or
 - iv. Radiology services and diagnostic imaging services; and
 - c. Is requesting authorization to operate a nutrition and feeding assistant training program; and
2. If the governing authority is requesting authorization to operate a nutrition and feeding assistant training program, the information and documentation in R9-10-116(B)(1)(a), (B)(1)(c), and (B)(2).

Historical Note

New Section R9-10-402 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-403. Administration**A. A governing authority shall:**

1. Consist of one or more individuals responsible for the organization, operation, and administration of a nursing care institution;
2. Establish, in writing, the nursing care institution's scope of services;
3. Designate, in writing, a nursing care institution administrator licensed according to A.R.S. Title 36, Chapter 4, Article 6;
4. Adopt a quality management program according to R9-10-404;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator licensed according to A.R.S. § Title 36, Chapter 4, Article 6, if the administrator is:
 - a. Expected not to be present on the nursing care institution's premises for more than 30 calendar days, or
 - b. Not present on the nursing care institution's premises for more than 30 calendar days; and
7. Except as permitted in subsection (A)(6), when there is a change of administrator, notify the Department according to A.R.S. § 36-425(I) and submit a copy of the new administrator's license under A.R.S. Title 36, Chapter 4, Article 6 to the Department.

B. An administrator:

1. Is directly accountable to the governing authority of a nursing care institution for the daily operation of the nursing care institution and all services provided by or at the nursing care institution;
 2. Has the authority and responsibility to manage the nursing care institution;
 3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the nursing care institution's premises and accountable for the nursing care institution when the administrator is not present on the nursing care institution's premises;
 4. Ensures the nursing care institution's compliance with A.R.S. § 36-411; and
 5. If the nursing care institution provides feeding and nutrition assistant training, ensures the nursing care institution complies with the requirements for the operation of a feeding and nutrition assistant training program in R9-10-116.
- C. An administrator shall ensure that:**
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students, including the training required in A.R.S. § 36-420.01;
 - c. Include how a personnel member may submit a complaint relating to resident care;
 - d. Include methods to prevent abuse or neglect of a resident and reporting requirements in compliance with A.R.S. §§ 13-3620 and 46-454, including:
 - i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
 - ii. Reporting of abuse or neglect of a resident;
 - e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - f. Cover requirements related to cardiopulmonary resuscitation including:
 - i. Which personnel members are required to obtain cardiopulmonary resuscitation training;
 - ii. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - iii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - iv. The time-frame for renewal of cardiopulmonary resuscitation training;
 - v. The documentation that verifies an individual has received cardiopulmonary resuscitation training; and
 - vi. The circumstances for providing cardiopulmonary resuscitation to a resident, consistent with A.R.S. § 36-420(B);
 - g. Cover requirements related to first aid, including training and the circumstances for providing first aid to a resident, consistent with A.R.S. § 36-420(B);

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- h. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
 - i. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;
 - j. Cover specific steps for:
 - i. A resident to file a complaint, and
 - ii. The nursing care institution to respond to a resident's complaint;
 - k. Cover health care directives;
 - l. Cover medical records, including electronic medical records;
 - m. Cover a quality management program, including incident reports and supporting documentation;
 - n. Cover contracted services;
 - o. Cover resident's personal accounts;
 - p. Cover petty cash funds;
 - q. Cover fees and refund policies;
 - r. Cover misappropriation of resident property;
 - s. Cover when an individual may visit a resident in a nursing care institution; and
 - t. Cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02; and
2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that:
- a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;
 - b. Cover the provision of physical health services and behavioral health services;
 - c. Include when general consent and informed consent are required;
 - d. Cover storing, dispensing, administering, and disposing of medication;
 - e. Cover infection control;
 - f. Cover how personnel members will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
 - g. Cover telehealth, if applicable; and
 - h. Cover environmental services that affect resident care;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
- a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a nursing care institution, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the nursing care institution.
- D.** Except for health screening services, an administrator shall ensure that medical services, nursing services, health-related services, behavioral health services, or ancillary services provided by a nursing care institution are only provided to a resident.
- E.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a nursing care institution's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
- 1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - 2. For a resident under 18 years of age, according to A.R.S. § 13-3620.
- F.** If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or § 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a nursing care institution's employee or personnel member, an administrator shall:
- 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the resident as follows:
 - a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 - 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 - 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 - 6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- G.** An administrator shall:
- 1. Allow a resident advocate to assist a resident, the resident's representative, or a resident group with a request or recommendation, and document in writing any complaint submitted to the nursing care institution;
 - 2. Ensure that a monthly schedule of recreational activities for residents is developed, documented, and implemented; and
 - 3. Ensure that the following are conspicuously posted on the premises:
 - a. The current nursing care institution license and quality rating issued by the Department;
 - b. The name, address, and telephone number of:
 - i. The Department's Office of Long Term Care,
 - ii. The State Long-Term Care Ombudsman Program, and

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- iii. Adult Protective Services of the Department of Economic Security;
- c. A notice that a resident may file a complaint with the Department concerning the nursing care institution;
- d. The monthly schedule of recreational activities; and
- e. One of the following:
 - i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect; or
 - ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.

H. An administrator shall provide written notification to the Department of a resident's:

- 1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
- 2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency medical services provider.

I. If an administrator administers a resident's personal account at the request of the resident or the resident's representative, the administrator shall:

- 1. Comply with policies and procedures established according to subsection (C)(1)(n);
- 2. Designate a personnel member who is responsible for the personal accounts;
- 3. Maintain a complete and separate accounting of each personal account;
- 4. Obtain written authorization from the resident or the resident's representative for a personal account transaction;
- 5. Document an account transaction and provide a copy of the documentation to the resident or the resident's representative upon request and at least every three months;
- 6. Transfer all money from the resident's personal account in excess of \$50.00 to an interest-bearing account and credit the interest to the resident's personal account; and
- 7. Within 30 calendar days after the resident's death, transfer, or discharge, return all money in the resident's personal account and a final accounting to the resident, the resident's representative, or the probate jurisdiction administering the resident's estate.

J. If a petty cash fund is established for use by residents, the administrator shall ensure that:

- 1. The policies and procedures established according to subsection (C)(1)(o) include:
 - a. A prescribed cash limit of the petty cash fund, and
 - b. The hours of the day a resident may access the petty cash fund; and
- 2. A resident's written acknowledgment is obtained for a petty cash transaction.

Historical Note

New Section R9-10-403 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final

rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-404. 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 services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident 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 resident 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 resident care; and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section R9-10-404 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-405. Contracted Services

An administrator shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section R9-10-405 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-406. Personnel

A. An administrator shall ensure that a behavioral health technician or behavioral health paraprofessional is at least 18 years old.

B. An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the residents receiving physical health services or behavioral health services from the personnel member according to the established job description; and

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- b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
- 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
- 3. Sufficient personnel members are present on a nursing care institution's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the nursing care institution's scope of services,
 - b. Meet the needs of a resident, and
 - c. Ensure the health and safety of a resident.
- C. An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.
- D. Except as provided in R9-10-415, an administrator shall ensure that, if a personnel member provides social services that require a license under A.R.S. Title 32, Chapter 33, Article 5, the personnel member is licensed under A.R.S. Title 32, Chapter 33, Article 5.
- E. An administrator shall ensure that an individual who is a licensed 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 4 A.A.C. 6, Article 1.
- F. An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis:
 - 1. On or before the date the individual begins providing services at or on behalf of the nursing care institution, and
 - 2. As specified in R9-10-113.
- G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
 - 1. The individual's name, date of birth, and contact telephone number;
 - 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 - 3. Documentation of:
 - a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's compliance with the requirements in A.R.S. § 36-411;
- d. Orientation and in-service education as required by policies and procedures;
- e. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;
- f. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
- g. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
- h. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-403(C)(1)(f);
- i. First aid training, if required for the individual according to this Article or policies and procedures; and
- j. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F); and
- k. If the individual is a nutrition and feeding assistant:
 - i. Completion of the nutrition and feeding assistant training course required in R9-10-116, and
 - ii. A nurse's observations required in R9-10-423(C)(6).
- H. An administrator shall ensure that personnel records are:
 - 1. Maintained:
 - a. Throughout the individual's period of providing services in or for the nursing care institution, and
 - b. For at least 24 months after the last date the individual provided services in or for the nursing care institution; and
 - 2. For a personnel member who has not provided physical health services or behavioral health services at or for the nursing care institution during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- I. An administrator shall ensure that:
 - 1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
 - 2. A personnel member completes orientation before providing behavioral health services or physical health services;
 - 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 - 4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;
 - 5. A personnel member's in-service education 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; and
 - 6. A work schedule of each personnel member is developed and maintained at the nursing care institution for at least 12 months after the date of the work schedule.
- J. An administrator shall designate a qualified individual to provide:
 - 1. Social services, and
 - 2. Recreational activities.

Historical Note

New Section R9-10-406 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

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Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-407. Admission

An administrator shall ensure that:

1. A resident is admitted only on a physician's order;
2. The physician's admitting order includes the nursing care institution services required to meet the immediate needs of a resident, such as medication and food services;
3. At the time of a resident's admission, a registered nurse conducts or coordinates an initial assessment on a resident to ensure the resident's immediate needs for nursing care institution services are met;
4. A resident's needs do not exceed the medical services and nursing services available at the nursing care institution as established in the nursing care institution's scope of services;
5. Before or at the time of admission, a resident or the resident's representative:
 - a. Receives a documented agreement with the nursing care institution that includes rates and charges,
 - b. Is informed of third-party coverage for rates and charges,
 - c. Is informed of the nursing care institution's refund policy, and
 - d. Receives written information concerning the nursing care institution's policies and procedures related to a resident's health care directives;
6. Within 30 calendar days before admission or 10 working days after admission, a medical history and physical examination is completed on a resident by:
 - a. A physician, or
 - b. A physician assistant or a registered nurse practitioner designated by the attending physician;
7. Except as specified in subsection (8), a resident provides evidence of freedom from infectious tuberculosis:
 - a. Before or within seven calendar days after the resident's admission, and
 - b. As specified in R9-10-113;
8. A resident who transfers from a nursing care institution to another nursing care institution is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
 - a. Fewer than 12 months have passed since the resident was screened for tuberculosis, and
 - b. The documentation of freedom from infectious tuberculosis required in subsection (7) accompanies the resident at the time of transfer; and
9. Compliance with the requirements in subsection (6) is documented in the resident's medical record.

Historical Note

New Section R9-10-407 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

Amended by final expedited rulemaking at 28 A.A.R.

1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-10-408. Transfer; Discharge

A. An administrator shall ensure that:

1. A resident is transferred or discharged if:
 - a. The nursing care institution is not authorized or not able to meet the needs of the resident, or
 - b. The resident's behavior is a threat to the health or safety of the resident or other individuals at the nursing care institution; and
2. Documentation of a resident's transfer or discharge includes:
 - a. The date of the transfer or discharge;
 - b. The reason for the transfer or discharge;
 - c. A 30-day written notice except:
 - i. In an emergency, or
 - ii. If the resident no longer requires nursing care institution services as determined by a physician or the physician's designee;
 - d. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1); and
 - e. If applicable, actions taken by a personnel member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the nursing care institution.

B. An administrator may transfer or discharge a resident for failure to pay for residency if:

1. The resident or resident's representative receives a 30-day written notice of transfer or discharge, and
2. The 30-day written notice includes an explanation of the resident's right to appeal the transfer or discharge.

C. Except for a transfer of a resident due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transfer.

D. Except in an emergency, a director of nursing shall ensure that before a resident is discharged:

1. Written follow-up instructions are developed with the resident or the resident's representative that includes:
 - a. Information necessary to meet the resident's need for medical services and nursing services; and
 - b. The state long-term care ombudsman's name, address, and telephone number;
2. A copy of the written follow-up instructions is provided to the resident or the resident's representative; and

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3. A discharge summary is developed by a personnel member and authenticated by the resident's attending physician or designee and includes:
 - a. The resident's medical condition at the time of transfer or discharge,
 - b. The resident's medical and psychosocial history,
 - c. The date of the transfer or discharge, and
 - d. The location of the resident after discharge.

Historical Note

New Section R9-10-408 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-409. Transport

- A. Except as provided in subsection (B), an administrator shall ensure that:
 1. A personnel member coordinates the transport and the services provided to the resident;
 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport,
 - b. Information from the resident's medical record is provided to a receiving health care institution, and
 - c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transport.
- B. Subsection (A) does not apply to:
 1. Transportation to a location other than a licensed health care institution,
 2. Transportation provided for a resident by the resident or the resident's representative,
 3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
 4. A transport to another licensed health care institution in an emergency.

Historical Note

New Section R9-10-409 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-410. Resident Rights

- A. An administrator shall ensure that:
 1. The requirements in subsection (B) and the resident rights in subsection (C) are conspicuously posted on the premises;
 2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C); and
 3. Policies and procedures include:

- a. How and when a resident or the resident's representative is informed of resident rights in subsection (C), and
- b. Where resident rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A resident has privacy in:
 - a. Treatment,
 - b. Bathing and toileting,
 - c. Room accommodations, and
 - d. A visit or meeting with another resident or an individual;
2. A resident is treated with dignity, respect, and consideration;
3. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by a nursing care institution's personnel members, employees, volunteers, or students; and
4. A resident or the resident's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed alternatives to psychotropic medication or a surgical procedure and the associated risks and possible complications of the psychotropic medication or surgical procedure;
 - d. Is informed of the following:
 - i. The health care institution's policy on health care directives, and
 - ii. The resident complaint process;
 - e. Consents to photographs of the resident before the resident is photographed, except that the resident may be photographed when admitted to a nursing care institution for identification and administrative purposes;
 - f. May manage the resident's financial affairs;
 - g. May review the nursing care institution's current license survey report and, if applicable, plan of correction in effect;
 - h. Has access to and may communicate with any individual, organization, or agency;
 - i. May participate in a resident group;
 - j. May review the resident's financial records within two working days and medical record within one working day after the resident's or the resident's representative's request;
 - k. May obtain a copy of the resident's financial records and medical record within two working days after the resident's request and in compliance with A.R.S. § 12-2295;

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- l. Except as otherwise permitted by law, consents, in writing, to the release of information in the resident's:
 - i. Medical record, and
 - ii. Financial records;
 - m. May select a pharmacy of choice if the pharmacy complies with policies and procedures and does not pose a risk to the resident;
 - n. Is informed of the method for contacting the resident's attending physician;
 - o. Is informed of the resident's total health condition;
 - p. Is provided with a copy of those sections of the resident's medical record that are required for continuity of care free of charge, according to A.R.S. § 12-2295, if the resident is transferred or discharged;
 - q. Is informed in writing of a change in rates and charges at least 60 calendar days before the effective date of the change; and
 - r. Except in the event of an emergency, is informed orally or in writing before the nursing care institution makes a change in a resident's room or roommate assignment and notification is documented in the resident's medical record.
- C.** A resident has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;
 3. To choose activities and schedules consistent with the resident's interests that do not interfere with other residents;
 4. To participate in social, religious, political, and community activities that do not interfere with other residents;
 5. To retain personal possessions including furnishings and clothing as space permits unless use of the personal possession infringes on the rights or health and safety of other residents;
 6. To share a room with the resident's spouse if space is available and the spouse consents;
 7. To receive a referral to another health care institution if the nursing care institution is not authorized or not able to provide physical health services or behavioral health services needed by the resident;
 8. To participate or have the resident's representative participate in the development of, or decisions concerning, treatment;
 9. To participate or refuse to participate in research or experimental treatment;
 10. To participate in religious visitation by a clergy member according to A.R.S. § 36-407.02; and
 11. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

Historical Note

New Section R9-10-410 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-411. Medical Records

- A.** An administrator shall ensure that:
1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
 2. An entry in a resident's medical record is:
 - a. Recorded only by an individual authorized by 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 resident's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 5. A resident's medical record is available to an individual:
 - a. Authorized to access the resident's medical record according to policies and procedures;
 - b. If the individual is not authorized to access the resident's medical record according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law; and
 6. A resident's medical record is protected from loss, damage, or unauthorized use.
- B.** If a nursing care institution maintains residents' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a resident's medical record contains:
1. Resident information that includes:
 - a. The resident's name;
 - b. The resident's date of birth; and
 - c. Any known allergies, including medication allergies;
 2. The admission date and, if applicable, the date of discharge;
 3. The admitting diagnosis or presenting symptoms;
 4. Documentation of general consent and, if applicable, informed consent;
 5. If applicable, the name and contact information of the resident's representative and:
 - a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;

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6. The medical history and physical examination required in R9-10-407(6);
7. A copy of the resident's living will or other health care directive, if applicable;
8. The name and telephone number of the resident's attending physician;
9. Orders;
10. Care plans;
11. Behavioral care plans, if the resident is receiving behavioral care;
12. Documentation of nursing care institution services provided to the resident;
13. Progress notes;
14. If applicable, documentation of any actions taken to comply with A.R.S. § 36-420;
15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
16. If applicable, documentation that evacuation from the nursing care institution would cause harm to the resident;
17. The disposition of the resident after discharge;
18. The discharge plan;
19. The discharge summary;
20. Transfer documentation;
21. If applicable:
 - a. A laboratory report,
 - b. A radiologic report,
 - c. A diagnostic report, and
 - d. A consultation report;
22. Documentation of freedom from infectious tuberculosis required in R9-10-407(7);
23. Documentation of a medication administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. The type of vaccine, if applicable;
 - d. For a medication administered for pain on a PRN basis:
 - i. An evaluation of the resident's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - e. For a psychotropic medication administered on a PRN basis:
 - i. An evaluation of the resident's symptoms before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - f. The identification, signature, and professional designation of the individual administering the medication; and
 - g. Any adverse reaction a resident has to the medication;
24. If the resident has been assessed for receiving nutrition and feeding assistance from a nutrition and feeding assistant, documentation of the assessment and the determination of eligibility; and
25. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-411 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-412. Nursing Services

- A.** An administrator shall ensure that:
 1. Nursing services are provided 24 hours a day in a nursing care institution;
 2. A director of nursing is appointed who:
 - a. Is a registered nurse,
 - b. Works full-time at the nursing care institution, and
 - c. Is responsible for the direction of nursing services;
 3. The director of nursing or an individual designated by the administrator participates in the quality management program; and
 4. If the daily census of the nursing care institution is 60 or more, the director of nursing does not provide direct care to residents on a regular basis.
- B.** A director of nursing shall ensure that:
 1. A method is established and documented that identifies the types and numbers of nursing personnel that are necessary to provide nursing services to residents based on the residents' comprehensive assessments, orders for physical health services and behavioral health services, and care plans and the nursing care institution's scope of services;
 2. Sufficient nursing personnel, as determined by the method in subsection (B)(1), are on the nursing care institution premises to meet the needs of a resident for nursing services;
 3. At least one nurse is present on the nursing care institution's premises and responsible for providing direct care to not more than 64 residents;
 4. Documentation of nursing personnel present on the nursing care institution's premises each day is maintained and includes:
 - a. The date,
 - b. The number of residents,
 - c. The name and license or certification title of each nursing personnel member who worked that day, and
 - d. The actual number of hours each nursing personnel member worked that day;
 5. The documentation of nursing personnel required in subsection (B)(4) is maintained for at least 12 months after the date of the documentation;
 6. As soon as possible but not more than 24 hours after one of the following events occur, a nurse notifies a resident's attending physician and, if applicable, the resident's representative, if the resident:
 - a. Is injured,
 - b. Is involved in an incident that may require medical services, or
 - c. Has a significant change in condition; and
 7. An unnecessary drug is not administered to a resident.

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Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-412 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-413. Medical Services

A. An administrator shall appoint a medical director.

B. A medical director shall ensure that:

1. A resident has an attending physician;
2. An attending physician is available 24 hours a day;
3. An attending physician designates a physician who is available when the attending physician is not available;
4. A physical examination is performed on a resident at least once every 12 months after the date of admission by an individual listed in R9-10-407(6);
5. As required in A.R.S. § 36-406, vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:
 - a. The attending physician provides documentation that the vaccination is medically contraindicated;
 - b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical record that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or
 - c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the previous five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention; and
6. If the any of the following services are not provided by the nursing care institution and needed by a resident, the resident is assisted in obtaining, at the resident's expense:
 - a. Vision services;
 - b. Hearing services;
 - c. Dental services;
 - d. Clinical laboratory services from a laboratory that holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
 - e. Psychosocial services;
 - f. Physical therapy;
 - g. Speech therapy;
 - h. Occupational therapy;
 - i. Behavioral health services; and
 - j. Services for an individual who has a developmental disability, as defined in A.R.S. Title 36, Chapter 5.1, Article 1.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-413

made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-414. Comprehensive Assessment; Care Plan

A. A director of nursing shall ensure that:

1. A comprehensive assessment of a resident:
 - a. Is conducted or coordinated by a registered nurse in collaboration with an interdisciplinary team;
 - b. Is completed for the resident within 14 calendar days after the resident's admission to a nursing care institution;
 - c. Is updated:
 - i. No later than 12 months after the date of the resident's previous comprehensive assessment, and
 - ii. When the resident experiences a significant change;
 - d. Includes the following information for the resident:
 - i. Identifying information;
 - ii. An evaluation of the resident's hearing, speech, and vision;
 - iii. An evaluation of the resident's ability to understand and recall information;
 - iv. An evaluation of the resident's mental status;
 - v. Whether the resident's mental status or behaviors:
 - (1) Put the resident at risk for physical illness or injury,
 - (2) Significantly interfere with the resident's care,
 - (3) Significantly interfere with the resident's ability to participate in activities or social interactions,
 - (4) Put other residents or personnel members at significant risk for physical injury,
 - (5) Significantly intrude on another resident's privacy, or
 - (6) Significantly disrupt care for another resident;
 - vi. Preferences for customary routine and activities;
 - vii. An evaluation of the resident's ability to perform activities of daily living;
 - viii. Need for a mobility device;
 - ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
 - x. Any diagnosis that impacts nursing care institution services that the resident may require;
 - xi. Any medical conditions that impact the resident's functional status, quality of life, or need for nursing care institution services;
 - xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;
 - xiii. An evaluation of the resident's oral and dental status;
 - xiv. An evaluation of the condition of the resident's skin;
 - xv. Identification of any medication or treatment administered to the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;

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- xvi. Identification of any treatment or medication ordered for the resident;
 - xvii. A description of the resident or resident's representative's participation in the comprehensive assessment;
 - xviii. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;
 - xix. Potential for rehabilitation; and
 - xx. Potential for discharge; and
 - e. Is signed and dated by:
 - i. The registered nurse who conducts or coordinates the comprehensive assessment or review; and
 - ii. If a behavioral health professional is required to review according to subsection (A)(2), the behavioral health professional who reviewed the comprehensive assessment or review;
 - 2. If any of the conditions in (A)(1)(d)(v) are answered in the affirmative during the comprehensive assessment or review, a behavioral health professional reviews a resident's comprehensive assessment or review and care plan to ensure that the resident's needs for behavioral health services are being met;
 - 3. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing care institution unless a physician, an individual designated by the physician, or a registered nurse determines the resident has a significant change in condition; and
 - 4. A resident's comprehensive assessment is reviewed by a registered nurse at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition.
- B.** An administrator shall ensure that a care plan for a resident:
- 1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1);
 - 2. Is reviewed and revised based on any change to the resident's comprehensive assessment; and
 - 3. Ensures that a resident is provided nursing care institution services that:
 - a. Address any medical condition or behavioral health issue identified in the resident's comprehensive assessment, and
 - b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-414 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-415. Behavioral Health Services

Except for behavioral care, if a nursing care institution is authorized to provide behavioral health services, an administrator shall ensure that:

- 1. The behavioral health services are provided:
 - a. Under the direction of a behavioral health professional licensed or certified to provide the type of behavioral health services in the nursing care institution's scope of services; and
 - b. In compliance with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
 - ii. For an assessment, in R9-10-1011(B); and
- 2. Except for a psychotropic drug ordered by a medical practitioner for a resident's out-of-control behavior or administered according to an order from a court of competent jurisdiction, informed consent is obtained from a resident or the resident's representative for a psychotropic drug and documented in the resident's medical record before the psychotropic drug is administered to the resident.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-415 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-416. Clinical Laboratory Services

If clinical laboratory services are authorized to be provided on a nursing care institution's premises, an administrator shall ensure that:

- 1. Clinical laboratory services and pathology services are provided through a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
- 2. A copy of the certificate of accreditation, certificate of compliance, or certificate of waiver in subsection (1) is provided to the Department for review upon the Department's request;
- 3. The nursing care institution:
 - a. Is able to provide the clinical laboratory services delineated in the nursing care institution's scope of services when needed by the residents,
 - b. Obtains specimens for the clinical laboratory services delineated in the nursing care institution's scope of services without transporting the residents from the nursing care institution's premises, and
 - c. Has the examination of the specimens performed by a clinical laboratory;
- 4. Clinical laboratory and pathology test results are:
 - a. Available to the ordering physician:
 - i. Within 24 hours after the test is complete with results if the test is performed at a laboratory on the nursing care institution's premises, or

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- ii. Within 24 hours after the test result is received if the test is performed at a laboratory outside of the nursing care institution's premises; and
- b. Documented in a resident's medical record;
- 5. If a test result is obtained that indicates a resident may have an emergency medical condition, as established in policies and procedures, personnel notify:
 - a. The ordering physician,
 - b. A registered nurse in the resident's assigned unit,
 - c. The nursing care institution's administrator, or
 - d. The director of nursing;
- 6. If a clinical laboratory report is completed on a resident, a copy of the report is included in the resident's medical record;
- 7. If the nursing care institution provides blood or blood products, policies and procedures are established, documented, and implemented for:
 - a. Procuring, storing, transfusing, and disposing of blood or blood products;
 - b. Blood typing, antibody detection, and blood compatibility testing; and
 - c. Investigating transfusion adverse reactions that specify a process for review through the quality management program; and
- 8. Expired laboratory supplies are discarded according to policies and procedures.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-416 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-417. Dialysis Services

If dialysis services are authorized to be provided on a nursing care institution's premises, an administrator shall ensure that the dialysis services are provided in compliance with the requirements in R9-10-1018.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-417 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-418. Radiology Services and Diagnostic Imaging Services

If radiology services or diagnostic imaging services are authorized to be provided on a nursing care institution's premises, an administrator shall ensure that:

- 1. Radiology services and diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
- 2. A copy of a certificate documenting compliance with subsection (1) is maintained by the nursing care institution;
- 3. When needed by a resident, radiology services and diagnostic imaging services delineated in the nursing care

institution's scope of services are provided on the nursing care institution's premises;

- 4. Radiology services and diagnostic imaging services are provided:
 - a. Under the direction of a physician; and
 - b. According to an order that includes:
 - i. The resident's name,
 - ii. The name of the ordering individual,
 - iii. The radiological or diagnostic imaging procedure ordered, and
 - iv. The reason for the procedure;
- 5. A medical director, attending physician, or radiologist interprets the radiologic or diagnostic image;
- 6. A radiologic or diagnostic imaging report is prepared that includes:
 - a. The resident's name;
 - b. The date of the procedure;
 - c. A medical director, attending physician, or radiologist's interpretation of the image;
 - d. The type and amount of radiopharmaceutical used, if applicable; and
 - e. The resident's adverse reaction to the radiopharmaceutical, if any; and
- 7. A radiologic or diagnostic imaging report is included in the resident's medical record.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-418 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-419. Respiratory Care Services

If respiratory care services are provided on a nursing care institution's premises, an administrator shall ensure that:

- 1. Respiratory care services are provided under the direction of a medical director or attending physician;
- 2. Respiratory care services are provided according to an order that includes:
 - a. The resident's name;
 - b. The name and signature of the ordering individual;
 - c. The type, frequency, and, if applicable, duration of treatment;
 - d. The type and dosage of medication and diluent; and
 - e. The oxygen concentration or oxygen liter flow and method of administration;
- 3. Respiratory care services provided to a resident are documented in the resident's medical record and include:
 - a. The date and time of administration;
 - b. The type of respiratory care services provided;
 - c. The effect of the respiratory care services;
 - d. The resident's adverse reaction to the respiratory care services, if any; and
 - e. The authentication of the individual providing the respiratory care services; and
- 4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-416.

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Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-419 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-420. Rehabilitation Services

If rehabilitation services are provided on a nursing care institution's premises, an administrator shall ensure that:

1. Rehabilitation services are provided:
 - a. Under the direction of an individual qualified according to policies and procedures,
 - b. By an individual licensed to provide the rehabilitation services, and
 - c. According to an order; and
2. The medical record of a resident receiving rehabilitation services includes:
 - a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis,
 - b. A documented care plan that is developed in coordination with the ordering individual and the individual providing the rehabilitation services,
 - c. The rehabilitation services provided,
 - d. The resident's response to the rehabilitation services, and
 - e. The authentication of the individual providing the rehabilitation services.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-420 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-421. Medication Services

A. An administrator shall ensure that policies and procedures for medication services:

1. Include:
 - a. A process for providing information to a resident about medication prescribed for the resident including:
 - 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:
 - i. A medication error,
 - ii. An adverse response to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a pharmacist reviews a resident's medications at least once every three months and provides documentation to the resident's attending physician and the director of nursing indicating

potential medication problems such as incompatible or duplicative medications;

- d. Procedures for documenting medication services; and
 - e. Procedures for assisting a resident in obtaining medication; and
2. 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. Policies and procedures for medication administration:
 - a. Are reviewed and approved by the director of nursing;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
 3. A medication administered to a resident:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the resident's medical record; and
 4. If a psychotropic medication is administered to a resident, the psychotropic medication:
 - a. Is only administered to a resident for a diagnosed medical condition; and
 - b. Unless clinically contraindicated or otherwise ordered by an attending physician or the attending physician's designee, is gradually reduced in dosage while the resident is simultaneously provided with interventions such as behavior and environment modification in an effort to discontinue the psychotropic medication, unless a dose reduction is attempted and the resident displays behavior justifying the need for the psychotropic medication, and the attending physician documents the necessity for the continued use and dosage.
- C.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members; and
 2. 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.
- D.** When medication is stored at a nursing care institution, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions on the medication container; and
 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for:

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- a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of residents who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
 - e. If applicable, donated medicine according to A.R.S. § 32-1909.
- E. An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the medical practitioner who ordered the medication and the nursing care institution's director of nursing.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-421 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-422. Infection Control

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the nursing care institution;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the nursing care institution;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the nursing care institution; and
 - d. Documentation of infection control activities including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:
 - a. Handling and disposal of biohazardous medical waste;
 - b. Sterilization, disinfection, and storage of medical equipment and supplies;
 - c. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;

- d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a resident;
 - e. Training of personnel members, employees, and volunteers in infection control practices; and
 - f. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 5. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas; and
 6. A personnel member, an employee, or a volunteer washes hands or uses a hand disinfection product after a resident contact and after handling soiled linen, soiled clothing, or potentially infectious material.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-422 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-423. Food Services

A. An administrator shall ensure that:

1. The nursing care institution has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
 2. A copy of the nursing care institution's food establishment license or permit is maintained;
 3. If a nursing care institution contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the nursing care institution:
 - a. A copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the nursing care institution; and
 - b. The nursing care institution is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
 4. A registered dietitian:
 - a. Reviews a food menu before the food menu is used to ensure that a resident's nutritional needs are being met,
 - b. Documents the review of a food menu, and
 - c. Is available for consultation regarding a resident's nutritional needs; 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 ensure that the nutritional needs of a resident are met.
- 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 resident such as cut, chopped, ground, pureed, or thickened;
 2. A food menu:

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- a. Is prepared at least one week in advance,
 - b. Includes the foods to be served on each day,
 - c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 3. Meals and snacks for each day are planned and served using the applicable guidelines in the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
 4. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and care plan;
 - b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(4)(d);
 - c. The option to have a daily evening snack identified in subsection (B)(4)(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 resident group agrees; and
 - ii. The resident 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;
 5. A resident is provided with food substitutions of similar nutritional value if the resident:
 - a. Refuses to eat the food served, or
 - b. Requests a substitution;
 6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning;
 7. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils;
 8. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair;
 9. A resident eats meals in a dining area unless the resident chooses to eat in the resident's room or is confined to the resident's room for medical reasons documented in the resident's medical record; and
 10. Water is available and accessible to residents.
- C. If a nursing care institution has nutrition and feeding assistants, an administrator shall ensure that:
1. A nutrition and feeding assistant:
 - a. Is at least 16 years of age;
 - b. If applicable, complies with the fingerprint clearance card requirements in A.R.S. § 36-411;
 - c. Completes a nutrition and feeding assistant training course within 12 months before initially providing nutrition and feeding assistance;
 - d. Provides nutrition and feeding assistance where nursing personnel are present;
 - e. Immediately reports an emergency to a nurse or, if a nurse is not present in the common area, to nursing personnel; and
 - f. If the nutrition and feeding assistant observes a change in a resident's physical condition or behavior, reports the change to a nurse or, if a nurse is not present in the common area, to nursing personnel;
 2. A resident is not eligible to receive nutrition and feeding assistance from a nutrition and feeding assistant if the resident:
 - a. Has difficulty swallowing,
 - b. Has had recurrent lung aspirations,
 - c. Requires enteral feedings,
 - d. Requires parenteral feedings, or
 - e. Has any other eating or drinking difficulty that may cause the resident's health or safety to be compromised if the resident receives nutrition and feeding assistance from a nutrition and feeding assistant;
 3. Only an eligible resident receives nutrition and feeding assistance from a nutrition and feeding assistant;
 4. A nurse determines if a resident is eligible to receive nutrition and feeding assistance from a nutrition and feeding assistant, based on:
 - a. The resident's comprehensive assessment,
 - b. The resident's care plan, and
 - c. An assessment conducted by the nurse when making the determination;
 5. A method is implemented that identifies eligible residents that ensures only eligible residents receive nutrition and feeding assistance from a nutrition and feeding assistant;
 6. When a nutrition and feeding assistant initially provides nutrition and feeding assistance and at least once every three months, a nurse observes the nutrition and feeding assistant while the nutrition and feeding assistant is providing nutrition and feeding assistance to ensure that the nutrition and feeding assistant is providing nutrition and feeding assistance appropriately;
 7. A nurse documents the nurse's observations required in subsection (C)(6); and
 8. A nutrition and feeding assistant is provided additional training:
 - a. According to policies and procedures, and
 - b. If a nurse identifies a need for additional training based on the nurse's observation in subsection (C)(6).

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-423 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-424. Emergency and Safety Standards

- A. An administrator shall ensure that:
1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where residents will be relocated, including:
 - i. Instructions for the evacuation or transfer of residents,

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- ii. Assigned responsibilities for each employee and personnel member, and
 - iii. A plan for continuing to provide services to meet a resident's needs;
 - b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
 - c. A plan for back-up power and water supply;
 - d. A plan to ensure a resident's medications will be available to administer to the resident during a disaster;
 - e. A plan to ensure a resident is provided nursing services and other services required by the resident during a disaster; and
 - f. A plan for obtaining food and water for individuals present in the nursing care institution or the nursing care institution's relocation site during a disaster;
2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 5. An evacuation drill for employees and residents:
 - a. Is conducted at least once every six months; and
 - b. Includes all individuals on the premises except for:
 - i. A resident whose medical record contains documentation that evacuation from the nursing care institution would cause harm to the resident, and
 - ii. Sufficient personnel members to ensure the health and safety of residents not evacuated according to subsection (A)(5)(b)(i);
 6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and residents to evacuate to a designated area;
 - c. If applicable:
 - i. An identification of residents needing assistance for evacuation, and
 - ii. An identification of residents who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
 7. An evacuation path is conspicuously posted on each hallway of each floor of the nursing care institution.
- B.** An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.
- C.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the fire inspection report, and
 3. Maintain documentation of a current fire inspection.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-424 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-425. Environmental Standards**A.** An administrator shall ensure that:

1. A nursing care institution's premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness and infection; and
 - b. Free from a condition or situation that may cause a resident or an individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Equipment used to provide direct care 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
5. Garbage and refuse are:
 - a. In areas used for food storage, food preparation, or food service, stored in a covered container lined with a plastic bag;
 - b. In areas not used for food storage, food preparation, or food service, stored:
 - i. According to the requirements in subsection (A)(5)(a), or
 - ii. In a paper-lined or plastic-lined container that is cleaned and sanitized as often as necessary to ensure that the container is clean; and
 - c. Removed from the premises at least once a week;
6. Heating and cooling systems maintain the nursing care institution at a temperature between 70° F and 84° F;
7. Common areas:
 - a. Are lighted to assure the safety of residents, and
 - b. Have lighting sufficient to allow personnel members to monitor resident activity;
8. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
9. Linens are clean before use, without holes and stains, and not in need of repair;
10. Oxygen containers are secured in an upright position;
11. Poisonous or toxic materials stored by the nursing care institution are maintained in labeled containers in a locked area separate from food preparation and storage,

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dining areas, and medications and are inaccessible to residents;

12. Combustible or flammable liquids stored by the nursing care institution are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
13. If pets or animals are allowed in the nursing care institution, pets or animals are:
 - a. Controlled to prevent endangering the residents and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
14. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
15. 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 tobacco products is not permitted within a nursing care institution, and
2. Smoking tobacco products may be permitted outside a nursing care institution 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. If a swimming pool is located on the premises, an administrator shall ensure that:

1. At least one personnel member with cardiopulmonary resuscitation training that meets the requirements in R9-10-403(C)(1)(e) is present in the pool area when a resident is in the pool area, and
2. At least two personnel members are present in the pool area when two or more residents are in the pool area.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-425 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-426. Physical Plant Standards

A. An administrator shall ensure that:

1. A nursing care institution complies with:
 - a. The applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the date the nursing care institution submitted the application including the notarized attestation of architectural plans according to R9-10-104; and

- b. The requirements for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01;

2. The premises and equipment are sufficient to accommodate:
 - a. The services stated in the nursing care institution's scope of services, and
 - b. An individual accepted as a resident by the nursing care institution;
3. A nursing care institution is ventilated by windows or mechanical ventilation, or a combination of both;
4. The corridors are equipped with handrails on each side that are firmly attached to the walls and are not in need of repair;
5. No more than two individuals reside in a resident room unless:
 - a. The nursing care institution was operating before October 31, 1982; and
 - b. The resident room has not undergone a modification as defined in A.R.S. § 36-401;
6. A resident has a separate bed, a nurse call system, and furniture to meet the resident's needs in a resident room or suite of rooms;
7. A resident room has:
 - a. A window to the outside with window coverings for controlling light and visual privacy, and the location of the window permits a resident to see outside from a sitting position;
 - b. A closet with clothing racks and shelves accessible to the resident; and
 - c. If the resident room contains more than one bed, a curtain or similar type of separation between the beds for privacy; and
8. A resident room or a suite of rooms:
 - a. Is accessible without passing through another resident's room; and
 - b. Does not open into any area where food is prepared, served, or stored.

B. If a swimming pool is located on the premises, an administrator shall ensure that:

1. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (B)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and
2. A life preserver or shepherd's crook is available and accessible in the pool area.

C. An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (B)(1) is covered and locked when not in use.

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Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-426 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-427. Quality Rating

- A. As required in A.R.S. § 36-425.02(A), the Department shall issue a quality rating to each licensed nursing care institution based on the results of a compliance inspection.
 - B. The following quality ratings are established:
 1. A quality rating of "A" for excellent is issued if the nursing care institution achieves a score of 90 to 100 points,
 2. A quality rating of "B" is issued if the nursing care institution achieves a score of 80 to 89 points,
 3. A quality rating of "C" is issued if the nursing care institution achieves a score of 70 to 79 points, and
 4. A quality rating of "D" is issued if the nursing care institution achieves a score of 69 or fewer points.
 - C. The quality rating is determined by the total number of points awarded based on the following criteria:
 1. Nursing Services:
 - a. 15 points: The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.
 - b. 5 points: The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.
 - c. 5 points: The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.
 2. Resident Rights:
 - a. 10 points: The nursing care institution is implementing a system that ensures a resident's privacy needs are met.
 - b. 10 points: The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.
 - c. 5 points: The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.
 3. Administration:
 - a. 10 points: The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last compliance inspection or a complaint investigation conducted between the last compliance inspection and the current compliance inspection.
 4. Environment and Infection Control:
 - a. 5 points: The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.
 - b. 1 point: The nursing care institution establishes and maintains a pest control program that complies with A.A.C. R3-8-201(C)(4).
 - c. 1 point: The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.
 - d. 1 point: The nursing care institution ensures orientation to the disaster plan for each personnel member is completed within the first scheduled week of employment.
 - e. 1 point: The nursing care institution maintains a clean and sanitary environment.
 - f. 5 points: The nursing care institution is implementing a system to prevent and control infection.
 - g. 1 point: An employee cleans the employee's hands after each direct resident contact or when hand cleaning is indicated to prevent the spread of infection.
 5. Food Services:
 - a. 1 point: The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license.
 - b. 3 points: The nursing care institution provides each resident with food that meets the resident's needs as
- b. 5 points: The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Department and as required by A.R.S. § 46-454.
- c. 5 points: The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.
- d. 1 point: The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.
- e. 1 point: The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.
- f. 2 points: The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.
- g. 1 point: The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.

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specified in the resident's comprehensive assessment and care plan.

- c. 2 points: The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs.
- d. 2 points: The nursing care institution provides assistance to a resident who needs help in eating so that the resident's nutritional, physical, and social needs are met.
- e. 1 point: The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.
- f. 1 point: The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.

- D. A nursing care institution's quality rating remains in effect until a subsequent compliance inspection or complaint investigation is conducted by the Department except as provided in subsection (E).
- E. If the Department issues a provisional license, the current quality rating is terminated. A provisional licensee may submit an application for a substantial compliance inspection. If the Department determines that, as a result of a substantial compliance inspection, the nursing care institution is in substantial compliance, the Department shall issue a new quality rating according to subsection (C).
- F. The issuance of a quality rating does not preclude the Department from seeking a civil penalty as provided in A.R.S. § 36-431.01, or suspension or revocation of a license as provided in A.R.S. § 36-427.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2). New Section R9-10-427 made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3334, effective October 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-428. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-429. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-430. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-431. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-432. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-433. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-434. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-435. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-436. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-437. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-438. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1). Section repealed by final rulemaking at 8 A.A.R. 2785, effective October 1, 2002 (Supp. 02-2).

R9-10-439. Repealed**Historical Note**

Adopted effective January 28, 1980 (Supp. 80-1).
Repealed effective October 30, 1989 (Supp. 89-4).

ARTICLE 5. INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES**R9-10-501. Definitions**

In addition to the definitions in A.R.S. §§ 36-401 and 36-551 and R9-10-101, the following definitions apply in this Article unless otherwise specified:

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1. "Active treatment" means rehabilitative services and habilitation services provided to a resident to address the resident's developmental disability and, if applicable, medical condition.
2. "Acuity" means a resident's need for medical services, nursing services, rehabilitative services, or habilitation services based on the patient's medical condition or developmental disability.
3. "Acuity plan" means a method for establishing requirements for nursing personnel or therapists by unit based on a resident's acuity.
4. "Advocate" means an individual who:
 - a. Assists a resident or the resident's representative to make the resident's wants and needs known,
 - b. Recommends a course of action to address the resident's wants and needs, and
 - c. Supports the resident or the resident's representative in addressing the resident's wants and needs.
5. "Assistive device" means a piece of equipment or mechanism that is designed to enable an individual to better carry out activities of daily living.
6. "Dental services" means activities, methods, and procedures included in the practice of dentistry, as described in A.R.S. § 32-1202.
7. "Direct care" means medical services, nursing services, rehabilitation services, or habilitation services provided to a resident.
8. "ICF/IID" means intermediate care facility for individuals with intellectual disabilities.
9. "Inappropriate behavior" means actions by a resident that may:
 - a. Put the resident at risk for physical illness or injury,
 - b. Significantly interfere with the resident's care,
 - c. Significantly interfere with the resident's ability to participate in activities or social interactions,
 - d. Put other residents or personnel members at significant risk for physical injury,
 - e. Significantly intrude on another resident's privacy, or
 - f. Significantly disrupt care for another resident.
10. "Medical care plan" means a documented guide for providing medical services and nursing services to a resident requiring continuous nursing services that includes measurable objectives and the methods for meeting the objectives.
11. "Nursing care plan" means a documented guide for providing intermittent nursing services to a resident that includes measurable objectives and the methods for meeting the objectives.
12. "Outing" means a social or recreational activity or habilitation services that:
 - a. Occur away from the premises, and
 - b. May be part of a resident's individual program plan.
13. "Qualified intellectual disabilities professional" means one of the following who has at least a bachelor's degree and one year of experience working directly with individuals who have developmental disabilities, consistent with the requirements in 42 CFR 483.430:
 - a. A physician;
 - b. A registered nurse;
 - c. A physical therapist;
 - d. An occupational therapist;
 - e. A psychologist, as defined in A.R.S. § 32-2061;
 - f. A speech-language pathologist;
 - g. An audiologist, as defined in A.R.S. § 36-1901;
 - h. A registered dietitian, as defined in A.R.S. § 36-416;
 - i. A licensed clinical social worker under A.R.S. § 32-3293; or
 - j. A nursing care institution administrator.
14. "Resident's representative" has the same meaning as "responsible person" in A.R.S. § 36-551.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency expired. Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-501 renumbered to R9-10-2101; new Section R9-10-501 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-502. Supplemental Application Requirements and Documentation Submission Requirements

- A. In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as an ICF/IID shall include:
 1. In a Department-provided format, whether the applicant is requesting authorization:
 - a. To admit residents who:
 - i. Require continuous nursing services,
 - ii. Require intermittent nursing services, or
 - iii. Do not require nursing services; and
 - b. To provide:
 - i. Active treatment to individuals under 18 years of age, including the licensed capacity requested;
 - ii. Seclusion;
 - iii. Clinical laboratory services;
 - iv. Respiratory care services, or
 - v. Services to residents who have a nursing care plan or medical care plan; and
 2. Documentation of the applicant's certification as an ICF/IID by the federal Centers for Medicare and Medicaid Services.
- B. A licensee shall submit to the Department, with the relevant fees required in R9-10-106(C) and in a Department-provided format:

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1. The information required in subsection (A)(1), as applicable, and
2. The documentation specified in subsection (A)(2).

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-502 renumbered to R9-10-2102; new Section R9-10-502 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4).

R9-10-503. Administration**A. A governing authority shall:**

1. Consist of one or more individuals responsible for the organization, operation, and administration of an ICF/IID;
2. Establish, in writing, the ICF/IID's scope of services;
3. Designate, in writing, an administrator for the ICF/IID who:
 - a. Is at least 21 years old; and
 - b. Either:
 - i. Is a nursing care institution administrator, or
 - ii. Has a minimum of three-years' experience working in an ICF/IID;
4. Adopt a quality management program according to R9-10-504;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who meets the requirements in subsection (A)(3), if the administrator is:
 - a. Expected not to be present on the premises of the ICF/IID for more than 30 calendar days, or
 - b. Not present on the premises of the ICF/IID for more than 30 calendar days; and
7. Except as permitted in subsection (A)(6), when there is a change of administrator, notify the Department according to A.R.S. § 36-425(I) and, if applicable, submit a copy of the new administrator's license under A.R.S. § 36-446.04 to the Department.

B. An administrator:

1. Is directly accountable to the governing authority of an ICF/IID for the daily operation of the ICF/IID and all services provided by or at the ICF/IID;
2. Has the authority and responsibility to manage the ICF/IID;

3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the premises of the ICF/IID and accountable for the ICF/IID when the administrator is not present on the ICF/IID's premises; and
 4. Ensures the ICF/IID's compliance with A.R.S. § 36-411 and, as applicable, A.R.S. § 8-804 or § 46-459.
- C. An administrator shall ensure that:**
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover the process for checking on a personnel member through the adult protective services registry established according to A.R.S. § 46-459;
 - c. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - d. Include methods to prevent abuse or neglect of a resident, including:
 - i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
 - ii. Reporting of abuse or neglect of a resident;
 - e. Include how a personnel member may submit a complaint relating to resident care;
 - f. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - g. Cover cardiopulmonary resuscitation training including:
 - i. Which personnel members are required to obtain cardiopulmonary resuscitation training,
 - ii. The method and content of cardiopulmonary resuscitation training,
 - iii. The qualifications for an individual to provide cardiopulmonary resuscitation training,
 - iv. The time-frame for renewal of cardiopulmonary resuscitation training, and
 - v. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
 - h. Cover first aid training;
 - i. Include a method to identify a resident to ensure the resident receives active treatment and other physical health services and behavioral care as ordered;
 - j. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;
 - k. Cover specific steps for:
 - i. A resident to file a complaint, and
 - ii. The ICF/IID to respond to a resident's complaint;
 - l. Cover health care directives;
 - m. Cover medical records, including electronic medical records;
 - n. Cover a quality management program, including incident reports and supporting documentation;
 - o. Cover contracted services;
 - p. Cover the process for receiving a fee for a resident and refunding a fee for a resident;
 - q. Cover resident's personal accounts;

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- r. Cover petty cash funds;
 - s. Cover fees and refund policies;
 - t. Cover smoking and the use of tobacco products on the premises; and
 - u. Cover when an individual may visit a resident in an ICF/IID; and
2. Policies and procedures for active treatment and other physical health services and behavioral care are established, documented, and implemented to protect the health and safety of a resident that:
- a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;
 - b. Cover the provision of active treatment and other physical health services and behavioral care;
 - c. Cover acuity, including a process for obtaining sufficient nursing personnel and therapists to meet the needs of residents;
 - d. Include when general consent and informed consent are required;
 - e. Cover storing, dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
 - f. Cover infection control;
 - g. Cover interventions to address a resident's inappropriate behavior, including:
 - i. The hierarchy for use;
 - ii. Use of time outs for inappropriate behavior; and
 - iii. Except in an emergency, require positive techniques for behavior modification to be used before more restrictive methods are used;
 - h. Cover restraints, both chemical restraints and physical restraints if applicable, that:
 - i. Require an order, including the frequency of monitoring and assessing the restraint; and
 - ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a resident's sudden, intense, or out-of-control behavior;
 - i. Cover seclusion of a resident including:
 - i. The requirements for an order, and
 - ii. The frequency of monitoring and assessing a resident in seclusion;
 - j. Cover telehealth, if applicable;
 - k. Cover environmental services that affect resident care;
 - l. Cover the security of a resident's possessions that are allowed on the premises;
 - m. Cover methods to encourage participation of a resident's family or friends or other individuals in activities planned according to R9-10-513(C)(2);
 - n. Include a method for obtaining an advocate for a resident, if necessary;
 - o. Cover resident outings;
 - p. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks; and
 - q. Cover whether pets and 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 residents or the public;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
- a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of an ICF/IID, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the ICF/IID.
- D.** An administrator shall designate an individual who is:
- 1. A qualified intellectual disabilities professional to oversee rehabilitation services provided by or on behalf of the ICF/IID; and
 - 2. If the facility is authorized to admit patients who require intermittent nursing services or continuous nursing services, a registered nurse is appointed as director of nursing to oversee nursing services provided by or on behalf of the ICF/IID.
- E.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from an ICF/IID's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
- 1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - 2. For a resident under 18 years of age, according to A.R.S. § 13-3620.
- F.** If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from an ICF/IID's employee or personnel member, an administrator shall:
- 1. Take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the resident as follows:
 - a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
 - c. Report to the Department:
 - i. Immediately but not later than two hours if the alleged violation involves abuse or results in serious bodily injury; or
 - ii. Not later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 - 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 - 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):

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- a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- G.** An administrator shall:
- 1. Allow a resident advocate to assist a resident or the resident's representative with a request or recommendation, and document in writing any complaint submitted to the ICF/IID;
 - 2. Ensure that a monthly schedule of recreational activities for residents is developed, documented, and implemented; and
 - 3. Ensure that the following are conspicuously posted on the premises:
 - a. The current ICF/IID license issued by the Department;
 - b. The name, address, and telephone number of:
 - i. The Department's Office of Long Term Care, and
 - ii. Adult Protective Services of the Department of Economic Security;
 - c. A notice that a resident may file a complaint with the Department concerning the ICF/IID;
 - d. The monthly schedule of recreational activities; and
 - e. One of the following:
 - i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect; or
 - ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.
- H.** An administrator shall provide written notification to the Department of a resident's:
- 1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
 - 2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- I.** An administrator shall:
- 1. Notify a resident's representative, family member, or other individual designated by the resident immediately, with no delay between staff awareness of the occurrence and reporting unless the situation is unstable in which case reporting should occur as soon as the safety of the resident is assured, after:
 - a. The resident's death,
 - b. There is a significant change in the resident's medical condition, or
 - c. The resident has an illness or injury that requires immediate intervention by an emergency medical services provider or treatment by a health care provider; and
 - 2. For an illness or injury in subsection (I)(1)(c), document the following:
 - a. The date and time of the illness or injury;
 - b. A description of the illness or injury;
 - c. If applicable, the names of individuals who observed the injury;
 - d. The actions taken by personnel members, according to policies and procedures;
 - e. The individuals notified by the personnel members; and
 - f. Any action taken to prevent the illness or injury from occurring in the future.
- J.** If an administrator administers a resident's personal account at the request of the resident or the resident's representative, the administrator shall:
- 1. Comply with policies and procedures established according to subsection (C)(1)(q);
 - 2. Designate a personnel member who is responsible for the personal accounts;
 - 3. Maintain a complete and separate accounting of each personal account;
 - 4. Obtain written authorization from the resident or the resident's representative for a personal account transaction;
 - 5. Document an account transaction and provide a copy of the documentation to the resident or the resident's representative upon request and at least every three months;
 - 6. Transfer all money from the resident's personal account in excess of \$50.00 to an interest-bearing account and credit the interest to the resident's personal account; and
 - 7. Within 30 calendar days after the resident's death, transfer, or discharge, return all money in the resident's personal account and a final accounting to the resident, the resident's representative, or the probate jurisdiction administering the resident's estate.
- K.** If a petty cash fund is established for use by residents, the administrator shall ensure that:
- 1. The policies and procedures established according to subsection (C)(1)(r) include:
 - a. A prescribed cash limit of the petty cash fund, and
 - b. The hours of the day a resident may access the petty cash fund; and
 - 2. A resident's written acknowledgment is obtained for a petty cash transaction.
- L.** An administrator shall ensure that an acuity plan is developed, documented, and implemented for each unit in the ICF/IID that:
- 1. Includes:
 - a. A method that establishes the types and numbers of personnel members that are required for each unit in the ICF/IID to ensure resident health and safety, and
 - b. A policy and procedure stating the steps the ICF/IID will take to obtain or assign the necessary personnel members to address resident acuity;
 - 2. Is used when making assignments for resident treatment; and
 - 3. Is reviewed and updated, as necessary, at least once every 12 months.
- M.** An administrator shall establish and document the criteria for determining when a resident's absence is unauthorized, including the criteria for a resident who:

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1. Is absent against medical advice,
 2. Is under the age of 18, or
 3. Does not return to the ICF/IID at the expected time after an authorized absence.
- N. An administrator shall ensure that the following are on the premises of the ICF/IID:
1. The most recent inspection report of the ICF/IID conducted by the Arizona Department of Economic Security under A.R.S. § 36-557(G)(1), and
 2. Documentation of the most recent monitoring of the ICF/IID conducted by the Arizona Department of Economic Security under A.R.S. § 36-557(G)(2).

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-503 renumbered to R9-10-2103; new Section R9-10-503 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-504. 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 services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident 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 resident 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 resident care; and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and

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

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-504 renumbered to R9-10-2104; new Section R9-10-504 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-505. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-505 renumbered to R9-10-2105; new Section R9-10-505 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-506. Personnel

A. An administrator shall ensure that:

1. A personnel member is:
 - a. At least 21 years old, or
 - b. At least 18 years old and is licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice;

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2. An employee is at least 18 years old;
 3. A student is at least 18 years old; and
 4. A volunteer is at least 21 years old.
- B.** An administrator shall ensure that:
1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of active treatment or other physical health services or behavioral care expected to be provided by the personnel member according to the established job description; and
 - ii. The acuity of the residents receiving active treatment or other physical health services or behavioral care from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected active treatment or other physical health services and behavioral care listed in the established job description;
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected active treatment or other physical health services or behavioral care listed in the established job description; and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected active treatment or other physical health services or behavioral care listed in the established job description;
 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides active treatment or other physical health services or behavioral care; and
 - b. According to policies and procedures; and
 3. Sufficient personnel members are present on an ICF/IID's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the ICF/IID's scope of services;
 - b. Meet the needs of a resident; and
 - c. Ensure the health and safety of a resident.
- C.** An administrator shall ensure that an organizational chart of the ICF/IID is established, updated as necessary, and maintained on the premises:
1. Outlining the roles, responsibilities, and relationships within the ICF/IID; and
 2. Including the name and, if applicable, the license or certification credential of each individual shown on the organizational chart.
- D.** An administrator shall ensure that, if a personnel member provides services that require a license under A.R.S. Title 32 or 36, the personnel member is licensed under A.R.S. Title 32 or 36, as applicable.
- E.** An administrator shall ensure that an individual who is a licensed 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 4 A.A.C. 6, Article 1.
- F.** An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the ICF/IID; and
 2. As specified in R9-10-113.
- G.** An administrator shall ensure that:
1. The types and numbers of nurses or therapists required according to the acuity plan in R9-10-503(L) are present in each unit in the ICF/IID;
 2. Documentation of the nurses or therapists present on the ICF/IID's premises each day is maintained and includes:
 - a. The date;
 - b. The number of residents;
 - c. The name, license or certification credential, and assigned duties of each nurse or therapist who worked that day; and
 - d. The actual number of hours each nurse or therapist worked that day; and
 3. The documentation of nurses or therapists required in subsection (G)(2) is maintained for at least 12 months after the date of the documentation.
- H.** An administrator shall ensure that a personnel member is:
1. On duty, on the premises, awake, and able to respond, according to policies and procedures, to injuries, symptoms of illness, or fire or other emergencies on the premises if the ICF/IID provides services to:
 - a. More than 16 residents;
 - b. A resident who has a nursing care plan or medical care plan; or
 - c. A resident who requires additional supervision because the resident:
 - i. Is aggressive;
 - ii. May cause harm to self or others; or
 - iii. May attempt an unauthorized absence; and
 2. On duty, on the premises, and able to respond, according to policies and procedures, to injuries, symptoms of illness, or fire or other emergencies on the premises if:
 - a. The ICF/IID provides services to 16 or fewer residents; and
 - b. None of the residents has a nursing care plan or medical care plan or requires additional supervision according to subsection (H)(1)(c).
- I.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's compliance with the requirements in A.R.S. § 36-411;
 - d. The ICF/IID's check on the individual in the adult protective services registry established according to A.R.S. § 46-459;

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- e. Orientation and in-service education as required by policies and procedures;
 - f. Training in preventing, recognizing, and reporting abuse or neglect, required according to R9-10-503(C)(1)(d)(i);
 - g. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - h. The individual's qualifications and on-going training for each type of restraint or seclusion used, as required in R9-10-515;
 - i. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-503(C)(1)(g);
 - j. First aid training, if required for the individual according to this Article or policies and procedures; and
 - k. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).
- J.** An administrator shall ensure that personnel records are:
- 1. Maintained:
 - a. Throughout the individual's period of providing services in or for the ICF/IID, and
 - b. For at least 24 months after the last date the individual provided services in or for the ICF/IID; and
 - 2. For a personnel member who has not provided active treatment or other physical health services or behavioral care at or for the ICF/IID during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- K.** An administrator shall ensure that:
- 1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
 - 2. A personnel member completes orientation before providing active treatment or other physical health services or behavioral care;
 - 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 - 4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;
 - 5. A personnel member's in-service education 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; and
 - 6. A work schedule of each personnel member is developed and maintained at the ICF/IID for at least 12 months after the date of the work schedule.
- L.** An administrator shall designate a qualified individual to provide:
- 1. Social services, and
 - 2. Recreational activities.
- M.** An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pur-

suant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-506 renumbered to R9-10-2106; new Section R9-10-506 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Section R9-10-506 renumbered to R9-10-2106; new Section R9-10-506 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-507. Admission

An administrator shall ensure that:

- 1. A resident is admitted only:
 - a. On a physician's order;
 - b. If the resident has a developmental disability or cognitive disability, as defined in A.R.S. § 36-551;
 - c. If the resident's placement evaluation indicates that the resident's needs can be met by the ICF/IID; and
 - d. Except when the resident's placement evaluation states that the resident would benefit from being part of a group that includes residents of different ages, developmental levels, or social needs, if the resident can be assigned to a room or unit within the ICF/IID with other residents of similar ages, developmental levels, or social needs;
- 2. The physician's admitting order or placement evaluation documentation includes the active treatment or other physical health services or behavioral care required to meet the immediate needs of a resident, such as habilitation services, medication, and food services;
- 3. At the time of a resident's admission, a registered nurse conducts or coordinates an initial assessment of a resident to determine the resident's acuity and ensure the resident's immediate needs are met;
- 4. A resident's needs do not exceed the medical services, rehabilitation services, and nursing services available at the ICF/IID as established in the ICF/IID's scope of services;
- 5. A resident is assigned to a unit in the ICF/IID based, as applicable, on the patient's:
 - a. Documented diagnosis,
 - b. Treatment needs,
 - c. Developmental level,
 - d. Social skills,
 - e. Verbal skills, and
 - f. Acuity;
- 6. A resident does not share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that, based on the other resident's documented diagnosis, treatment needs, developmental

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- level, social skills, verbal skills, and personal history, may present a threat to the resident's health and safety;
7. Within 30 calendar days before admission or 10 working days after admission, a medical history and physical examination is completed on a resident by:
 - a. A physician, or
 - b. A physician assistant or a registered nurse practitioner designated by the attending physician;
 8. Compliance with the requirements in subsection (7) is documented in the resident's medical record;
 9. Except as specified in subsection (10), a resident provides evidence of freedom from infectious tuberculosis:
 - a. Before or within seven calendar days after the resident's admission, and
 - b. As specified in R9-10-113; and
 10. A resident who transfers from an ICF/IID or nursing care institution to the ICF/IID is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
 - a. Fewer than 12 months have passed since the resident was screened for tuberculosis, and
 - b. The documentation of freedom from infectious tuberculosis required in subsection (9) accompanies the resident at the time of transfer.
- b. The reason for the transfer or discharge;
 - c. A 30-day written notice except:
 - i. In an emergency, or
 - ii. If the resident no longer requires rehabilitation services or habilitation services as determined by a physician or the physician's designee;
 - d. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1); and
 - e. If applicable, actions taken by a personnel member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the ICF/IID and beyond the ICF/IID's scope of services.
- B.** Except for a transfer of a resident due to an emergency, an administrator shall ensure that:
1. A qualified intellectual disabilities professional or, if the resident has a nursing care plan or medical care plan, a registered nurse coordinates the transfer and the services provided to the resident;
 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains the risks and benefits of the transfer to the resident or the resident's representative; and
 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transfer.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-507 renumbered to R9-10-2107; new Section R9-10-507 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-508. Transfer; Discharge

- A.** An administrator, in coordination with the Arizona Department of Economic Security, Division of Developmental Disabilities, shall ensure that:
1. A resident is transferred or discharged if:
 - a. The ICF/IID is not authorized or not able to meet the needs of the resident, or
 - b. The resident's behavior is a threat to the health or safety of the resident or other individuals at the ICF/IID; and
 2. Documentation of a resident's transfer or discharge includes:
 - a. The date of the transfer or discharge;
- b. The reason for the transfer or discharge;
 - c. A 30-day written notice except:
 - i. In an emergency, or
 - ii. If the resident no longer requires rehabilitation services or habilitation services as determined by a physician or the physician's designee;
 - d. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1); and
 - e. If applicable, actions taken by a personnel member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the ICF/IID and beyond the ICF/IID's scope of services.
- B.** Except in an emergency, a qualified intellectual disabilities professional or, if the resident has a nursing care plan or medical care plan, a registered nurse shall ensure that before a resident is discharged:
1. Written follow-up instructions are developed with the resident or the resident's representative that include:
 - a. Information necessary to meet the resident's need for medical services and nursing services; and
 - b. The state long-term care ombudsman's name, address, and telephone number;
 2. A copy of the written follow-up instructions is provided to the resident or the resident's representative; and
 3. A discharge summary:
 - a. Is developed by a qualified intellectual disabilities professional or, if the resident has a nursing care plan or medical care plan, a registered nurse;
 - b. Authenticated by the resident's attending physician or designee; and
 - c. Includes:
 - i. The resident's need for rehabilitation services or habilitation services at the time of transfer or discharge;
 - ii. The resident's need for medical services or nursing services;
 - iii. The resident's developmental, behavioral, social, and nutritional status;

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- iv. The resident's medical and psychosocial history;
- v. The date of the discharge; and
- vi. The location of the resident after discharge.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2).

Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-508 renumbered to R9-10-2108; new Section R9-10-508 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-509. Transport

- A.** Except as provided in subsections (B) and (C), an administrator shall ensure that:
 - 1. A personnel member authorized by policies and procedures coordinates the transport and the services provided to the resident;
 - 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport,
 - b. Information from the resident's medical record is provided to a receiving health care institution, and
 - c. A personnel member explains the risks and benefits of the transport to the resident or the resident's representative; and
 - 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transport.
- B.** If the transport of a resident is to provide the resident with rehabilitation services or habilitation services off the premises, an administrator shall ensure that:
 - 1. The rehabilitation services or habilitation services are included in the resident's individual program plan,
 - 2. A qualified intellectual disabilities professional coordinates the transport and the services provided to the resident, and
 - 3. The resident is transported according to R9-10-510(A).
- C.** Subsection (A) does not apply to:

- 1. Except as provided in subsection (B), transportation according to R9-10-510 to a location other than a licensed health care institution;
- 2. Transportation provided for a resident by the resident or the resident's representative;
- 3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative; or
- 4. A transport to another licensed health care institution in an emergency.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-509 renumbered to R9-10-2109; new Section R9-10-509 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-510. Transportation; Resident Outings

- A.** An administrator of an ICF/IID that uses a vehicle owned or leased by the ICF/IID to provide transportation to a resident shall ensure that:
 - 1. The vehicle:
 - a. Is safe and in good repair,
 - b. Contains a first aid kit,
 - c. Contains drinking water sufficient to meet the needs of each resident present in the vehicle, and
 - d. Contains a working heating and air conditioning system;
 - 2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
 - 3. A driver of the vehicle:
 - a. Is 21 years of age or older;
 - b. Has a valid driver license;
 - c. Operates the vehicle in a manner that does not endanger a resident in the vehicle;
 - d. Does not leave in the vehicle an unattended:
 - i. Child;
 - ii. Resident who may be a threat to the health, safety, or welfare of the resident or another individual; or
 - iii. Resident who is incapable of independent exit from the vehicle; and
 - e. Ensures the safe and hazard-free loading and unloading of residents; and

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4. Transportation safety is maintained as follows:
 - a. An individual in the vehicle is sitting in a seat, which may include the seat of a wheel chair, and wearing a working seat belt while the vehicle is in motion; and
 - b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a resident's body.
- B. An administrator shall ensure that an outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each resident participating in the outing.
- C. An administrator shall ensure that:
 1. Except when only one resident is participating in an outing, at least two personnel members are present on the outing;
 2. In addition to the personnel members required in subsection (C)(1), a sufficient number of personnel members are present on an outing to ensure the health and safety of a resident on the outing;
 3. Each personnel member on the outing has documentation of current training in cardiopulmonary resuscitation according to R9-10-503(C)(1)(g) and first aid training according to R9-10-503(C)(1)(h);
 4. Documentation is developed before an outing that includes:
 - a. The name of each resident 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 a vehicle used to provide transportation for the outing;
 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 a resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
 - a. The resident's name;
 - b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
 - c. The resident's allergies; and
 - d. The name and telephone number of a designated individual, who is present on the ICF/IID's premises, to notify in case of an emergency.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent

rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-510 renumbered to R9-10-2110; new Section R9-10-510 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-511. Resident Rights

- A. An administrator shall ensure that:
 1. The requirements in subsection (B) and the resident rights in subsection (C) are conspicuously posted on the premises;
 2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C); and
 3. Policies and procedures include:
 - a. How and when a resident or the resident's representative is informed of resident rights in subsection (C), and
 - b. Where resident rights are posted as required in subsection (A)(1).
- B. An administrator shall ensure that:
 1. A resident has privacy in:
 - a. Treatment,
 - b. Bathing and toileting,
 - c. Room accommodations, and
 - d. Visiting or meeting with another resident or an individual;
 2. A resident is treated with dignity, respect, and consideration;
 3. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Except as allowed in R9-10-515, seclusion or restraint;
 - i. Retaliation for submitting a complaint to the Department or another entity;
 - j. Misappropriation of personal and private property by an ICF/IID's personnel members, employees, volunteers, or students; or
 - k. Segregation solely based on the resident's disability; and
 4. A resident or the resident's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed alternatives to psychotropic medication and the

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- associated risks and possible complications of the psychotropic medication;
- d. Is informed of the following:
 - i. The health care institution's policy on health care directives, and
 - ii. The resident complaint process;
 - e. Consents to photographs of the resident before the resident is photographed, except that the resident may be photographed when admitted to an ICF/IID for identification and administrative purposes;
 - f. May manage the resident's financial affairs;
 - g. Has access to and may communicate with any individual, organization, or agency;
 - h. Except as provided in the resident's individual program plan, has privacy:
 - i. In interactions with other residents or visitors to the ICF/IID,
 - ii. In the resident's mail, and
 - iii. For telephone calls made by or to the resident;
 - i. May review the ICF/IID's current license survey report and, if applicable, plan of correction in effect;
 - j. May review the resident's financial records within two working days and medical records within one working day after the resident's or the resident's representative's request;
 - k. May obtain a copy of the resident's financial records and medical records within two working days after the resident's request and in compliance with A.R.S. § 12-2295;
 - l. Except as otherwise permitted by law, consents, in writing, to the release of information in the resident's:
 - i. Medical record, and
 - ii. Financial records;
 - m. May select a pharmacy of choice if the pharmacy complies with policies and procedures and does not pose a risk to the resident;
 - n. Is informed of the method for contacting the resident's attending physician;
 - o. Is informed of the resident's overall physical and psychosocial well-being, as determined by the resident's comprehensive assessment;
 - p. Is provided with a copy of those sections of the resident's medical record that are required for continuity of care free of charge, according to A.R.S. § 12-2295, if the resident is transferred or discharged; and
 - q. Except in the event of an emergency, is informed orally or in writing before the ICF/IID makes a change in a resident's room or roommate assignment and notification is documented in the resident's medical record.
- C. In addition to the rights in A.R.S. § 36-551.01, a resident has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;
 3. To choose activities and schedules consistent with the resident's interests that do not interfere with other residents;
 4. To participate in social, religious, political, and community activities that do not interfere with other residents;

5. To retain personal possessions including furnishings and clothing as space permits unless the use of the personal possession infringes on the rights or health and safety of other residents;
6. To share a room with the resident's spouse if space is available and the spouse consents;
7. To receive a referral to another health care institution if the ICF/IID is not authorized or not able to provide active treatment or other physical health services or behavioral care needed by the resident;
8. To participate or have the resident's representative participate in the development of the resident's individual program plan or decisions concerning treatment;
9. To participate or refuse to participate in research or experimental treatment; and
10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

Historical Note

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R9-10-512. Medical Records

- A. An administrator shall ensure that:
1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
 2. An entry in a resident's medical record is:
 - a. Recorded only by an individual authorized by 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 resident's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signa-

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- ture the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A resident's medical record is available to an individual:
 - a. Authorized to access the resident's medical record according to policies and procedures;
 - b. If the individual is not authorized to access the resident's medical record according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law; and
 6. A resident's medical record is protected from loss, damage, or unauthorized use.
- B.** If an ICF/IID maintains residents' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a resident's medical record contains:
1. Resident information that includes:
 - a. The resident's name;
 - b. The resident's date of birth; and
 - c. Any known allergies, including medication allergies;
 2. The admission date and, if applicable, the date of discharge;
 3. The admitting diagnosis or presenting symptoms;
 4. Documentation of the resident's placement evaluation;
 5. Documentation of general consent and, if applicable, informed consent;
 6. If applicable, the name and contact information of the resident's representative and:
 - a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 7. The name and contact information of the resident's representative, family member, or other individual designated by the resident;
 8. Documentation of the initial assessment required in R9-10-507(3) to determine acuity;
 9. The medical history and physical examination required in R9-10-516(A)(4);
 10. A copy of the resident's living will or other health care directive, if applicable;
 11. The name and telephone number of the resident's attending physician;
 12. Orders;
 13. Documentation of the resident's comprehensive assessment;
 14. Individual program plans, including nursing care plans or medical care plans, if applicable;
 15. Documentation of active treatment and other physical health services or behavioral care provided to the resident;
 16. Progress notes, including data needed to evaluate the effectiveness of the methods, schedule, and strategies being used to accomplish the goals in the resident's individual program plan;
 17. If applicable, documentation of restraint or seclusion;
 18. If applicable, documentation of any actions other than restraint or seclusion taken to control or address the resident's behavior to prevent harm to the resident or another individual or to improve the resident's social interactions;
 19. If applicable, documentation that evacuation from the ICF/IID would cause harm to the resident;
 20. The disposition of the resident after discharge;
 21. Transfer documentation;
 22. The discharge plan and summary;
 23. If applicable:
 - a. A laboratory report,
 - b. A radiologic report,
 - c. A diagnostic report, and
 - d. A consultation report;
 24. Documentation of freedom from infectious tuberculosis required in R9-10-507(9);
 25. Documentation of a medication administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. The type of vaccine, if applicable;
 - d. For a medication administered for pain on a PRN basis:
 - i. An evaluation of the resident's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - e. For a psychotropic medication administered on a PRN basis:
 - i. An evaluation of the resident's symptoms before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - f. The identification, signature, and professional designation of the individual administering the medication; and
 - g. Any adverse reaction a resident has to the medication; and
 26. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended

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by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-512 renumbered to R9-10-2112; new Section R9-10-512 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-513. Rehabilitation Services and Habilitation Services

A. Except as provided in subsection (D), an administrator shall ensure that:

1. Personnel members are available to provide the following rehabilitation services:
 - a. Physical therapy, as defined in A.R.S. § 32-2001;
 - b. Occupational therapy, A.R.S. § 32-3401;
 - c. Psychological service, as defined in A.R.S. § 32-2061;
 - d. Speech-language pathology, as defined in A.R.S. § 36-1901; and
 - e. Audiology, as defined in A.R.S. § 36-1901;
2. Rehabilitation services are provided:
 - a. Under the direction of a qualified intellectual disabilities professional according to policies and procedures, and
 - b. According to an order;
3. A resident receives the rehabilitation services required in the resident's individual program plan;
4. Unless otherwise required in the resident's individual program plan:
 - a. A resident does not remain in bed or in the resident's bedroom;
 - b. If the resident is not able to independently move from place to place, even with the use of an assistive device, the resident is moved from place to place in the ICF/IID; and
 - c. A resident receiving rehabilitation services is encouraged to participate in activities that are planned according to subsection (C)(2) and are appropriate to objectives in the resident's individual program plan;
5. A qualified intellectual disabilities professional reviews the rehabilitation services provided to a resident and revises the frequency, duration, method, or type of rehabilitation services being provided in the resident's individual program plan:
 - a. As necessary, if the resident is losing skills or failing to progress; or
 - b. If a goal in the resident's individual program plan has been accomplished and a new objective is to be initiated; and
6. The medical record of a resident receiving rehabilitation services includes:
 - a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis;
 - b. The resident's individual program plan, including all updates;
 - c. The rehabilitation services provided;
 - d. The resident's response to the rehabilitation services; and

e. The authentication of the individual providing the rehabilitation services.

B. Except as provided in subsection (D), an administrator shall ensure that:

1. Personnel members are available to provide a resident with habilitation services required in the resident's individual program plan;
2. A personnel member is only assigned to provide the habilitation services the personnel member has the documented skills and knowledge to perform;
3. A resident receives the habilitation services in the resident's individual program plan;
4. If applicable, a personnel member:
 - a. Suggests techniques a resident may use to maintain or improve the resident's independence in performing activities of daily living; and
 - b. Provides assistance with, supervises, or directs a resident's personal hygiene according to the resident's individual program plan;
5. A resident receiving habilitation services is encouraged to participate in activities of the resident's choosing that are planned according to subsection (C)(2); and
6. The medical record of a resident receiving habilitation services includes:
 - a. The resident's individual program plan, including all updates;
 - b. The habilitation services provided;
 - c. The resident's response to the habilitation services; and
 - d. The authentication of the individual providing the habilitation services.

C. An administrator shall ensure that:

1. Multiple media sources, such as daily newspapers, current magazines, internet sources, and a variety of reading materials, are available and accessible to a resident to maintain the resident's continued awareness of current news, social events, and other noteworthy information;
2. Daily social or recreational activities are planned according to residents' preferences, needs, and abilities;
3. A calendar of planned activities is:
 - a. Prepared at least one week in advance of the date the activity is provided,
 - b. Posted in a location that is easily seen by residents,
 - c. Updated as necessary to reflect substitutions in the activities provided, and
 - d. Maintained for at least 12 months after the last scheduled activity;
4. Equipment and supplies are available and accessible to accommodate a resident who chooses to participate in a planned activity on the premises;
5. Outings are provided according to R9-10-510(B) and (C); and
6. If necessary and unless otherwise required in the resident's individual program plan, a resident is assisted to participate in outings and other opportunities to leave the premises of the ICF/IID.

D. An administrator is not required to ensure that personnel members providing rehabilitation services or habilitation services are on the premises if no resident of the ICF/IID is on the premises because the residents are:

1. Receiving rehabilitation services off the premises,
2. Receiving habilitation services off the premises,
3. Participating in an outing, or
4. Otherwise absent from the ICF/IID.

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Historical Note

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R9-10-514. Individual Program Plan

A. An administrator shall ensure that:

1. A comprehensive assessment of a resident:
 - a. Is conducted or coordinated by a qualified intellectual disabilities professional, in collaboration with an interdisciplinary team that includes:
 - i. The resident's attending physician or designee;
 - ii. A registered nurse;
 - iii. If the resident is receiving medications as part of active treatment, a pharmacist; and
 - iv. Personnel members qualified to provide each type of rehabilitation services identified in a placement evaluation or the initial assessment required in R9-10-507(3);
 - b. Is completed for the resident within 30 calendar days after the resident's admission to an ICF/IID;
 - c. Is updated:
 - i. No later than 12 months after the date of the resident's last comprehensive assessment, and
 - ii. When the resident experiences a significant change;
 - d. Includes the following information for the resident:
 - i. Identifying information;
 - ii. An evaluation of the resident's hearing, speech, and vision;
 - iii. An evaluation of the resident's ability to understand and recall information;
 - iv. An evaluation of the resident's mental status;
 - v. Whether the resident demonstrates inappropriate behavior;
 - vi. Preferences for customary routine and activities;
 - vii. An evaluation of the resident's ability to perform activities of daily living;
 - viii. Need for a mobility device;
 - ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
 - x. Any diagnosis that impacts rehabilitation services or other physical health services or

- behavioral care that the resident may require;
- xi. Any medical conditions that impact the resident's functional status, quality of life, or need for nursing services;
- xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;
- xiii. An evaluation of the resident's oral and dental status;
- xiv. An evaluation of the condition of the resident's skin;
- xv. Identification of any medication or treatment administered to the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
- xvi. Identification of any treatment or medication ordered for the resident;
- xvii. Identification of interventions that may support the resident towards independence;
- xviii. Identification of any assistive devices needed by the resident;
- xix. Identification of the active treatment needed by the resident, including active treatment not provided by the ICF/IID;
- xx. Identification of measurable goals and behavioral objective for the active treatment, in priority order, with time limits for attainment;
- xxi. Identification of the methods, schedule, and strategies to accomplish the goals, including the personnel member responsible;
- xxii. Evaluation procedures for determining if the methods and strategies in subsection (A)(1)(d)(xix) are working, including the type of data required and frequency of collection;
- xxiii. Whether any restraints have been used for the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
- xxiv. If the resident demonstrates inappropriate behavior, as reported according to subsection (A)(1)(d)(v), identification of the methods, schedule, and strategies for replacement of the inappropriate behavior with appropriate behavioral expressions, including the hierarchy for use;
- xxv. If restraint or seclusion is included in subsection (A)(1)(d)(xxiii), the specific restraints or conditions of seclusion that may be used because of the resident's inappropriate behavior;
- xxvi. A description of the resident or resident's representative's participation in the comprehensive assessment;
- xxvii. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;
- xxviii. Potential for rehabilitation, including the resident's strengths and specific developmental or behavioral health needs; and
- xxix. Potential for discharge;

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- e. Is signed and dated by the qualified intellectual disabilities professional who conducts or coordinates the comprehensive assessment or review; and
- f. Is used to determine or update the resident's acuity;
- 2. If the condition in subsection (A)(1)(d)(v) is answered in the affirmative during the comprehensive assessment or review, a behavioral health professional reviews a resident's comprehensive assessment or review and individual program plan to ensure that the resident's needs for behavioral care are being met;
- 3. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to an ICF/IID unless a physician, an individual designated by the physician, a qualified intellectual disabilities professional, or a registered nurse determines the resident has a significant change in condition; and
- 4. A resident's comprehensive assessment is reviewed at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition by:
 - a. A qualified intellectual disabilities professional; and
 - b. If the resident has a nursing care plan or medical care plan, a registered nurse.
- B.** An administrator shall ensure that an individual program plan for a resident:
 - 1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1);
 - 2. Includes the acuity of the resident;
 - 3. Is reviewed at least annually by the interdisciplinary team required in subsection (A)(1)(a) and revised based on any change to the resident's comprehensive assessment; and
 - 4. Ensures that a resident is provided rehabilitation services and other physical health services or behavioral care that:
 - a. Address any medical condition or behavioral care issue identified in the resident's comprehensive assessment, and
 - b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-514 renumbered to R9-10-2114; new Section R9-10-514 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18,

2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-515. Seclusion; Restraint

- A.** An administrator shall ensure that:
 - 1. An ICF/IID's policies and procedures for managing a resident's inappropriate behavior, as described in R9-10-503(C)(2)(g) are reviewed, approved, and monitored through the quality management process in R9-10-504; and
 - 2. Restraint is provided according to the requirements in subsection (C).
- B.** An administrator of an ICF/IID authorized to provide seclusion shall ensure that:
 - 1. Seclusion is provided according to the requirements in subsection (C);
 - 2. If a resident 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 resident's bedroom or a sleeping area;
 - c. Allows full view of the resident 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. Except as provided in subsection (B)(3), contains a non-adjustable bed that:
 - i. Consists of a mattress on a solid platform that is:
 - (1) Constructed of a durable, non-hazardous material; and
 - (2) Raised off of the floor;
 - ii. Does not have wire springs or a storage drawer; and
 - iii. Is securely anchored in place;
 - 3. If a room used for seclusion does not contain a non-adjustable bed required in subsection (B)(2)(f):
 - a. A piece of equipment is available that:
 - i. Is commercially manufactured to safely and humanely restrain a resident's body;
 - ii. Provides support to the trunk and head of a resident's body;
 - iii. Provides restraint to the trunk of a resident's body;
 - iv. Is able to restrict movement of a resident's arms, legs, body, and head;
 - v. Allows a resident's body to recline; and
 - vi. Does not inflict harm on a resident's body; and
 - b. Documentation of the manufacturer's specifications for the piece of equipment in subsection (B)(3)(a) is maintained; and
 - 4. A seclusion room may be used for services or activities other than seclusion if:
 - a. A sign stating the service or activity scheduled or being provided in the room is conspicuously posted outside the room;
 - b. No permanent equipment other than the bed required in subsection (B)(2)(f) is in the room;
 - c. Policies and procedures:
 - i. Delineate which services or activities other than seclusion may be provided in the room,

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- ii. List what types of equipment or supplies may be placed in the room for the delineated services, and
 - iii. Provide for the prompt removal of equipment and supplies from the room before the room is used for seclusion; and
 - d. The sign required in subsection (B)(4)(a) and equipment and supplies in the room, other than the bed required in subsection (B)(2)(f), are removed before use as a seclusion room.
- C. An administrator shall ensure that:
 - 1. Policies and procedures for providing restraint or seclusion are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Establish the process for resident assessment, including identification of a resident's medical conditions and criteria for the on-going monitoring of any identified medical condition;
 - b. Identify each type of restraint or seclusion used and include for each type of restraint or seclusion used:
 - i. The qualifications of a personnel member who can:
 - (1) Order the restraint or seclusion,
 - (2) Place a resident in the restraint or seclusion,
 - (3) Monitor a resident in the restraint or seclusion,
 - (4) Evaluate a resident's physical and psychological well-being after being placed in the restraint or seclusion and when released from the restraint or seclusion, or
 - (5) Renew the order for restraint or seclusion;
 - ii. On-going training requirements for a personnel member who has direct resident contact while the resident is in a restraint or seclusion; and
 - iii. Criteria for monitoring and assessing a resident including:
 - (1) Frequencies of monitoring and assessment based on a resident's medical condition and risks associated with the specific restraint or seclusion;
 - (2) For the renewal of an order for restraint or seclusion, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
 - (3) Assessment content, which may include, depending on a resident's condition, the resident's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
 - (4) If a mechanical restraint is used, how often the mechanical restraint is loosened; and
 - (5) A process for meeting a resident's nutritional needs and elimination needs;
 - c. Establish the criteria and procedures for renewing an order for restraint or seclusion;
 - d. Establish procedures for internal review of the use of restraint or seclusion; and
 - e. Establish medical record and personnel record documentation requirements for restraint and seclusion, if applicable;
- 2. An order for restraint or seclusion is:
 - a. Obtained from a physician or registered nurse practitioner, and
 - b. Not written as a standing order or on an as-needed basis;
- 3. Restraint or seclusion is:
 - a. Not used as a means of coercion, discipline, convenience, or retaliation;
 - b. Only used when all of the following conditions are met:
 - i. Except as provided in subsection (C)(4), after obtaining an order for the restraint or seclusion;
 - ii. For the management of a resident's aggressive, violent, or self-destructive behavior;
 - iii. When less restrictive interventions have been determined to be ineffective; and
 - iv. To ensure the immediate physical safety of the resident, to prevent imminent harm to the resident or another individual, or to stop physical harm to another individual; and
 - c. Discontinued at the earliest possible time;
- 4. If as a result of a resident's aggressive, violent, or self-destructive behavior, harm to the resident or another individual is imminent or the resident or another individual is being physically harmed, a personnel member:
 - a. May initiate an emergency application of restraint or seclusion for the resident before obtaining an order for the restraint or seclusion, and
 - b. Obtains an order for the restraint or seclusion of the resident during the emergency application of the restraint or seclusion;
- 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 three continuous hours;
- 7. If an order for restraint or seclusion of a resident is not provided by the resident's attending physician, the resident's attending physician is notified as soon as possible;
- 8. A medical practitioner or personnel member does not participate in restraint or seclusion, assess or monitor a resident during restraint or seclusion, or evaluate a resident 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 resident behaviors, events, and environmental factors that may

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- 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 resident'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 resident 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 resident while the resident is in restraint or seclusion according to policies and procedures; and
 - vii. Except for the medical practitioner, training exercises in which the 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 to policies and procedures;
- 9. When a resident is placed in restraint or seclusion:
 - a. The restraint or seclusion is conducted according to policies and procedures;
 - b. The restraint or seclusion is proportionate and appropriate to the severity of the resident's behavior and the resident'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. The resident is monitored and assessed according to policies and procedures;
 - e. A physician or registered nurse assesses the resident within one hour after the resident is placed in the restraint or seclusion and determines:
 - i. The resident's current behavior;
 - ii. The resident's reaction to the restraint or seclusion used;
 - iii. The resident's medical and behavioral condition, and
 - iv. Whether to continue or terminate the restraint or seclusion;
 - f. The resident is given the opportunity:
 - i. To eat during mealtime, and
 - ii. To use the toilet; and
 - g. The restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order;
- 10. A medical practitioner or personnel member documents the following information in a resident's medical record before the end of the shift in which the resident is placed in restraint or seclusion or, if the resident's restraint or seclusion does not end during the shift in which it began, during the shift in which the resident's restraint or seclusion ends:
 - a. The emergency situation that required the resident to be restrained or put in seclusion,
 - b. The times the resident's restraint or seclusion actually began and ended,
 - c. The monitoring and time of the assessment,
 - d. The names of the medical practitioners and personnel members with direct resident contact while the resident was in the restraint or seclusion,
 - e. The times the resident was given the opportunity to eat or use the toilet according to subsection (C)(9)(f), and
 - f. The resident evaluation required in subsection (C)(12);
- 11. If an emergency situation continues beyond the time limit of an order for restraint or seclusion, the order is renewed according to 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
- 12. A resident is evaluated after restraint or seclusion is no longer being used for the resident.

Historical Note

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R9-10-516. Physical Health Services

- A. An administrator shall ensure that:
 - 1. A resident has an attending physician;
 - 2. An attending physician is available 24 hours a day;
 - 3. An attending physician designates a physician who is available when the attending physician is not available;
 - 4. A physical examination is performed on a resident by a physician or by a physician assistant or registered nurse practitioner designated by the resident's attending physician;

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- a. If indicated, based on the resident's placement evaluation or comprehensive assessment; and
 - b. At least once every 12 months after the date of admission, including an assessment of the acuity of the resident's medical condition;
- 5. If a resident's physical examination, placement evaluation, or comprehensive assessment indicates a need for:
 - a. Intermittent nursing services, the resident's attending physician, in conjunction with the director of nursing, develops a nursing care plan of treatment for the resident, which is integrated into the resident's individual program plan; or
 - b. Continuous nursing services, the resident's attending physician, in conjunction with the director of nursing, develops a medical care plan of treatment for the resident, which is integrated into the resident's individual program plan; and
- 6. Vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:
 - a. The attending physician provides documentation that the vaccination is medically contraindicated;
 - b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical record that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or
 - c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the last five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention.
- B.** An administrator shall ensure that:
 - 1. Nursing services are available 24 hours a day in an ICF/IID;
 - 2. For an ICF/IID authorized to admit a resident requiring:
 - a. Continuous nursing services, a registered nurse is on the premises; or
 - b. Intermittent nursing services, a nurse is on the premises according to the schedule in a resident's nursing care plan; and
 - 3. The director of nursing or an individual designated by the director of nursing participates in the quality management program.
- C.** A director of nursing shall ensure that:
 - 1. A method is established and documented that identifies the types and numbers of nursing personnel that are necessary to provide nursing services to residents based on:
 - a. The acuity of the residents, and
 - b. The ICF/IID's scope of services;
 - 2. Sufficient nursing personnel, as determined by the method in subsection (C)(1), are on the ICF/IID's premises to meet the needs of a resident for nursing services;
 - 3. A registered nurse participates in the development, review, and updating of a resident's nursing care plan or medical care plan;
 - 4. Personnel members providing direct care to a resident with a nursing care plan or medical care plan receive direction from a nurse;
 - 5. At least once every three months, a nurse:
 - a. Assesses the health of a resident without a nursing care plan or medical care plan;
 - b. Documents the results in the resident's medical record; and
 - c. If the assessment indicates the need for physical health services or behavioral care, initiate action, according to policies and procedures, to address the resident's needs;
- 6. Nursing personnel provide education and training to:
 - a. Residents on hygiene and other behaviors that promote health; and
 - b. Personnel members on:
 - i. Detecting signs of illness or injury or significant changes in condition,
 - ii. First aid, and
 - iii. Basic skills for caring for residents;
- 7. A nurse notifies a resident's attending physician and, if applicable, the resident's representative immediately or within 24 hours after one of the following events occur:
 - a. Is injured,
 - b. Is involved in an incident that requires medical services, or
 - c. Has a significant change in condition; and
- 8. Only a medication required by an order is administered to a resident.
- D.** An administrator shall ensure that:
 - 1. Dental services are provided to a resident by an individual licensed as:
 - a. A dentist under A.R.S. Title 32, Chapter 11, Article 2; or
 - b. A dental hygienist under A.R.S. Title 32, Chapter 11, Article 4;
 - 2. If needed, based on a resident's initial assessment, a dentist or dental hygienist in subsection (D)(1) participates as part of an interdisciplinary team in the development of the resident's individual program plan;
 - 3. A resident is provided with a complete dental examination within one month after admission, unless the ICF/IID has documentation of the resident's dental examination completed within 12 months before admission;
 - 4. If a resident's dental examination indicates the resident needs dental treatment:
 - a. A dentist or dental hygienist in subsection (D)(1) participates as part of an interdisciplinary team in the review and updating of the resident's individual program plan, and
 - b. The resident is provided with dental treatment;
 - 5. A dental examination is performed by a dentist or dental hygienist in subsection (D)(1) on a resident at least once every 12 months and treatment is provided as needed;
 - 6. If needed, a resident is provided with emergency dental services;
 - 7. A resident is provided with education and training in oral hygiene; and
 - 8. A resident's medical record contains documentation of:
 - a. Each dental examination of the resident,
 - b. All dental treatment provided to the resident, and
 - c. The resident's education and training in oral hygiene.
- E.** An administrator shall ensure that:
 - 1. A resident's vision and hearing are assessed as part of the resident's comprehensive assessment and, if applicable, as part of the update of the comprehensive assessment; and
 - 2. If an issue is identified with the resident's vision or hearing, the resident is provided, as applicable, with:

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- a. Treatment to address the identified issue, or
- b. An assistive device to address an issue.

Historical Note

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R9-10-517. Behavioral Care**A.** An administrator shall ensure that:

1. A resident who receives behavioral care from the ICF/IID is evaluated by a behavioral health professional or medical practitioner:
 - a. Within 30 calendar days before the resident is admitted to the ICF/IID or before the resident begins receiving behavioral care, and
 - b. At least once every six months throughout the duration of the resident's need for behavioral care;
2. A behavioral health professional or medical practitioner:
 - a. Documents that the behavioral care needed by the resident is within the ICF/IID's scope of services, and
 - b. Includes measurable objectives for the behavioral care and the methods for meeting the objectives in the resident's individual program plan; and
3. The documentation in subsection (A)(2) is included in the resident's medical record.

B. If a resident of an ICF/IID requires behavioral health services provided by a behavioral health professional on an intermittent basis as part of behavioral care, an administrator shall ensure that:

1. The behavioral health services are provided by a behavioral health professional licensed or certified to provide the type of behavioral health services required by the resident; and
2. Except for a psychotropic drug used as a chemical restraint or administered according to an order from a court of competent jurisdiction, informed consent is obtained from a resident or the resident's representative for a psychotropic drug and documented in the resident's medical record before the psychotropic drug is administered to the resident.

Historical Note

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R9-10-518. Clinical Laboratory Services

If clinical laboratory services are authorized to be provided on an ICF/IID's premises, an administrator shall ensure that:

1. Clinical laboratory services and pathology services are provided through a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation, certificate of compliance, or certificate of waiver in subsection (1) is provided to the Department for review upon the Department's request;
3. The ICF/IID:
 - a. Is able to provide the clinical laboratory services delineated in the ICF/IID's scope of services when needed by the residents,
 - b. Obtains specimens for the clinical laboratory services delineated in the ICF/IID's scope of services without transporting the residents from the ICF/IID's premises, and
 - c. Has the examination of the specimens performed by a clinical laboratory;
4. Clinical laboratory and pathology test results are:
 - a. Available to the ordering physician within 24 hours after the test:
 - i. Is complete with results if the test is performed at a laboratory on the ICF/IID's premises, or
 - ii. Result is received if the test is performed at a laboratory outside of the ICF/IID's premises; and
 - b. Documented in a resident's medical record;
5. If a test result is obtained that indicates a resident may have an emergency medical condition, as established in policies and procedures, personnel notify:
 - a. The ordering physician,
 - b. A registered nurse in the resident's assigned unit,
 - c. The ICF/IID's administrator, or
 - d. The director of nursing;

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6. If a clinical laboratory report is completed on a resident, a copy of the report is included in the resident's medical record;
7. If the ICF/IID provides blood or blood products, policies and procedures are established, documented, and implemented for:
 - a. Procuring, storing, transfusing, and disposing of blood or blood products;
 - b. Blood typing, antibody detection, and blood compatibility testing; and
 - c. Investigating transfusion adverse reactions that specify a process for review through the quality management program; and
8. Expired laboratory supplies are discarded according to policies and procedures.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed effective April 4, 1994 (Supp. 94-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section R9-10-518 renumbered to R9-10-2118; new Section R9-10-518 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-519. Respiratory Care Services

If respiratory care services are authorized to be provided on an ICF/IID's premises, an administrator shall ensure that:

1. Respiratory care services are provided under the direction of an attending physician;
2. Respiratory care services are provided according to an order that includes:
 - a. The resident's name;
 - b. The name and signature of the ordering individual;
 - c. The type, frequency, and, if applicable, duration of treatment;
 - d. The type and dosage of medication and diluent; and
 - e. The oxygen concentration or oxygen liter flow and method of administration;
3. Respiratory care services provided to a resident are documented in the resident's medical record and include:
 - a. The date and time of administration;
 - b. The type of respiratory care services provided;
 - c. The effect of the respiratory care services;
 - d. The resident's adverse reaction to the respiratory care services, if any; and
 - e. The authentication of the individual providing the respiratory care services; and

4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-518.

Historical Note

R9-10-519 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-520. Medication Services

- A. An administrator shall ensure that policies and procedures for medication services:
 1. Include:
 - a. A process for providing information to a resident about medication prescribed for the resident including:
 - 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:
 - i. A medication error,
 - ii. An adverse response to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a pharmacist reviews a resident's medications at least once every three months and provides documentation to the resident's attending physician and the director of nursing indicating potential medication problems such as incompatible or duplicative medications;
 - d. Procedures for documenting medication services; and
 - e. Procedures for assisting a resident in obtaining medication; and
 2. 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. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a pharmacist;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
 3. A medication administered to a resident:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the resident's medical record; and
 4. If a psychotropic medication is administered to a resident, the psychotropic medication:
 - a. Is only administered to a resident for a diagnosed medical condition; and
 - b. Unless clinically contraindicated or otherwise ordered by an attending physician or the attending physician's designee, is gradually reduced in dosage while the resident is simultaneously provided with

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interventions such as behavior and environment modification in an effort to discontinue the psychotropic medication, unless a dose reduction is attempted and the resident displays behavior justifying the need for the psychotropic medication, and the attending physician documents the necessity for the continued use and dosage.

C. If an ICF/IID provides assistance in the self-administration of medication, an administrator shall ensure that:

1. A resident's medication is stored by the ICF/IID;
 2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the resident;
 - c. Observing the resident while the resident removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the resident's attending physician by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label,
 - ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from the resident's attending physician dated later than the date on the medication container label, and
 - iii. The resident is taking the medication at the time stated on the medication container label or according to an order from the resident's attending physician dated later than the date on the medication container label; or
 - e. Observing the resident while the resident takes the medication;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by the resident's attending physician or registered nurse;
 4. Training for a personnel member, other than a physician, physician assistant, or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by the resident's attending physician, another physician, a physician assistant, or a registered nurse or an individual trained by a physician, physician assistant, or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a physician, physician assistant, or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a resident:
 - a. Is in compliance with an order, and
 - b. Is documented in the resident's medical record.
- D.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members;

2. If applicable, pharmaceutical services are provided under the direction of a pharmacist and comply with A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and

3. A copy of the pharmacy license is provided to the Department upon request.

E. When medication is stored at an ICF/IID, an administrator shall ensure that:

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

F. An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the resident's attending physician or the physician who ordered the medication and the ICF/IID's director of nursing.

Historical Note

R9-10-520 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-521. Infection Control

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the ICF/IID;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the ICF/IID;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the ICF/IID; and
 - d. Documentation of infection control activities including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:

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- a. Handling and disposal of biohazardous medical waste;
 - b. Sterilization, disinfection, and storage of medical equipment and supplies;
 - c. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
 - d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a resident;
 - e. Cleaning of a resident's bedroom, furniture, and bedding after the resident's discharge before the bedroom is reassigned to another resident;
 - f. Training of personnel members, employees, and volunteers in infection control practices; and
 - g. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
 4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 5. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
 6. A resident's personal laundry is washed separately from towels, sheets, and bedding; and
 7. A personnel member, an employee, or a volunteer washes hands or uses a hand disinfection product after a resident contact and after handling soiled linen, soiled clothing, or potentially infectious material.
- 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 resident such as cut, chopped, ground, pureed, or thickened;
 2. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served on each day,
 - c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 3. Meals and snacks for each day are planned and served using the applicable guidelines in the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
 4. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and individual program plan;
 - b. Food served in sufficient quantities to meet the resident's nutritional needs and at an appropriate temperature;
 - c. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(4)(e);
 - d. The option to have a daily evening snack identified in subsection (B)(4)(e)(ii) or other snack; and
 - e. The option to extend the time span between the evening meal and breakfast from 14 hours to 16 hours if:
 - i. A resident group agrees; and
 - ii. The resident 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;
 5. A resident is provided with food substitutions of similar nutritional value if:
 - a. The resident refuses to eat the food served, or
 - b. The resident requests a substitution;
 6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning;
 7. If food is used as a part of a program to manage a resident's inappropriate behavior:
 - a. A special diet is included as part of the resident's individual program plan, and
 - b. The special diet is reviewed and evaluated by a physician and a dietitian to ensure the special diet meets the resident's nutritional needs;
 8. Meals are served to residents at tables in a dining area and in a manner that allows the resident to eat from an upright position, unless otherwise specified in the resident's individual program plan or by an attending physician;
 9. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils;

Historical Note

R9-10-521 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-522. Food Services

- A.** An administrator shall ensure that:
 1. The ICF/IID has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
 2. A copy of the ICF/IID's food establishment license or permit is maintained;
 3. If the ICF/IID contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the ICF/IID:
 - a. A copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the ICF/IID; and
 - b. The ICF/IID is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
 4. A registered dietitian:
 - a. Participates as part of an interdisciplinary team for a resident requiring a modified or special diet,
 - b. Reviews a food menu before the food menu is used to ensure that a resident's nutritional needs are being met,
 - c. Documents the review of a food menu, and
 - d. Is available for consultation regarding a resident's nutritional needs; 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 ensure that the nutritional needs of a resident are met.

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10. Personnel members supervise meals in dining areas to:
 - a. Direct a resident's self-help dining procedures,
 - b. Ensure a resident consumes enough food to meet the resident's nutritional needs, and
 - c. Ensure that a resident eats in a manner consistent with the resident's developmental level;
11. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair; and
12. Water is available and accessible to residents.

Historical Note

R9-10-522 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

R9-10-523. Emergency and Safety Standards**A.** An administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. A floor plan of the facility showing emergency protection equipment, evacuation routes, and exits;
 - b. When, how, and where residents will be relocated, including:
 - i. Instructions for the evacuation or transfer of residents,
 - ii. Assigned responsibilities for each employee and personnel member, and
 - iii. A plan for continuing to provide services to meet a resident's needs;
 - c. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
 - d. A plan for back-up power and water supply;
 - e. A plan to ensure a resident's medications will be available to administer to the resident during a disaster;
 - f. A plan to ensure a resident is provided nursing services, rehabilitation services, and other services required by the resident during a disaster; and
 - g. A plan for obtaining food and water for individuals present in the ICF/IID or the ICF/IID's relocation site during a disaster;
2. Personnel members receive training on the content and use of the disaster plan required in subsection (A)(1);
3. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
4. Documentation of a disaster plan review required in subsection (A)(3) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
5. A disaster drill for employees is conducted on each shift at least once every three months and documented;
6. An evacuation drill for employees is conducted on each shift at least once every three months and documented;
7. An evacuation drill for residents:
 - a. Is conducted at least once each year on each shift and documented; and
 - b. Includes all residents on the premises except for:
 - i. A resident whose medical record contains documentation that evacuation from the ICF/IID would cause harm to the resident, and
 - ii. Sufficient personnel members to ensure the health and safety of residents not evacuated according to subsection (A)(7)(b)(i);
8. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and residents to evacuate to a designated area;
 - c. If applicable:
 - i. An identification of residents needing assistance for evacuation, and
 - ii. An identification of residents who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
9. An evacuation path is conspicuously posted on each hallway of each floor of the ICF/IID.

B. An administrator shall ensure that, if an ICF/IID has:

1. More than 16 residents or a resident who has a medical care plan or whose medical record contains documentation that evacuation from the ICF/IID would cause harm to the resident:
 - a. A fire alarm system is installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and is in working order; and
 - b. A sprinkler system is installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, and is in working order; and
2. Sixteen or fewer residents, none of whom have a medical care plan or whose medical record contains documentation that evacuation from the ICF/IID would cause harm to the resident:
 - a. A fire alarm system and a sprinkler system meeting the requirements in subsection (B)(1) are installed and in working order; or
 - b. The ICF/IID has:
 - i. A fire extinguisher that is:
 - (1) Labeled as rated at least 2A-10-BC by the Underwriters Laboratories;
 - (2) Accessible to personnel members and inaccessible to residents;
 - (3) If a disposable fire extinguisher, replaced when its indicator reaches the red zone; and
 - (4) If a rechargeable fire extinguisher, is serviced at least once every 12 months, as documented by a tag attached to the fire extinguisher that specifies the date of the last servicing and the identification of the person who serviced the fire extinguisher; and
 - ii. Smoke detectors that are:
 - (1) Installed in each bedroom, hallway that

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- adjoins a bedroom, storage room, laundry room, attached garage, and room or hallway adjacent to the kitchen, and other places recommended by the manufacturer;
- (2) Either battery operated or, if hard-wired into the electrical system of the ICF/IID, has a back-up battery;
- (3) In working order; and
- (4) Tested at least once a month, with documentation of the test maintained for at least 12 months after the date of the test.

C. An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

D. An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.

Historical Note

R9-10-523 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4).

R9-10-524. Environmental Standards

A. An administrator shall ensure that:

1. An ICF/IID's premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness and infection; and
 - b. Free from a condition or situation that may cause a resident or an individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Equipment used to provide direct care 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
5. Garbage and refuse are:
 - a. In areas used for food storage, food preparation, or food service, stored in a covered container lined with a plastic bag;
 - b. In areas not used for food storage, food preparation, or food service, stored:
 - i. According to the requirements in subsection (A)(5)(a), or
 - ii. In a paper-lined or plastic-lined container that is cleaned and sanitized as often as necessary to ensure that the container is clean; and
 - c. Removed from the premises at least once a week;
6. Heating and cooling systems maintain the ICF/IID at a temperature between 70° F and 84° F;
7. Common areas:

- a. Are lighted to assure the safety of residents, and
- b. Have lighting sufficient to allow personnel members to monitor resident activity;
8. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
9. The temperature of the hot water does not exceed 120° F;
10. Linens are clean before use, without holes and stains, and not in need of repair;
11. Oxygen containers are secured in an upright position;
12. Poisonous or toxic materials stored by the ICF/IID are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;
13. Combustible or flammable liquids stored by the ICF/IID are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
14. If pets or animals are allowed in the ICF/IID, pets or animals are:
 - a. Controlled to prevent endangering the residents and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
16. 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 tobacco products are not permitted within an ICF/IID; and
2. Smoking tobacco products may be permitted outside an ICF/IID 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. If a swimming pool is located on the premises, an administrator shall ensure that:

1. At least one personnel member with cardiopulmonary resuscitation training that meets the requirements in R9-10-503(C)(1)(g) is present in the pool area when a resident is in the pool area, and
2. At least two personnel members are present in the pool area when two or more residents are in the pool area.

Historical Note

R9-10-524 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-525. Physical Plant Standards

A. An administrator shall ensure that, if an ICF/IID has:

1. More than 16 residents, the ICF/IID complies with:
 - a. The applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the earlier of:

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- i. The date the ICF/IID was originally certified as an ICF/IID by the federal Centers for Medicare and Medicaid Services, or
 - ii. The date the ICF/IID submitted the application packet including the notarized attestation of architectural plans according to R9-10-104; and
 - b. The requirements for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01; and
 - 2. Sixteen or fewer residents, the ICF/IID complies with the requirements for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01.
- B.** An administrator shall ensure that:
- 1. The premises and equipment are sufficient to accommodate:
 - a. The services stated in the ICF/IID's scope of services, and
 - b. An individual accepted as a resident by the ICF/IID;
 - 2. A common area for use by residents is provided that has sufficient space and furniture to accommodate the recreational and socialization needs of residents;
 - 3. A dining area has sufficient space and tables and chairs to accommodate the needs of the residents;
 - 4. At least one bathroom is accessible from a common area and:
 - a. May be used by residents and visitors;
 - b. Does not open into an area in which food is prepared;
 - c. Provides privacy when in use; and
 - d. Contains the following:
 - i. At least one working sink with running water,
 - ii. At least one working toilet that flushes and has a seat,
 - iii. Toilet tissue for each toilet,
 - iv. Soap in a dispenser accessible from each sink,
 - v. Paper towels in a dispenser or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A window that opens or another means of ventilation;
 - 5. An outside activity space is provided and available that:
 - a. Is on the premises,
 - b. Has a hard-surfaced section for wheelchairs, and
 - c. Has an available shaded area;
 - 6. Exterior doors are equipped with ramps or other devices to allow use by a resident using a wheelchair or other assistive device; and
 - 7. The key to the door of a lockable bathroom or bedroom is available to a personnel member.
- C.** An administrator shall ensure that:
- 1. For every eight residents there is at least one working toilet that flushes and has a seat and one sink with running water;
 - 2. For every eight residents there is at least one working bathtub or shower;
 - 3. A resident bathroom provides privacy when in use and contains:
 - a. A mirror;
 - b. Toilet tissue for each toilet;
 - c. Soap accessible from each sink;
 - d. Paper towels in a dispenser or a mechanical air hand dryer for a bathroom that is used by more than one resident;
 - e. A window that opens or another means of ventilation;
 - f. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
 - g. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
 - 4. An ICF/IID is ventilated by windows or mechanical ventilation, or a combination of both;
 - 5. If required for the residents of the ICF/IID, the corridors are equipped with handrails on each side that are firmly attached to the walls and are not in need of repair;
 - 6. No more than two individuals reside in a resident bedroom; and
 - 7. A resident's bedroom;
 - a. Is accessible without passing through a storage area, an equipment room, or another resident's bedroom;
 - b. Is constructed and furnished to provide unimpeded access to the door;
 - c. Has floor-to-ceiling walls with at least one door;
 - d. Does not open into any area where food is prepared, served, or stored;
 - e. If a private bedroom, has at least 80 square feet of floor space, not including a closet or bathroom;
 - f. If a shared bedroom, has at least 60 square feet of floor space for each individual occupying the shared bedroom, not including a closet or bathroom;
 - g. Has a separate bed, at least 36 inches in width and 72 inches in length, for each resident, consisting of at least a frame and mattress that is clean and in good repair;
 - h. Has clean linen, including a mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, a bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for the resident;
 - i. Has furniture to meet the resident's needs and sufficient light for reading;
 - j. Has an openable window to the outside with window coverings for controlling light and visual privacy, and the location of the window permits a resident to see outside from a sitting position;
 - k. Has individual storage space for a resident's possessions and assistive devices; and
 - l. Has a closet with clothing racks and shelves accessible to the resident.
- D.** If a swimming pool is located on the premises, an administrator shall ensure that:
- 1. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (D)(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 swimming pool,

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- ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and
 - 2. A life preserver or shepherd's crook is available and accessible in the pool area.
- E.** An administrator shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (D)(1) is covered and locked when not in use.

Historical Note

R9-10-525 made by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by exempt rulemaking, at 26 A.A.R. 72 with an effective date of January 1, 2020 (Supp. 19-4). Amended by final expedited rulemaking at 31 A.A.R. 1263 (April 18, 2025), with an immediate effective date of April 1, 2025 (Supp. 25-2).

ARTICLE 6. HOSPICES**R9-10-601. Definitions**

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

1. "Medical social services" means assistance, other than medical services or nursing services, provided by a personnel member to a patient to assist the patient to cope with concerns about the patient's illness, finances, or personal issues and may include problem-solving, interventions, and identification of resources to address the patient's or the patient's family's concerns.
2. "Palliative care" means medical services or nursing services provided to a patient that is not curative and is designed for pain control or symptom management.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-602. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a hospice service agency or hospice inpatient facility shall include on the application:

1. For an application as a hospice service agency:
 - a. The hours of operation for the hospice's administrative office, and
 - b. The geographic region to be served by the hospice service agency; and
2. For an application as a hospice inpatient facility, the requested licensed capacity.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-603. Administration**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of the hospice;
2. Establish, in writing:

- a. A hospice's scope of services, and
 - b. Qualifications for an administrator;
 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
 4. Adopt a quality management plan according to R9-10-604;
 5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
 6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
 - a. Expected not to be present:
 - i. At a hospice service agency's administrative office for more than 30 calendar days, or
 - ii. On a hospice inpatient facility's premises for more than 30 calendar days; or
 - b. Not present:
 - i. At a hospice service agency's administrative office for more than 30 calendar days, or
 - ii. On a hospice inpatient facility's premises for more than 30 calendar days; and
 7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.
- B.** An administrator:
1. Is directly accountable to the governing authority of a hospice for the daily operation of the hospice and all services provided by or through the hospice;
 2. Has the authority and responsibility to manage the hospice;
 3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the hospice's premises and accountable for the:
 - a. Hospice service agency when the administrator is not present at the hospice service agency's administrative office, or
 - b. Inpatient hospice facility when the administrator is not on hospice inpatient facility's premises; and
 4. Designates a personnel member to provide direction for volunteers.
- C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to patient care;
 - d. Include methods to prevent abuse or neglect of a patient, including:
 - i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
 - ii. Reporting of abuse or neglect of a patient;
 - e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - f. Include a method to identify a patient to ensure the patient receives hospice services as ordered;

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- g. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
 - h. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The hospice service agency or hospice inpatient facility to respond to a patient's complaint;
 - i. Cover health care directives;
 - j. Cover medical records, including electronic medical records;
 - k. Cover a quality management program, including incident reports and supporting documentation;
 - l. Cover contracted services; and
 - m. Cover information and education to a patient or a patient's representative of proper disposal of schedule II controlled substances in compliance with A.R.S. § 36-425.04;
2. Policies and procedures for hospice services are established, documented, and implemented to protect the health and safety of a patient that:
- a. Cover patient screening, admission, transfer, discharge planning, and discharge;
 - b. Cover the provision of hospice services;
 - c. Include when general consent and informed consent are required;
 - d. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 - e. Cover dispensing, administering, and disposing of medication;
 - f. Cover infection control; and
 - g. Cover telemedicine, if applicable;
 - h. Cover clergy visitation procedures in compliance with A.R.S. § 36-407.02;
3. For a hospice inpatient facility, policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
- a. Cover visitation of a patient, including:
 - i. Allowing visitation by individuals 24 hours a day, and
 - ii. Allowing a visitor to bring a pet to visit the patient;
 - b. Cover the use and display of a patient's personal belongings; and
 - c. Cover environmental services that affect patient care;
4. Policies and procedures are reviewed and updated at least once every three years;
5. Policies and procedures are available to personnel members, employees, volunteers, and students; and
6. Unless otherwise stated:
- a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a hospice, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the hospice.
- D.** An administrator shall designate, in writing, a:
- 1. Physician as the medical director who has the authority and responsibility for providing direction for the medical services provided by the hospice, and
 - 2. Registered nurse as the director of nursing who has the authority and responsibility for managing nursing services provided by the hospice.
- E.** An administrator shall ensure that the following are conspicuously posted:
- 1. The current Department-issued license;
 - 2. The current telephone number of the Department; and
 - 3. The location at which the following are available for review:
 - a. A copy of the most recent Department inspection report;
 - b. A list of the services provided by the hospice; and
 - c. A written copy of rates and charges, as required in A.R.S. § 36-436.03.
- Historical Note**
- New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 2499 (August 2, 2024), with an immediate effective date of July 8, 2024 (Supp. 24-3).
- R9-10-604. 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 services provided to patients;
 - 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 change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
 - 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.
- Historical Note**
- New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).
- R9-10-605. Contracted Services**
- An administrator shall ensure that:
- 1. Contracted services are provided according to the requirements in this Article, and

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2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-606. Personnel**A.** An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services, and
 - b. According to policies and procedures;
3. Sufficient personnel members are available and, for a hospice inpatient facility, present on the hospice inpatient facility's premises, with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the hospice's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient;
4. Orientation occurs within the first week of providing hospice services and includes:
 - a. Informing personnel about Department rules for licensing and regulating hospices and where the rules may be obtained,
 - b. Reviewing the process by which a personnel member may submit a complaint about patient care to a hospice, and
 - c. Providing the information required by hospice policies and procedures;
5. Personnel receive in-service education according to criteria established in hospice policies and procedures;

6. In-service education documentation for a personnel member includes:
 - a. The subject matter,
 - b. The date of the in-service education, and
 - c. The signature of each individual who participated in the in-service education; and
 7. A personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
 - a. On or before the date the individual begins providing services at or on behalf of the hospice service facility or hospice inpatient facility, and
 - b. As specified in R9-10-113; and
 8. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.
- B.** An administrator shall ensure that record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures; and
 - e. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(7).
 - f. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;

C. An administrator shall ensure that personnel records are:

1. Maintained:
 - a. Throughout the individual's period of providing services in or for the hospice, and
 - b. For at least 24 months after the last date the individual provided services in or for the hospice; and
2. For a personnel member who has not provided physical health services at or for the hospice during the previous 12 months, provided to the Department within 72 hours after the Department's request.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-607. Admission

- A.** Before admitting an individual as a patient, an administrator shall obtain:
1. The name of the individual's physician;

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2. Documentation that the individual has a diagnosis by a physician that indicates that the individual has a specific, progressive, normally irreversible disease that is likely to cause the individual's death in six months or less; and
3. Documentation from the individual or the individual's representative acknowledging that:
 - a. Hospice services include palliative care and supportive services and are not curative, and
 - b. The individual or individual's representative has received a list of services to be provided by the hospice.
- B.** At the time of admission, a physician or registered nurse shall:
 1. Assess a patient's medical, social, nutritional, and psychological needs; and
 2. As applicable, obtain informed consent or general consent.
- C.** Before or at the time of admission, a personnel member qualified according to policies and procedures shall assess the social and psychological needs of a patient's family, if applicable.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-608. Care Plan

- A.** An administrator shall ensure that a care plan is developed for each patient:
 1. Based on the:
 - a. Assessment of the:
 - i. Patient; and
 - ii. Patient's family, if applicable;
 - b. Hospice service agency's or inpatient hospice facility's scope of service;
 2. With participation from a:
 - a. Physician,
 - b. Registered nurse, and
 - c. Another personnel member as designated in R9-10-612(A)(4); and
 3. That includes:
 - a. The patient's diagnosis;
 - b. The patient's health care directives;
 - c. The patient's cognitive awareness of self, location, and time;
 - d. The patient's functional abilities and limitations;
 - e. Goals for pain control and symptom management;
 - f. The type, duration, and frequency of services to be provided to the patient and, if applicable, the patient's family;
 - g. Treatments the patient is receiving from a health care institution or health care professional other than the hospice, if applicable;
 - h. Medications ordered for the patient;
 - i. Any known allergies;
 - j. Nutritional requirements and preferences; and
 - k. Specific measures to improve the patient's safety and protect the patient against injury.
- B.** An administrator shall ensure that:
 1. A request for participation in a patient's care plan is made to the patient or patient's representative;

2. An opportunity for participation in the patient's care plan is provided to the patient, patient's representative, or patient's family; and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the patient's medical record.
- C.** An administrator shall ensure that:
 1. Hospice services are provided to a patient and, if applicable, the patient's family according to the patient's care plan;
 2. A patient's care plan is reviewed and updated:
 - a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of the services being provided;
 - b. If the patient's physician orders a change in the care plan; and
 - c. At least every 30 calendar days; and
 3. A patient's physician authenticates the care plan with a signature within 14 calendar days after the care plan is initially developed and whenever the care plan is reviewed or updated.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-608 renumbered to R9-10-609; new Section R9-10-608 renumbered from R9-10-611 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-609. Transfer

Except for a transfer of a patient due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-609 renumbered to R9-10-610; new Section R9-10-609 renumbered from R9-10-608 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-610. Patient Rights

- A.** An administrator shall ensure that:
 1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;

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2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
 - b. Where patient rights are posted as required in subsection (A)(1).
- B.** An administrator shall ensure that:
 1. A patient is treated with dignity, respect, and consideration;
 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by the hospice's personnel members, employees, volunteers, or students; and
 3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;
 - d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospice for identification and administrative purposes;
 - e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records;
 - f. Is informed of:
 - i. The components of hospice services provided by the hospice;
 - ii. The rates and charges for the components of hospice services before the components are initiated and before a change in rates, charges, or services;
 - iii. The hospice's policy on health care directives; and
 - iv. The patient complaint process; and
 - g. Is informed that a written copy of rates and charges, as required in A.R.S. § 36-436.03, may be requested.
- C.** A patient has the following rights:
 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
 3. To receive privacy in treatment and care for personal needs;
 4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 5. To receive a referral to another health care institution if the hospice inpatient facility is not authorized or not able to provide physical health services needed by the patient;
 6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
 7. To participate or refuse to participate in research or experimental treatment;
 8. To participate in religious visitation by a clergy member according to A.R.S. § 36-407.02; and
 9. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-610 renumbered to R9-10-611; new Section R9-10-610 renumbered from R9-10-609 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 2499 (August 2, 2024), with an immediate effective date of July 8, 2024 (Supp. 24-3).

R9-10-611. Medical Records

- A.** An administrator shall ensure that:
 1. A patient's medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
 2. An entry in a patient's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner issuing the order;
 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of a patient or the patient's representative; or
 - c. As permitted by law; and
 6. A patient's medical record is protected from loss, damage, or unauthorized use.
- B.** If a hospice maintains patients' medical records electronically, an administrator shall ensure that:
 1. Safeguards exist to prevent unauthorized access, and

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2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C. An administrator shall ensure that a patient's medical record contains:
 1. Patient information that includes:
 - a. The patient's name,
 - b. The patient's address,
 - c. The patient's telephone number,
 - d. The patient's date of birth, and
 - e. Any known allergy;
 2. The admission date and, if applicable, the date that the patient stopped receiving services from the hospice;
 3. The name and telephone number of the patient's physician;
 4. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Is a legal guardian, a copy of the court order establishing guardianship; or
 - ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
 5. The admitting diagnosis;
 6. If applicable, documented general consent and informed consent, by the patient or the patient's representative;
 7. Documentation of medical history;
 8. A copy of the patient's living will, health care power of attorney, or other health care directive, if applicable;
 9. Orders;
 10. The assessment required in R9-10-607(B)(1);
 11. Care plans;
 12. Progress notes for each patient contact, including:
 - a. The date of the patient contact,
 - b. The services provided,
 - c. A description of the patient's condition, and
 - d. Instructions given to the patient or patient's representative;
 13. Documentation of hospice services provided to the patient;
 14. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 15. Documentation of coordination of patient care;
 16. Documentation of contacts with the patient's physician by a personnel member;
 17. The discharge summary, if applicable;
 18. If applicable, transfer documentation from a sending health care institution; and
 19. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain, when initially administered or when administered on a PRN basis:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication, when initially administered or when administered on a PRN basis:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering the medication; and
 - f. Any adverse reaction a patient has to the medication.

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-611 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). R9-10-611 renumbered to R9-10-608; new Section R9-10-611 renumbered from R9-10-610 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-612. Hospice Services

- A. An administrator shall ensure that the following are included in the hospice services provided by the hospice:
 1. Medical services;
 2. Nursing services;
 3. Nutritional services, including menu planning and the designation of the kind and amount of food appropriate for a patient;
 4. Medical social services, provided as follows by a personnel member:
 - a. Qualified according to policies and procedures to coordinate medical social services; and
 - b. Who is licensed under A.R.S. Title 32, Chapter 33, Article 5, if applicable;
 5. Bereavement counseling for a patient's family for at least one year after the death of the patient; and
 6. Spiritual counseling services, consistent with a patient's customs, religious preferences, cultural background, and ethnicity.
- B. In addition to the services specified in subsection (A), an administrator of a hospice service agency shall ensure that the following are included in the hospice services provided by the hospice:
 1. Home health aide services;
 2. Respite care services; and
 3. Supportive services, as defined in A.R.S. § 36-151.
- C. An administrator shall ensure that the medical director provides direction for medical services provided by or through the hospice.
- D. A medical director shall ensure that:
 1. A patient's need for medical services is met, according to the patient's care plan and the hospice's scope of services; and
 2. If a patient is receiving medical services not provided by or through the hospice, hospice services are coordinated with the physician providing medical services to the patient.
- E. A director of nursing shall ensure that:

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1. A registered nurse or practical nurse provides nursing services according to the hospice's policies and procedures;
2. A sufficient number of nurses are available to provide the nursing services identified in each patient's care plan;
3. The care plan for a patient is implemented;
4. A personnel member is only assigned to provide services the personnel member can competently perform;
5. A registered nurse:
 - a. Assigns tasks in writing to a home health aide who is providing home health aide service to a patient,
 - b. Provides direction for the home health aide services provided to a patient, and
 - c. Verifies the competency of the home health aide in performing assigned tasks;
6. A registered dietitian or a personnel member under the direction of a registered dietitian plans menus for a patient;
7. A patient's condition and the services provided to the patient are documented in the patient's medical record after each patient contact;
8. A patient's physician is immediately informed of a change in the patient's condition that requires medical services; and
9. The implementation of a patient's care plan is coordinated among the personnel members providing hospice services to the patient.

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-612 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 2499 (August 2, 2024), with an immediate effective date of July 8, 2024 (Supp. 24-3).

R9-10-613. Medication Services

- A. An administrator shall ensure that policies and procedures for medication services:
 1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient including:
 - 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:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a patient's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs;
 - d. Procedures for:
 - i. Documenting medication administration; and
 - ii. Monitoring a patient who self-administers medication;
 - e. Procedures for assisting a patient in obtaining medication; and
 - f. If applicable, procedures for providing medication administration off the premises; and
 2. 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. If a hospice provides medication administration, an administrator shall ensure that:
 1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
 3. A medication administered to a patient:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the patient's medical record.
- C. 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 on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by the hospice's policies and procedures is established to:
 - i. Develop a drug formulary,
 - ii. Update the drug formulary at least every 12 months,
 - iii. Develop medication usage and medication substitution policies and procedures, and
 - iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
 - b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. The pharmaceutical services comply with ARS Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
 - d. A copy of the pharmacy license is provided to the Department upon request.
- D. When medication is stored at a hospice inpatient facility, an administrator shall ensure that:
 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions on the medication container; and

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3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication;
 - d. Storing, inventorying, and dispensing controlled substances; and
 - e. If applicable, donated medicine according to A.R.S. § 32-1909.
- E. An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the hospice's director of nursing.

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-613 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-614. Infection Control

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases; and
 - d. Documenting infection control activities including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken relating to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documents are maintained for at least 12 months after the date of the documents;
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Handling and disposal of biohazardous medical waste;
 - b. Sterilization and disinfection of medical equipment and supplies;

- c. Use of personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
 - d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a patient;
 - e. Training of personnel members in infection control practices; and
 - f. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures; and
 5. A personnel member washes hands or use a hand disinfection product after each patient contact and after handling soiled linen, soiled clothing, or potentially infectious material.

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-614 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-615. Food Services for a Hospice Inpatient Facility

- A. An administrator of a hospice inpatient facility shall ensure that:
 1. Meals and snacks provided by the hospice inpatient facility are served according to a patient's dietary needs and preferences;
 2. Meals and snacks for each day are planned using:
 - a. The applicable most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture, and
 - b. Preferences for meals and snacks obtained from patients;
 3. 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
 4. Water is available and accessible to patients at all times, unless otherwise stated in a patient's care plan.
- B. An administrator of a hospice inpatient facility 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. 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;
 4. 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 145° F for 15 seconds, except that:

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- i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 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.
- C. An administrator shall ensure that:
 - 1. For a hospice inpatient facility with a licensed capacity of more than 20 beds, the hospice inpatient facility:
 - a. Has a license or permit as a food establishment under 9 A.A.C. 8, Article 1, and
 - b. Maintains a copy of the hospice inpatient facility's food establishment license or permit;
 - 2. If the hospice inpatient facility contracts with food establishment, as defined in 9 A.A.C. 8, Article 1, to prepare and deliver food to the hospice inpatient facility a copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the hospice inpatient facility; and
 - 3. Food is stored, refrigerated, and reheated to meet the dietary needs of a patient.
- iii. A plan for providing continuing services to meet patient's needs;
 - b. How each patient's medical record will be available to individuals 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 hospice inpatient facility or the hospice inpatient facility's relocation site during a disaster;
 - 2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
 - 3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 - 4. A disaster drill for employees is conducted on each shift at least once every three months and documented; and
 - 5. An evacuation path is conspicuously posted on each hallway of each floor of the hospice inpatient facility.
- B. An administrator shall:
 - 1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 - 2. Make any repairs or corrections stated on the fire inspection report, and
 - 3. Maintain documentation of a current fire inspection.

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-615 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 2499 (August 2, 2024), with an immediate effective date of July 8, 2024 (Supp. 24-3).

R9-10-616. Emergency and Safety Standards for a Hospice Inpatient Facility

- A. An administrator of a hospice inpatient facility shall ensure that:
 - 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where patients will be relocated, including:
 - i. Instructions for the evacuation or transfer of patients,
 - ii. Assigned responsibilities for each employee and personnel member, and

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-616 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-617. Environmental Standards for a Hospice Inpatient Facility

- A. An administrator of a hospice inpatient facility shall ensure that:
 - 1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Cleaning and storing of soiled linens and clothing,
 - b. Housekeeping procedures that ensure a clean environment, and
 - c. Isolation of a patient who may spread an infection;
 - 2. The premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness or infection; and
 - b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury or illness;

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3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
 4. Equipment used at the hospice inpatient 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 the hospice inpatient facility's policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 6. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
 7. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
 8. Heating and cooling systems maintain the hospice inpatient facility at a temperature between 70° F and 84° F at all times;
 9. Common areas:
 - a. Are lighted to assure the safety of patients, and
 - b. Have lighting sufficient to allow personnel members to monitor patient activity;
 10. 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;
 11. Oxygen containers are secured in an upright position;
 12. Poisonous or toxic materials stored by the hospice inpatient facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
 13. Except for medical supplies needed by a patient, combustible or flammable liquids and hazardous materials are stored by the hospice inpatient facility in the original labeled containers or safety containers in a locked area inaccessible to patients;
 14. If pets or animals are allowed in the hospice inpatient facility, pets or animals are:
 - a. Controlled to prevent endangering the patients and to maintain sanitation, and
 - b. Licensed consistent with local ordinances;
 15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink, and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
 16. 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 of a hospice inpatient facility shall ensure that a patient is allowed to use and display personal belongings.
- Historical Note**
- Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-617 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).
- R9-10-618. Physical Plant Standards for a Hospice Inpatient Facility**
- A.** An administrator shall ensure that a hospice inpatient facility complies with applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01.
- B.** An administrator of a hospice inpatient facility shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the hospice inpatient facility's scope of services, and
 2. An individual accepted as a patient by the hospice inpatient facility.
- C.** An administrator of a hospice inpatient facility shall ensure that a patient's sleeping area:
1. Is shared by no more than four patients;
 2. Measures at least 80 square feet of floor space per patient, not including a closet;
 3. Has walls from floor to ceiling;
 4. Contains a door that opens into a hallway, common area, or outdoors;
 5. Is at or above ground level;
 6. Is vented to the outside of the hospice inpatient facility;
 7. Has a working thermometer for measuring the temperature in the sleeping area;
 8. For each patient, has a:
 - a. Bed,
 - b. Bedside table,
 - c. Bedside chair,
 - d. Reading light,
 - e. Privacy screen or curtain, and
 - f. Closet or drawer space;
 9. Is equipped with a bell, intercom, or other mechanical means for a patient to alert a personnel member;
 10. Is no farther than 20 feet from a room containing a toilet and a sink;
 11. Is not used as a passageway to another sleeping area, a toilet room, or a bathing room;
 12. Contains one of the following to provide sunlight:
 - a. A window to the outside of the hospice inpatient facility, or
 - b. A transparent or translucent door to the outside of the hospice inpatient facility; and
 13. Has coverings for windows and for transparent or translucent doors that provide patient privacy.
- D.** An administrator of a hospice inpatient facility shall ensure that there is:

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1. For every six patients, a toilet room that contains:
 - a. At least one working toilet that flushes and has a seat;
 - b. At least one working sink with running water;
 - c. Soap for hand washing;
 - d. Paper towels or a mechanical air hand dryer;
 - e. Grab bars attached to a wall that an individual may hold onto to assist the individual in becoming or remaining erect;
 - f. A mirror;
 - g. Lighting;
 - h. Space for a personnel member to assist a patient;
 - i. A bell, intercom, or other mechanical means for a patient to alert a personnel member; and
 - j. An operable window to the outside of the hospice inpatient facility or other means of ventilation;
2. For every 12 patients, at least one working bathtub or shower accessible to a wheeled shower chair, with a slip-resistant surface, located in a toilet room or in a separate bathing room;
3. For a patient occupying a sleeping area with one or more other patients, a separate room in which the patient can meet privately with family members;
4. Space in a lockable closet, drawer, or cabinet for a patient to store the patient's private or valuable items;
5. A room other than a sleeping area that can be used for social activities;
6. Sleeping accommodations for family members;
7. A designated toilet room, other than a patient toilet room, for personnel and visitors that:
 - 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;
8. If the hospice inpatient facility has a kitchen with a stove or oven, a mechanism to vent the stove or oven to the outside of the hospice inpatient facility; and
9. Space designated for administrative responsibilities that is separate from sleeping areas, toilet rooms, bathing rooms, and drug storage areas.

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-618 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-619. Repealed**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-619 repealed effective November 1, 1998,

under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

R9-10-620. Repealed**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-620 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

R9-10-621. Repealed**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Correction, subsection (H), after "... 105° F" added "nor more than 110° F" as certified effective November 6, 1978 (Supp. 87-2). Section R9-10-621 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

R9-10-622. Repealed**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-622 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

R9-10-623. Repealed**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-623 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

R9-10-624. Repealed**Historical Note**

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-624 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

ARTICLE 7. BEHAVIORAL HEALTH RESIDENTIAL FACILITIES**R9-10-701. Definitions**

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

"Emergency safety response" means physically holding a resident to manage the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days

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(Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2).

Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted without changes effective October 30, 1989 (Supp. 89-4). Section R9-10-701 repealed, new Section R9-10-701 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-702. Supplemental Application and Documentation Submission Requirements

- A.** In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a behavioral health residential facility shall include on the application:
1. Whether the applicant is planning to provide:
 - a. Behavioral health services to individuals under 18 years of age, including the licensed capacity requested;
 - b. Behavioral health services to individuals 18 years of age and older, including the licensed capacity requested; or
 - c. Respite services;
 2. Whether the applicant is requesting authorization to provide an outdoor behavioral health care program, including:
 - a. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 12 to 17 years of age, and
 - b. The requested licensed capacity for providing the outdoor behavioral health care program to individuals 18 to 24 years of age;
 3. Whether the applicant is requesting authorization to provide:
 - a. Court-ordered evaluation,
 - b. Court-ordered treatment,
 - c. Behavioral health services to individuals 18 years of age or older whose behavioral health issue limits the individuals' ability to function independently, or
 - d. Personal care services;
 4. Whether the applicant is requesting authorization to provide recidivism reduction services as an adult residential care institution, including the requested licensed capacity for providing recidivism reduction services;
 5. For a behavioral health residential facility requesting authorization to provide respite services, the requested number of individuals the behavioral health residential facility plans to admit for respite services who:
 - a. Are included in the requested licensed capacities in subsections (A)(1)(a) and (b),
 - b. Are under 18 years of age and who do not stay overnight in the behavioral health residential facility, and

- c. Are 18 years of age and older and who do not stay overnight in the behavioral health residential facility; and

6. For an outdoor behavioral health care program, a copy of the outdoor behavioral health care program's current accreditation report.

- B.** A licensee of an outdoor behavioral health care program shall submit a copy of the outdoor behavioral health care program's current accreditation report to the Department with the relevant fees required in R9-10-106(C).

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-702 repealed, new Section R9-10-702 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-703. Administration

- A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of a behavioral health residential facility;
 2. Establish, in writing:
 - a. A behavioral health residential facility's scope of services, and
 - b. Qualifications for an administrator;
 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
 4. Adopt a quality management program according to R9-10-704;
 5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
 6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b), if the administrator is:
 - a. Expected not to be present on the behavioral health residential facility's premises for more than 30 calendar days, or
 - b. Not present on the behavioral health residential facility's premises for more than 30 calendar days; and
 7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there

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is a change in the administrator and identify the name and qualifications of the new administrator.

B. An administrator:

1. Is directly accountable to the governing authority of a behavioral health residential facility for the daily operation of the behavioral health residential facility and all services provided by or at the behavioral health residential facility;
2. Has the authority and responsibility to manage the behavioral health residential facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the behavioral health residential facility's premises and accountable for the behavioral health residential facility when the administrator is not present on the behavioral health residential facility's premises.

C. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a resident;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training including:
 - i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - 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 that the individual has received cardiopulmonary resuscitation training;
 - f. Cover implementation of the requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;
 - g. Cover implementation of the requirements in A.R.S. § 8-804, if applicable;
 - h. Cover first aid training;
 - i. Include a method to identify a resident to ensure the resident receives physical health services and behavioral health services as ordered;
 - j. Cover resident rights, including assisting a resident who does not speak English or who has a physical or other disability to become aware of resident rights;
 - k. Cover specific steps for:
 - i. A resident to file a complaint, and
 - ii. The behavioral health residential facility to respond to a resident complaint;
 - l. Cover health care directives;
 - m. Cover medical records, including electronic medical records;
 - n. Cover a quality management program, including incident reports and supporting documentation;

- o. Cover contracted services; and
 - p. Cover when an individual may visit a resident in a behavioral health residential facility;
2. Policies and procedures for behavioral health services and physical health services are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover resident screening, admission, assessment, treatment plan, transport, transfer, discharge planning, and discharge;
 - b. Cover the provision of behavioral health services and physical health services;
 - c. Include when general consent and informed consent are required;
 - d. Cover emergency safety responses;
 - e. Cover a resident's personal funds account;
 - f. Cover dispensing medication, administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
 - g. Cover prescribing a controlled substance to minimize substance abuse by a resident;
 - h. Cover respite services, including, as applicable, respite services for individuals who are admitted:
 - i. To receive respite services for up to 30 calendar days as a resident of the behavioral health residential facility, and
 - ii. For respite services and do not stay overnight in the behavioral health residential facility;
 - i. Cover services provided by an outdoor behavioral health care program, if applicable;
 - j. Cover infection control;
 - k. Cover resident time-out;
 - l. Cover resident outings;
 - m. Cover environmental services that affect resident care;
 - n. Cover whether pets and other animals are allowed on the premises, including procedures to ensure that any pets or other animals allowed on the premises do not endanger the health or safety of residents or the public;
 - o. If animals are used as part of a therapeutic program, cover:
 - i. Inoculation/vaccination requirements, and
 - ii. Methods to minimize risks to a resident's health and safety;
 - p. Cover the process for receiving a fee from a resident and refunding a fee to a resident;
 - q. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks;
 - r. Cover the security of a resident's possessions that are allowed on the premises;
 - s. Cover smoking and the use of tobacco products on the premises; and
 - t. Cover how the behavioral health residential facility will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
 3. Policies and procedures are reviewed at least once every three years and updated as needed;
 4. Policies and procedures are available to personnel members, employees, volunteers, and students; and

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5. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health residential facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health residential facility.
- D. If an applicant requests or a behavioral health residential facility has a licensed capacity of 10 or more residents, an administrator shall designate a clinical director who:
 1. Provides direction for the behavioral health services provided by or at the behavioral health residential facility;
 2. Is a behavioral health professional; and
 3. May be the same individual as the administrator, if the individual meets the qualifications in subsections (A)(2)(b) and (D)(1) and (2).
- E. Except for respite services, an administrator shall ensure that medical services, nursing services, health-related services, or ancillary services provided by a behavioral health residential facility are only provided to a resident who is expected to be present in the behavioral health residential facility for more than 24 hours.
- F. The administrator of a behavioral health residential facility providing services to children shall notify the Department within 30 calendar days after:
 1. Beginning to contract exclusively with the federal government, and
 2. Receiving only federal monies for services provided.
- G. An administrator shall provide written notification to the Department of a resident's:
 1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
 2. Self-injury, within two working days after the resident inflicts a self-injury or has an accident that requires immediate intervention by an emergency medical services provider.
- H. If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a behavioral health residential facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
 1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 2. For a resident under 18 years of age, according to A.R.S. § 13-3620.
- I. If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a behavioral health residential facility's employee or personnel member, the administrator shall:
 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Report the suspected abuse, neglect, or exploitation of the resident:
 - a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (I)(1); and
 - c. The report in subsection (I)(2);
4. Maintain the documentation in subsection (I)(3) for at least 12 months after the date of the report in subsection (I)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in (I)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (I)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- J. In addition to the notification requirements in subsections (F), (G), (H), and (I), an administrator of a behavioral health residential facility providing services to children that contracts exclusively with the federal government and receives only federal monies for services provided shall comply with A.R.S. § 36-418.
- K. An administrator shall:
 1. Establish and document requirements regarding residents, personnel members, employees, and other individuals entering and exiting the premises;
 2. For a behavioral health residential facility licensed according to A.R.S. § 36-425.06 and in addition to the requirements in subsection (K)(1), establish and document requirements for a resident admitted according to A.R.S. § 36-550.09, consistent with R9-10-722(D);
 3. Establish and document guidelines for meeting the needs of an individual residing at a behavioral health residential facility with a resident, such as a child accompanying a parent in treatment, if applicable;
 4. If children under the age of 12, who are not admitted to a behavioral health residential facility, are residing at the behavioral health residential facility and being cared for by employees or personnel members, ensure that:
 - a. An employee or personnel member caring for children has current cardiopulmonary resuscitation and first aid training specific to the ages of children being cared for; and
 - b. The staff-to-children ratios in A.A.C. R9-5-404(A) are maintained, based on the age of the youngest child in the group;
 5. Establish and document the process for responding to a resident's need for immediate and unscheduled behavioral health services or physical health services;
 6. Establish and document the criteria for determining when a resident's absence is unauthorized, including criteria for a resident who:
 - a. Was admitted under A.R.S. Title 36, Chapter 5, Articles 3, 4, 5, or 10;

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- b. Is absent against medical advice; or
 - c. Is under the age of 18;
- 7. If a resident's absence is unauthorized as determined according to the criteria in subsection (K)(5), within an hour after determining that the resident's absence is unauthorized, notify:
 - a. For a resident who is under 18 years of age, the resident's parent or legal guardian; and
 - b. For a resident who is under a court's jurisdiction, the appropriate court;
- 8. Maintain a written log of unauthorized absences for at least 12 months after the date of a resident's absence that includes the:
 - a. Name of a resident absent without authorization,
 - b. Name of the individual to whom the report required in subsection (K)(6) was submitted, and
 - c. Date of the report; and
- 9. Evaluate and take action related to unauthorized absences under the quality management program in R9-10-704.
- L.** An administrator shall ensure that a personnel member who is able to read, write, understand, and communicate in English is on the premises of the behavioral health residential facility.
- M.** An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, employee, resident, or a resident's representative:
 - 1. The behavioral health residential facility's current license,
 - 2. The location at which inspection reports required in R9-10-720(C) are available for review or can be made available for review, and
 - 3. The calendar days and times when a resident may accept visitors or make telephone calls.
- N.** An administrator shall ensure that:
 - 1. Labor performed by a resident for the behavioral health residential facility is consistent with A.R.S. § 36-510;
 - 2. A resident who is a child is only released to the child's custodial parent, guardian, or custodian or as authorized in writing by the child's custodial parent, guardian, or custodian;
 - 3. The administrator obtains documentation of the identity of the parent, guardian, custodian, or family member authorized to act on behalf of a resident who is a child; and
 - 4. A resident, who is an incapacitated person according to A.R.S. § 14-5101 or who is gravely disabled, is assisted in obtaining a resident's representative to act on the resident's behalf.
- O.** If an administrator determines that a resident is incapable of handling the resident's financial affairs, the administrator shall:
 - 1. Notify the resident's representative or contact a public fiduciary or a trust officer to take responsibility of the resident's financial affairs, and
 - 2. Maintain documentation of the notification required in subsection (O)(1) in the resident's medical record for at least 12 months after the date of the notification.
- P.** If an administrator manages a resident's money through a personal funds account, the administrator shall ensure that:
 - 1. Policies and procedure are established, developed, and implemented for:
 - a. Using resident's funds in a personal funds account,
 - b. Protecting resident's funds in a personal funds account,
 - c. Investigating a complaint about the use of resident's funds in a personal funds account and ensuring that the complaint is investigated by an individual who does not manage the personal funds account,
 - d. Processing each deposit into and withdrawal from a personal funds account, and
 - e. Maintaining a record for each deposit into and withdrawal from a personal funds account; and
 - 2. The personal funds account is only initiated after receiving a written request that:
 - a. Is provided:
 - i. Voluntarily by the resident,
 - ii. By the resident's representative, or
 - iii. By a court of competent jurisdiction;
 - b. May be withdrawn at any time; and
 - c. Is maintained in the resident's record.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-703 repealed, new Section R9-10-703 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1). At the request of the Department clerical errors have been corrected to R9-10-703(K)(7) and (8)(b), referencing subsections that were not amended when subsection (I) was renamed to subsection (K) at 26 A.A.R. 551 (Supp. 21-2).

R9-10-704. 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 services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident 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 resident care; and

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

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-704 repealed, new Section R9-10-704 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-705. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-705 repealed, new Section R9-10-705 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at

20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-706. Personnel

A. An administrator shall ensure that:

1. A personnel member, an employee, or a student is at least 18 years old; and
2. A volunteer is at least 21 years old.

B. An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the residents receiving behavioral health services or physical health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;

2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures; and
3. Sufficient personnel members are present on a behavioral health residential facility's premises with the qualifications, experience, skills, and knowledge necessary to:
 - a. Provide the services in the behavioral health residential facility's scope of services,
 - b. Meet the needs of a resident, and
 - c. Ensure the health and safety of a resident.

C. An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.

D. An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as 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 A.A.C. R4-6-101.

E. An administrator shall ensure that:

1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;

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2. A personnel member completes orientation before providing behavioral health services or physical health services;
 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 4. A written plan is developed and implemented to provide in-service education specific to the duties of a personnel member; and
 5. A personnel member's in-service education 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.
- F.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and
 2. As specified in R9-10-113.
- G.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. The individual's compliance with requirements in A.R.S. §§ 36-411, 36-411.01, and 36-425.03, as applicable;
 - f. The individual's compliance with the requirements in A.R.S. § 8-804, if applicable;
 - g. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - h. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-703(C)(1)(e);
 - i. First aid training, if required for the individual according to this Article or policies and procedures; and
 - j. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F).
- H.** An administrator shall ensure that personnel records are:
1. Maintained:
 - a. Throughout an individual's period of providing services at or for the behavioral health residential facility, and
 - b. For at least 24 months after the last date the individual provided services in or for the behavioral health residential facility; and
 2. For a personnel member who has not provided physical health services or behavioral health services at or for the behavioral health residential facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- I.** An administrator shall ensure that a personnel member who is recidivism reduction staff at an adult residential care institution:
1. Submits an application for a fingerprint clearance card according to A.R.S. § 36-411; and
 2. If the personnel member is denied a fingerprint clearance card, is evaluated to determine whether the personnel member:
 - a. Has successfully completed treatment for recidivism reduction as shown by:
 - i. Documentation of completion of treatment for recidivism reduction;
 - ii. If applicable, continued negative results on random drug screening tests;
 - iii. If applicable, continued participation in a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous, or a support group related to the personnel member's behavioral health issue; and
 - iv. No arrests or convictions of the personnel member related to the reason for denial of the fingerprint clearance card within the previous two years; and
 - b. Is not likely to be a threat to the health or safety of staff or residents through:
 - i. Review of the reasons for denial of a fingerprint clearance card;
 - ii. Assessment of the situations or circumstances that may have contributed to the reasons for denial of a fingerprint clearance card;
 - iii. Review of the steps taken by the personnel member to address the situations or circumstances that may have contributed to the reasons for denial of a fingerprint clearance card;
 - iv. Observation of the personnel member's interactions with residents while under direct visual supervision, as defined in A.R.S. § 36-411, by personnel members having a valid fingerprint clearance card; and
 - v. Institution of any other methods, according to policies and procedures, specific to the:
 - (1) Behavioral health residential facility;
 - (2) Issues of the residents that place them at risk for a future threat of prosecution, diversion, or incarceration; and
 - (3) Recidivism reduction services that are expected to be provided by the personnel member.
- J.** An administrator shall ensure that the following personnel members have first-aid and cardiopulmonary resuscitation training specific to the populations served by the behavioral health residential facility:
1. At least one personnel member who is present at the behavioral health residential facility during hours of operation of the behavioral health residential facility, and
 2. Each personnel member participating in an outing.

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K. An administrator shall ensure that:

1. At least one personnel member is present and awake at the behavioral health residential facility when a resident is on the premises;
2. In addition to the personnel member in subsection (K)(1), at least one personnel member is on-call and available to come to the behavioral health residential facility if needed;
3. There is a daily staffing schedule that:
 - a. Indicates the date, scheduled work hours, and name of each employee assigned to work, including on-call personnel members;
 - b. Includes documentation of the employees who work each calendar day and the hours worked by each employee; and
 - c. Is maintained for at least 12 months after the last date on the documentation;
4. A behavioral health professional is present at the behavioral health residential facility or on-call;
5. A registered nurse is present at the behavioral health residential facility or on-call; and
6. If a resident requires services that the behavioral health residential facility is not authorized or not able to provide, a personnel member arranges for the resident to be transported to a hospital or another health care institution where the services can be provided.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-706 repealed, new Section R9-10-706 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). The Notice of Final Expedited rulemaking filed by the Department and published at 26 A.A.R. 3041 (File no. R20-200), contained omissions of amended rule text previously codified. This notice did not include amendments made to subsections R9-10-706(G)(3)(e), and R9-10-706(I), (J), and (K) as published at 25 A.A.R. 1583 (File no. R19-115); amendments to subsections R9-10-706(G)(3)(f), (g), (h), (i) and (j) as published at 25 A.A.R. 551 (File no. R20-42); the new Section R9-10-706 as made with subsection R9-10-

706(B)(2)(b), including the word “and” after the semicolon as published at 19 A.A.R. 2015 (File no. R13-15). This notice also erroneously included a change to the reference of a subsection in (G)(3)(h) which has been corrected to R9-10-703(C)(1)(e) as originally made at 19 A.A.R. 2015 and amended at 20 A.A.R. 1409 (File no. R14-68). The omission of amendments to these subsections were published as filed by the Department and have been corrected as amended in the original notices at the Department’s request (Supp. 21-2). Due to a Department error published at 26 A.A.R. 551, subsections R9-10-706(I), (J), and (K) have been corrected as amended at 25 A.A.R. 1583 (Supp. 21-3).

R9-10-707. Admission; Assessment**A.** An administrator shall ensure that:

1. A resident is admitted based upon:
 - a. The resident’s primary condition for which the resident is admitted to the behavioral health residential facility being a behavioral health issue, and
 - b. The resident’s behavioral health issue and treatment needs are within the behavioral health residential facility’s scope of services;
2. A behavioral health professional, authorized by policies and procedures to admit a resident, is available;
3. Except as provided in subsection (A)(4), general consent is obtained from:
 - a. An adult resident or the resident’s representative before or at the time of admission, or
 - b. A resident’s representative, if the resident is not an adult;
4. General consent is not required from a patient receiving a court-ordered evaluation or court-ordered treatment;
5. The general consent obtained in subsection (A)(3) is documented in the resident’s medical record;
6. Except as provided in subsection (E)(1)(a), a medical practitioner performs a medical history and physical examination or a registered nurse performs a nursing assessment on a resident within 30 calendar days before admission or within 72 hours after admission and documents the medical history and physical examination or nursing assessment in the resident’s medical record within 72 hours after admission;
7. If a medical practitioner performs a medical history and physical examination or a nurse performs a nursing assessment on a resident before admission, the medical practitioner enters an interval note or the nurse enters a progress note in the resident’s medical record within seven calendar days after admission;
8. If a behavioral health assessment is conducted by a:
 - a. Behavioral health technician or registered nurse, within 24 hours a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the resident; or
 - b. Behavioral health paraprofessional, a behavioral health professional, certified or licensed to provide the behavioral health services needed by the resident, supervises the behavioral health paraprofessional during the completion of the assessment and signs the assessment to ensure that the assessment identifies the behavioral health services needed by the resident;

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9. Except as provided in subsection (A)(10), a behavioral health assessment for a resident is completed before treatment for the resident is initiated;
 10. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the behavioral health residential facility or if the behavioral health residential facility has a medical record for the resident that contains a behavioral health assessment that was completed within 12 months before the date of the resident's current admission:
 - a. The resident's assessment information is reviewed before treatment for the resident is initiated and updated if additional information that affects the resident's assessment is identified, and
 - b. The review and update of the resident's assessment information is documented in the resident's medical record within 48 hours after the review is completed;
 11. A behavioral health assessment:
 - a. Documents a resident's:
 - i. Presenting issue;
 - ii. Substance abuse history;
 - iii. Co-occurring disorder;
 - iv. Legal history, including:
 - (1) Custody,
 - (2) Guardianship, and
 - (3) Pending litigation;
 - v. Criminal justice record;
 - vi. Family history;
 - vii. Behavioral health treatment history;
 - viii. Symptoms reported by the resident; and
 - ix. Referrals needed by the resident, if any;
 - b. Includes:
 - i. Recommendations for further assessment or examination of the resident's needs,
 - ii. The physical health services or ancillary services that will be provided to the resident until the resident's treatment plan is completed, and
 - iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
 - c. Is documented in resident's medical record;
 12. A resident is referred to a medical practitioner if a determination is made that the resident requires immediate physical health services or the resident's behavioral health issue may be related to the resident's medical condition; and
 13. Except as provided in subsection (E)(1)(d), a resident provides evidence of freedom from infectious tuberculosis:
 - a. Before or within seven calendar days after the resident's admission, and
 - b. As specified in R9-10-113.
- B.** An administrator shall ensure that:
1. A request for participation in a resident's behavioral health assessment is made to the resident or the resident's representative,
 2. An opportunity for participation in the resident's behavioral health assessment is provided to the resident or the resident's representative, and
 3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.
- C.** An administrator shall ensure that a resident's behavioral health assessment information is documented in the medical record within 48 hours after completing the behavioral health assessment.
- D.** If information in subsection (A)(10) is obtained about a resident after the resident's behavioral health assessment is completed, an administrator shall ensure that an interval note, including the information, is documented in the resident's medical record within 24 hours after the information is obtained.
- E.** If a behavioral health residential facility is authorized to provide respite services, an administrator shall ensure that:
1. Upon admission of a resident for respite services:
 - a. Except as provided in subsection (F), a medical history and physical examination of the resident:
 - i. Is performed; or
 - ii. If dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;
 - b. A treatment plan that meets the requirements in R9-10-708:
 - i. Is developed; or
 - ii. If dated within the previous 12 months, is available in the resident's medical record from a previous admission to the behavioral health residential facility;
 - c. If a treatment plan, dated within the previous 12 months, is available, the treatment plan is reviewed, updated, and documented in the resident's medical record; and
 - d. The resident is not required to comply with the requirements in subsection (A)(13) if the resident is not expected to be present in the behavioral health residential facility:
 - i. For more than seven consecutive days, or
 - ii. For 10 days or more days in a 90-consecutive-day period;
 2. The common area required in R9-10-722(B)(1)(b) provides at least 25 square feet for each resident, including residents who do not stay overnight; and
 3. In addition to the requirements in R9-10-722(B)(3), toilets and hand-washing sinks are available to residents, including residents who do not stay overnight, as follows:
 - a. There is at least one working toilet that flushes and has a seat and one sink with running water for every 10 residents,
 - b. There are at least two working toilets that flush and have seats and two sinks with running water if there are 11 to 25 residents, and
 - c. There is at least one additional working toilet that flushes and has a seat and one additional sink with running water for each additional 20 residents.
- F.** A medical history and physical examination is not required for a child who is admitted or expected to be admitted to a residential behavioral health facility for less than 10 days in a 90-consecutive-day period.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as

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an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-707 repealed, new Section R9-10-707 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-708. Treatment Plan

- A.** An administrator shall ensure that a treatment plan is developed and implemented for each resident that:
1. Is based on the medical history and physical examination or nursing assessment required in R9-10-707(A)(6) or (E)(1)(a) and the behavioral health assessment required in R9-10-707(A)(9) or (10) and on-going changes to the behavioral health assessment of the resident;
 2. Is completed:
 - a. By a behavioral health professional or a behavioral health technician under the clinical oversight of a behavioral health professional, and
 - b. Before the resident receives physical health services or behavioral health services or within 48 hours after the assessment is completed;
 3. Is documented in the resident's medical record within 48 hours after the resident first receives physical health services or behavioral health services;
 4. Includes:
 - a. The resident's presenting issue;
 - b. The physical health services or behavioral health services to be provided to the resident;
 - c. The signature of the resident or the resident's representative and date signed, or documentation of the refusal to sign;
 - d. The date when the resident'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, is reviewed and signed by a behavioral health professional within 24 hours after the completion of the treatment plan to ensure that the treatment plan is complete and accurate and meets the resident'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 changed,

- c. When additional information that affects the resident's behavioral health assessment is identified, and
- d. When a resident 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 resident's treatment plan is made to the resident or the resident's representative,
2. An opportunity for participation in developing the resident's treatment plan is provided to the resident or the resident's representative, and
3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-708 repealed, new Section R9-10-708 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-709. Discharge

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

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3. The request in subsection (B)(1) and the opportunity in subsection (B)(2) are documented in the resident's medical record.
- C. An administrator shall ensure that a resident is discharged from a behavioral health residential facility when the resident's treatment needs are not consistent with the services that the behavioral health residential facility is authorized and able to provide.
- D. An administrator shall ensure that there is a documented discharge order by a medical practitioner or behavioral health professional before a resident is discharged unless the resident leaves the behavioral health residential facility against a medical practitioner's or behavioral health professional's advice.
- E. An administrator shall ensure that, at the time of discharge, a resident receives a referral for treatment or ancillary services that the resident may need after discharge, if applicable.
- F. If a resident is discharged to any location other than a health care institution, an administrator shall ensure that:
 1. Discharge instructions are documented, and
 2. The resident or the resident's representative is provided with a copy of the discharge instructions.
- G. An administrator shall ensure that a discharge summary for a resident:
 1. Is entered into the resident's medical record within 10 working days after a resident's discharge; and
 2. Includes:
 - a. The following information authenticated by a medical practitioner or behavioral health professional:
 - i. The resident's presenting issue and other physical health and behavioral health issues identified in the resident's treatment plan;
 - ii. A summary of the treatment provided to the resident;
 - iii. The resident'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 ordered for the resident by a medical practitioner at the behavioral health residential facility at the time of the resident's discharge; and
 - b. A description of the disposition of the resident's possessions, funds, or medications brought to the behavioral health residential facility by the resident.
- H. An administrator shall ensure that a resident who is dependent upon a prescribed medication is offered a written referral to detoxification services or opioid treatment before the resident is discharged from the behavioral health residential facility if a medical practitioner for the behavioral health residential facility will not be prescribing the medication for the resident at or after discharge.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989

(Supp. 89-4). Section R9-10-709 repealed, new Section R9-10-709 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-710. Transport; Transfer

- A. Except as provided in subsection (B), an administrator shall ensure that:
 1. A personnel member coordinates the transport and the services provided to the resident;
 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport,
 - b. Information from the resident's medical record is provided to a receiving health care institution, and
 - c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transport.
- B. Subsection (A) does not apply to:
 1. Transportation to a location other than a licensed health care institution,
 2. Transportation provided for a resident by the resident or the resident's representative,
 3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
 4. A transport to another licensed health care institution in an emergency.
- C. Except for a transfer of a resident due to an emergency, an administrator shall ensure that:
 1. A personnel member coordinates the transfer and the services provided to the resident;
 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transfer.

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Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section R9-10-710 repealed, new Section R9-10-710 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-711. Resident Rights**A.** An administrator shall ensure that:

1. The requirements in subsection (B) and the resident rights in subsection (E) are conspicuously posted on the premises;
2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (E); and
3. Policies and procedures include:
 - a. How and when a resident or the resident's representative is informed of the resident rights in subsection (E), and
 - b. Where resident rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A resident is treated with dignity, respect, and consideration;
2. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity;
 - k. Misappropriation of personal and private property by the behavioral health residential facility's personnel members, employees, volunteers, or students;
 - l. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the resident's treatment needs, except as established in a fee agreement signed by the resident or the resident's representative; or
 - m. Treatment that involves the denial of:
 - i. Food,
 - ii. The opportunity to sleep, or

- iii. The opportunity to use the toilet;
3. Except as provided in subsection (C) or (D), and unless restricted by the resident's representative, a resident is allowed to:
 - a. Associate with individuals of the resident's choice, receive visitors, and make telephone calls during the hours established by the behavioral health residential facility;
 - b. Have privacy in correspondence, communication, visitation, financial affairs, and personal hygiene; and
 - c. Unless restricted by a court order, send and receive uncensored and unopened mail; and
4. A resident or the resident's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated, unless the treatment is:
 - i. Ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01;
 - ii. Necessary to save the resident's life or physical health; or
 - iii. Provided according to A.R.S. § 36-512;
 - c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;
 - d. Is informed of the following:
 - i. The behavioral health residential facility's policy on health care directives, and
 - ii. The resident complaint process; and
 - e. Except as otherwise permitted by law, provides written consent to the release of information in the resident's:
 - i. Medical record, or
 - ii. Financial records.
- C.** For a behavioral health residential facility with licensed capacity of less than 10 residents, if a behavioral health professional determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the behavioral health professional shall:
 1. Document a specific treatment purpose in the resident's medical record that justifies restricting the resident from the activity,
 2. Inform the resident or resident's representative of the reason why the activity is being restricted, and
 3. Inform the resident or resident's representative of the resident's right to file a complaint and the procedure for filing a complaint.
- D.** For a behavioral health residential facility with a licensed capacity of 10 or more residents, if a clinical director determines that a resident's treatment requires the behavioral health residential facility to restrict the resident's ability to participate in the activities in subsection (B)(3), the clinical director shall comply with the requirements in subsections (C)(1) through (3).
- E.** A resident has the following rights:
 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that:
 - a. Supports and respects the resident's individuality, choices, strengths, and abilities;

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- b. Supports the resident's personal liberty and only restricts the resident's personal liberty according to a court order, by the resident's or the resident's representative's general consent, or as permitted in this Chapter; and
 - c. Is provided in the least restrictive environment that meets the resident's treatment needs;
 - 3. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
 - a. A resident may be photographed when admitted to a behavioral health residential facility for identification and administrative purposes;
 - b. For a resident receiving treatment according to A.R.S. Title 36, Chapter 37; or
 - c. For video recordings used for security purposes that are maintained only on a temporary basis;
 - 4. Not to be prevented or impeded from exercising the resident's civil rights unless the resident has been adjudicated incompetent or a court of competent jurisdiction has found that the resident is not able to exercise a specific right or category of rights;
 - 5. To review, upon written request, the resident's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 - 6. To be provided locked storage space for the resident's belongings while the resident receives treatment;
 - 7. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
 - 8. To be informed of the requirements necessary for the resident's discharge or transfer to a less restrictive physical environment;
 - 9. To receive a referral to another health care institution if the behavioral health residential facility is not authorized or not able to provide physical health services or behavioral health services needed by the resident;
 - 10. To participate or have the resident's representative participate in the development of a treatment plan or decisions concerning treatment;
 - 11. To participate or refuse to participate in research or experimental treatment; and
 - 12. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.
- a. Recorded only by a personnel member authorized by 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 resident's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 5. A resident's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the resident's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law;
 - 6. Policies and procedures include the maximum time-frame to retrieve a resident's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
 - 7. A resident's medical record is protected from loss, damage, or unauthorized use.
 - B.** If a behavioral health residential facility maintains residents' medical records electronically, an administrator shall ensure that:
 - 1. Safeguards exist to prevent unauthorized access, and
 - 2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.
 - C.** An administrator shall ensure that a resident's medical record contains:
 - 1. Resident information that includes:
 - a. The resident's name;
 - b. The resident's address;
 - c. The resident's date of birth; and
 - d. Any known allergies, including medication allergies;
 - 2. The name of the admitting medical practitioner or behavioral health professional;
 - 3. An admitting diagnosis or presenting behavioral health issues;
 - 4. The date of admission and, if applicable, date of discharge;
 - 5. If applicable, the name and contact information of the resident's representative and:
 - a. If the resident is 18 years of age or older or an emancipated minor, the document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-712. Medical Records**A.** An administrator shall ensure that:

- 1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
- 2. An entry in a resident's medical record is:

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- ii. Is a legal guardian, a copy of the court order establishing guardianship;
- 6. If applicable, documented general consent and informed consent for treatment by the resident or the resident's representative;
- 7. Documentation of medical history and results of a physical examination;
- 8. A copy of resident's health care directive, if applicable;
- 9. Orders;
- 10. If applicable, documentation that evaluation or treatment was ordered by a court according to A.R.S. Title 36, Chapter 5 or A.R.S. § 8-341.01;
- 11. Assessment;
- 12. Treatment plans;
- 13. Interval notes;
- 14. Progress notes;
- 15. Documentation of behavioral health services and physical health services provided to the resident;
- 16. If applicable, documentation of the use of an emergency safety response;
- 17. If applicable, documentation of time-out required in R9-10-714(6);
- 18. Except as allowed in R9-10-707(E)(1)(d), documentation of freedom from infectious tuberculosis required in R9-10-707(A)(13);
- 19. The disposition of the resident after discharge;
- 20. The discharge plan;
- 21. The discharge summary, if applicable;
- 22. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Diagnostic reports, and
 - d. Consultation reports; and
- 23. Documentation of medication administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain, when administered initially or on a PRN basis:
 - i. An assessment of the resident's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication, when administered initially or on a PRN basis:
 - i. An assessment of the resident's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or providing assistance in the self-administration of the medication; and
 - f. Any adverse reaction a resident has to the medication.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

tive July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-713. Transportation; Resident Outings

- A.** An administrator of a behavioral health residential facility that uses a vehicle owned or leased by the behavioral health residential facility to provide transportation to a resident shall ensure that:
 - 1. The vehicle:
 - a. Is safe and in good repair,
 - b. Contains a first aid kit,
 - c. Contains drinking water sufficient to meet the needs of each resident present in the vehicle, and
 - d. Contains a working heating and air conditioning system;
 - 2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle are maintained;
 - 3. A driver of the vehicle:
 - a. Is 21 years of age or older;
 - b. Has a valid driver license;
 - c. Operates the vehicle in a manner that does not endanger a resident in the vehicle;
 - d. Does not leave in the vehicle an unattended:
 - i. Child,
 - ii. Resident who may be a threat to the health or safety of the resident or another individual, or
 - iii. Resident who is incapable of independent exit from the vehicle; and
 - e. Ensures the safe and hazard-free loading and unloading of residents; and
 - 4. Transportation safety is maintained as follows:
 - a. Each individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
 - b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a resident's body.
- B.** An administrator shall ensure that:
 - 1. An outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each resident participating in the outing;
 - 2. At least two personnel members are present on an outing;
 - 3. In addition to the personnel members required in subsection (B)(2), a sufficient number of personnel members are present to ensure each resident's health and safety on the outing;
 - 4. Documentation is developed before an outing that includes:
 - a. The name of each resident 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 resident;
 - 5. The documentation described in subsection (B)(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

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6. Emergency information for each resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
 - a. The resident's name;
 - b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
 - c. The resident's allergies; and
 - d. The name and telephone number of a designated individual to notify in case of an emergency, who is present on the behavioral health residential facility's premises.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-714. Resident Time-Out

An administrator shall ensure that a time-out:

1. Is provided to a resident who voluntarily decides to go in a time-out;
2. Takes place in an area that is unlocked, lighted, quiet, and private;
3. Is time-limited and does not exceed the amount of time as determined by the resident;
4. Does not result in a resident missing a meal if the resident is in time-out at mealtime;
5. Includes monitoring of the resident by a personnel member at least once every 15 minutes to ensure the resident's health and safety and to discuss with the resident if the resident is ready to leave time-out; and
6. Is documented in the resident's medical record, to include:
 - a. The date of the time-out,
 - b. The reason for the time-out,
 - c. The duration of the time-out, and
 - d. The action planned and taken by the administrator to prevent the use of time-out in the future.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-715. Physical Health Services

An administrator of a behavioral health residential facility that is authorized to provide personal care services shall ensure that:

1. Personnel members who provide personal care services have documentation of completion of a caregiver training program that complies with A.A.C. R4-33-702(A)(5);
2. Residents receive personal care services according to the requirements in R9-10-814(A), (D), (E), and (F); and
3. A resident who has a stage 3 or stage 4 pressure sore is not admitted to the behavioral health residential facility.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-716. Behavioral Health Services

A. An administrator shall ensure that:

1. If a behavioral health residential facility is authorized to provide court-ordered evaluation or court-ordered treatment:
 - a. Court-ordered evaluation is provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 4; and
 - b. Court-ordered treatment is provided in compliance with the requirements in A.R.S. Title 36, Chapter 5, Article 5;
2. If a behavioral health residential facility is authorized to provide behavioral health services to individuals whose behavioral health issue limits the individuals' ability to function independently, a resident admitted to the behavioral health residential facility with limited ability to function independently receives:
 - a. Behavioral health services and personal care services as indicated in the resident's treatment plan, and
 - b. Continuous protective oversight;
3. A resident admitted to the behavioral health residential facility who needs behavioral health services to maintain or enhance the resident's ability to function independently:
 - a. Receives behavioral health services, and, if indicated in the resident's treatment plan, personal care services; and
 - b. Is provided an opportunity to participate in activities designed to maintain or enhance the resident's ability to function independently while:
 - i. The resident receives services to maintain the resident's health, safety, or personal hygiene; or
 - ii. Homemaking functions are performed for the resident;
4. Behavioral health services are provided to meet the needs of a resident and are consistent with a behavioral health residential facility's scope of services;
5. Behavioral health services listed in the behavioral health residential facility's scope of services are provided on the premises;
6. Before a resident participates in behavioral health services provided in a setting or activity with more than one resident participating, the diagnoses, treatment needs,

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developmental levels, social skills, verbal skills, and personal histories, including any history of physical or sexual abuse, of the residents participating are reviewed to ensure that the:

- a. Health and safety of each resident is protected, and
- b. Treatment needs of each resident participating are being met; and

7. A resident does not:

- a. Use or have access to any materials, furnishings, or equipment or participate in any activity or treatment that may present a threat to the resident's health or safety based on the resident's documented diagnosis, treatment needs, developmental levels, social skills, verbal skills, or personal history; or
- b. Share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that may present a threat to the resident's health or safety, based on the other resident's documented 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 behavioral health residential facility's scope of services,
- 2. Provided according to the frequency and number of hours identified in the resident'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. Each counseling session is documented in a resident's medical record to include:
 - a. The date of the counseling session;
 - b. The amount of time spent in the counseling session;
 - c. Whether the counseling was individual counseling, family counseling, or group counseling;
 - d. The treatment goals addressed in the counseling session; and
 - e. The signature of the personnel member who provided the counseling and the date signed.

D. An administrator of a behavioral health residential facility authorized to provide behavioral health services to individuals under 18 years of age:

- 1. May continue to provide behavioral health services to a resident who is 18 years of age or older:
 - a. If the resident:
 - i. Was admitted to the behavioral health residential facility before the resident's 18th birthday;
 - ii. Is not 21 years of age or older; and
 - iii. Is:
 - (1) Attending classes or completing coursework to obtain a high school or a high school equivalency diploma, or
 - (2) Participating in a job training program; or
 - b. Through the last calendar day of the month of the resident's 18th birthday; and
- 2. Shall ensure that:
 - a. A resident does not receive the following from other residents at the behavioral health residential facility:
 - i. Threats,
 - ii. Ridicule,
 - iii. Verbal harassment,
 - iv. Punishment, or
 - v. Abuse;

- b. The interior of the behavioral health residential facility has furnishings and decorations appropriate to the ages of the residents receiving services at the behavioral health residential facility;
- c. A resident older than three years of age does not sleep in a crib;
- d. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to residents on the premises in a quantity sufficient to meet each resident's needs and are appropriate to each resident's age, developmental level, and treatment needs; and
- e. A resident's educational needs are addressed according to A.R.S. Title 15, Chapter 7, Article 4.

E. An administrator shall ensure that:

- 1. An emergency safety response is:
 - a. Only used:
 - i. By a personnel member trained to use an emergency safety response,
 - ii. For the management of a resident's violent or self-destructive behavior, and
 - iii. When less restrictive interventions have been determined to be ineffective; and
 - b. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;
- 2. Within 24 hours after an emergency safety response is used for a resident, the following information is entered into the resident medical record:
 - a. The date and time the emergency safety response was used;
 - b. The name of each personnel member who used an emergency safety response;
 - c. The specific emergency safety response used;
 - d. The personnel member or resident behavior, event, or environmental factor that caused the need for the emergency safety response; and
 - e. Any injury that resulted from the use of the emergency safety response;
- 3. Within 10 working days after an emergency safety response is used for a resident, the administrator or clinical director reviews the information in subsection (E)(2); and
- 4. After the review required in subsection (E)(3), the following information is entered, according to policies and procedures, into the resident's medical record:
 - a. Actions taken or planned actions to prevent the need for the use of an emergency safety response for the resident,
 - b. A determination of whether the resident is appropriately placed at the behavioral health residential facility, and
 - c. Whether the resident's treatment plan was reviewed or needs to be reviewed and amended to ensure that the resident's treatment plan is meeting the resident's treatment needs.

F. An administrator shall ensure that:

- 1. A personnel member whose job description includes the ability to use an emergency safety response:
 - a. Completes training in crisis intervention that includes:

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- i. Techniques to identify personnel member and resident behaviors, events, and environmental factors that may trigger the need for the use of an emergency safety response;
 - ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods; and
 - iii. The safe use of an emergency safety response including the ability to recognize and respond to signs of physical distress in a client who is receiving an emergency safety response; and
- b. Completes training required in subsection (F)(1)(a):
 - i. Before providing behavioral health services, and
 - ii. At least once every 12 months after the date the personnel member completed the initial training;
- 2. Documentation of the completed training in subsection (F)(1)(a) includes:
 - a. The name and credentials of the individual providing the training,
 - b. Date of the training, and
 - c. Verification of a personnel member's ability to use the training; and
- 3. The materials used to provide the completed training in crisis intervention, including handbooks, electronic presentations, and skills verification worksheets, are maintained for at least 12 months after each personnel member who received training using the materials no longer provides services at the behavioral health residential facility.
- 4. Communication is available between the outdoor behavioral health care program personnel and:
 - a. A behavioral health professional,
 - b. A registered nurse,
 - c. An emergency medical response team, and
 - d. The behavioral health residential facility's administrative office for the outdoor behavioral health care program.
- B. An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program 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 resident such as cut, chopped, ground, pureed, or thickened;
 - 2. A food menu is prepared based on the number of calendar days scheduled for the behavioral health care program;
 - 3. Meals and snacks provided by the behavioral health care program are served according to menus;
 - 4. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2015>;
 - 5. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident'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 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 the resident agrees;
 - 6. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan;
 - 7. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
 - 8. Food is protected from potential contamination; and
 - 9. Food being maintained in coolers containing ice is not in direct contact with ice or water if water may enter the food because of the nature of the food's packaging, wrapping, or container or the positioning of the food in the ice or water.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-717. Outdoor Behavioral Health Care Programs

- A. An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program shall ensure that:
 - 1. Behavioral health services are provided to a resident participating in the outdoor behavioral health care program consistent with the age, developmental level, physical ability, medical condition, and treatment needs of the resident;
 - 2. Continuous protective oversight is provided to a resident;
 - 3. Transportation is provided to a resident from the behavioral health residential facility's administrative office for the outdoor behavioral health care program to the location where the outdoor behavioral health care program is provided and from the location where the outdoor behavioral health care program is provided to the behavioral health residential facility's administrative office for the outdoor behavioral health care program; and
- C. An administrator of a behavioral health residential facility authorized to provide an outdoor behavioral health care program shall ensure that:
 - 1. The location and, if applicable, equipment used by the outdoor behavioral health care program are sufficient to accommodate the activities, treatment, and ancillary services required by the residents participating in the behavioral health care program;
 - 2. The location and equipment are maintained in a condition that allows the location and equipment to be used for the original purpose of the location and equipment;
 - 3. Garbage and refuse are:
 - a. Stored in plastic bags in covered containers, and
 - b. Removed from the location used by the outdoor behavioral health care program at least once a week;
 - 4. Common areas:
 - a. Are lighted when in use to assure the safety of residents, and

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- b. Have sufficient lighting to allow personnel members to monitor resident activity;
- 5. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
- 6. Soiled clothing is stored in closed containers away from food storage, medications, and eating areas;
- 7. Poisonous or toxic materials are maintained in labeled containers, secured, and separate from food preparation and storage, eating areas, and medications and inaccessible to residents;
- 8. Combustible or flammable liquids and hazardous materials are stored in the original labeled containers or safety containers, secured, and inaccessible to residents;
- 9. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
- 10. Smoking or the use of tobacco products may be permitted away from the residents.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-717.01. Recidivism Reduction Services

An administrator of a behavioral health residential facility that is an adult residential care institution and is authorized to provide recidivism reduction services shall ensure that:

- 1. A personnel member who is recidivism reduction staff at the adult residential care institution does not provide:
 - a. Behavioral health services other than recidivism reduction services; or
 - b. Recidivism reduction services to a resident who has not been referred by a physician, behavioral health professional, or court of competent jurisdiction to receive recidivism reduction services;
- 2. The adult residential care institution accepts an individual as a resident only if the individual:
 - a. Is at least 18 years of age; and
 - b. Has documentation of a referral to receive recidivism reduction services that:
 - i. Was made by a physician, behavioral health professional, or court of competent jurisdiction; and
 - ii. Complies with the requirements in A.R.S. § 36-411.01(D);
- 3. The referral is included in the resident's medical record; and

- 4. The recidivism reduction services provided to a resident are:
 - a. Consistent with the age, developmental level, physical ability, medical condition, and treatment needs of the resident; and
 - b. Provided by recidivism reduction staff whose experience is compatible with the experience of the resident.

Historical Note

New Section made by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-718. Medication Services

- A. An administrator shall ensure that policies and procedures for medication services:
 - 1. Include:
 - a. A process for providing information to a resident about medication prescribed for the resident including:
 - 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 any of the following:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a resident's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
 - d. Procedures for documenting, as applicable, medication administration and assistance in the self-administration of medication;
 - e. A process for monitoring a resident who self-administers medication;
 - f. Procedures for assisting a resident in obtaining medication; and
 - g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 - 2. 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. If a behavioral health residential facility provides medication administration, an administrator shall ensure that:
 - 1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a resident only as ordered; and
 - d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
 - 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and

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3. A medication administered to a resident:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the resident's medical record.
- C. If a behavioral health residential facility provides assistance in the self-administration of medication, an administrator shall ensure that:
 1. A resident's medication is stored by the behavioral health residential facility;
 2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the resident;
 - c. Observing the resident while the resident removes the medication from the container;
 - d. Verifying that the medication is taken as prescribed by the resident's medical practitioner by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label,
 - ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
 - iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
 - e. Observing the resident while the resident takes the medication;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a resident:
 - a. Is in compliance with an order, and
 - b. Is documented in the resident's medical record.
- D. 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; and
 3. If pharmaceutical services are provided on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - i. Develop a drug formulary,
 - ii. Update the drug formulary at least once every 12 months,
 - iii. Develop medication usage and medication substitution policies and procedures, and
 - iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical practitioner specifically orders otherwise;
 - b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. 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
 - d. A copy of the pharmacy license is provided to the Department upon request.
- E. When medication is stored at a behavioral health residential facility, an administrator shall ensure that:
 1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions on the medication container; and
 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of residents who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
- F. An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the medical practitioner who ordered or prescribed the medication and, if applicable, the behavioral health residential facility's clinical director.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-719. Food Services

- A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:
 1. For a behavioral health residential facility that has a licensed capacity of more than 10 residents:

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- a. The behavioral health residential facility obtains a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
- b. A copy of the behavioral health residential facility's food establishment license or permit is maintained;
2. If a behavioral health residential facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health residential facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health residential facility;
3. Food is stored, refrigerated, and reheated to meet the dietary needs of a resident;
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 residents.
- B.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, 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 resident, such as cut, chopped, ground, pureed, or thickened;
 2. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 3. Meals and snacks provided by the behavioral health residential facility are served according to posted menus;
 4. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2015>;
 5. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident'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. The resident agrees; and
 - ii. The resident 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 resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
 7. Water is available and accessible to residents unless otherwise stated in a resident's treatment plan.
- C.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, 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; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 165° F;
 4. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
 5. Frozen foods are stored at a temperature of 0° F or below; and
 6. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-720. Emergency and Safety Standards

- A.** Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that a behavioral health residential facility has:
 1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and a sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that are in working order; or
 2. An alternative method to ensure resident's safety that is documented and approved by the local jurisdiction.

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B. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where residents will be relocated;
 - b. How each resident's medical record will be available to individuals providing services to the resident during a disaster;
 - c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
 - d. A plan for obtaining food and water for individuals present in the behavioral health residential facility, under the care and supervision of personnel members, or in the behavioral health residential facility's relocation site during a disaster;
2. The disaster plan required in subsection (B)(1) is reviewed at least once every 12 months;
3. Documentation of a disaster plan review required in subsection (B)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
5. An evacuation drill for employees and residents on the premises is conducted at least once every six months on each shift;
6. Documentation of each evacuation drill is created, is maintained for 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for all employees and residents to evacuate the behavioral health residential facility;
 - c. Names of employees participating in the evacuation drill;
 - d. An identification of residents needing assistance for evacuation;
 - e. Any problems encountered in conducting the evacuation drill; and
 - f. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health residential facility.

C. An administrator shall:

1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
2. Make any repairs or corrections stated on the fire inspection report, and
3. Maintain documentation of a current fire inspection.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp.

98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-721. Environmental Standards

A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that:

1. The premises and equipment are:
 - a. Maintained in a condition that allows the premises and equipment to be used for the original purpose of the premises and equipment;
 - b. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
 - c. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
4. Equipment used at the behavioral health residential 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
6. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
7. Heating and cooling systems maintain the behavioral health residential facility at a temperature between 70° F and 84° F;
8. A space heater is not used;
9. Common areas:
 - a. Are lighted to assure the safety of residents, and
 - b. Have lighting sufficient to allow personnel members to monitor resident activity;
10. Hot water temperatures are maintained between 95° F and 120° F in the areas of the behavioral health residential facility used by residents;
11. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
12. Soiled linen and soiled clothing stored by the behavioral health residential facility are maintained separate from clean linen and clothing and 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 behavioral health residential facility are maintained in labeled con-

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tainers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;

15. Combustible or flammable liquids and hazardous materials stored by a behavioral health residential facility are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
16. If pets or animals are allowed in the behavioral health residential facility, pets or animals are:
 - a. Controlled to prevent endangering the residents and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
17. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 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 tobacco products is not permitted within a behavioral health residential facility; and
2. Smoking tobacco products may be permitted on the premises outside a behavioral health residential 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. If a swimming pool is located on the premises, an administrator shall ensure that:

1. On each day that a resident uses the swimming pool, an employee:
 - a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
 - i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-phenylenediamine test;
 - ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-phenylenediamine test; or
 - iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
 - b. Records the results of the water quality tests in a log that includes each testing date and test result;
2. Documentation of the water quality test is maintained for at least 12 months after the date of the test;
3. A swimming pool is not used by a resident if a water quality test shows that the swimming pool water does not comply with subsection (C)(1)(a);
4. At least one personnel member, with cardiopulmonary resuscitation training that meets the requirements in R9-10-703(C)(1)(e), is present in the pool area when a resident is in the pool area; and
5. At least two personnel members are present in the pool area if two or more residents are in the pool area.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

R9-10-722. Physical Plant Standards

- A.** Except for a behavioral health outdoor program, an administrator shall ensure that the premises and equipment are sufficient to accommodate:
 1. The services in the behavioral health residential facility's scope of services, and
 2. An individual admitted as a resident by the behavioral health residential facility.
- B.** An administrator shall ensure that:
 1. A behavioral health residential facility has a:
 - a. Room that provides privacy for a resident to receive treatment or visitors; and
 - b. Common area and a dining area that contain furniture and materials to accommodate the recreational and socialization needs of the residents and other individuals in the behavioral health residential facility;
 2. At least one bathroom is accessible from a common area that:
 - a. May be used by residents and visitors;
 - b. Provides privacy when in use; and
 - c. Contains the following:
 - i. At least one working sink with running water,
 - ii. At least one working toilet that flushes and has a seat,
 - iii. Toilet tissue for each toilet,
 - iv. Soap in a dispenser accessible from each sink,
 - v. Paper towels in a dispenser or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A window that opens or another means of ventilation;
 3. For every six residents who stay overnight at the behavioral health residential facility, there is at least one working toilet that flushes and has a seat, and one sink with running water;
 4. For every eight residents who stay overnight at the behavioral health residential facility, there is at least one working bathtub or shower;
 5. A resident bathroom provides privacy when in use and contains:
 - a. A shatter-proof mirror, unless the resident's treatment plan allows for otherwise;
 - b. A window that opens or another means of ventilation; and
 - c. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers;
 6. If a resident bathroom door locks from the inside, an employee has a key and access to the bathroom;
 7. Each resident is provided a sleeping area that is in a bedroom; and
 8. A resident bedroom complies with the following:

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- a. Is not used as a common area;
 - b. 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;
 - c. Contains a door that opens into a hallway, common area, or outdoors;
 - d. Is constructed and furnished to provide unimpeded access to the door;
 - e. Has window or door covers that provide resident privacy;
 - f. Has floor to ceiling walls;
 - g. 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 eight residents;
 - (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and
 - (3) Provides at least three feet of floor space between beds or bunk beds;
 - h. Contains for each resident 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 shelves, a dresser, or chest of drawers;
 - i. Has clean linen for each bed including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
 - j. Has sufficient lighting for a resident occupying the bedroom to read; and
 - k. Has a clothing rod or hook in the bedroom designed to minimize the opportunity for a resident to cause self-injury.
- C.** A behavioral health residential facility that was licensed as a Level 4 transitional agency before October 1, 2013 may continue to use a shared bedroom that provides at least 40 square feet of floor space, not including a closet, for each individual occupying the shared bedroom. If there is a modification to the shared bedroom, the behavioral health residential facility shall comply with the requirement in subsection (B)(8)(g).
- D.** For a behavioral health residential facility licensed according to A.R.S. § 36-425.06, an administrator shall ensure that:
- 1. The premises are secure, as defined in A.R.S. § 36-425.06; and
 - 2. There is a means of exiting the facility for a resident who does not have special knowledge for egress that meets one of the following:
 - a. Provides access to an outside area that:
 - i. Allows the resident to be at least 30 feet away from the facility, and
 - ii. Controls or alerts employees of the egress of a resident from the facility;
 - b. Provides access to an outside area:
 - i. From which a resident may exit to a location at least 30 feet away from the facility, and
 - ii. Controls or alerts employees of the egress of a resident from the facility; or
 - c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the Uniform Building Code incorporated by reference in A.A.C. R9-10-104.01.
- E.** If a swimming pool is located on the premises, an administrator shall ensure that:
- 1. The swimming pool is equipped with the following:
 - a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
 - i. A removable strainer,
 - ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
 - iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
 - b. An operational vacuum cleaning system;
 - 2. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (E)(2)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and
 - 3. A life preserver or shepherd's crook 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)(2) is covered and locked when not in use.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 26 A.A.R. 551, with an immediate effective date of March 3, 2020 (Supp. 20-1).

R9-10-723. Repealed**Historical Note**

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-724. Repealed

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Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). Repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

ARTICLE 8. ASSISTED LIVING FACILITIES**R9-10-801. Definitions**

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

1. "Accept" or "acceptance" means:
 - a. An individual begins living in and receiving assisted living services from an assisted living facility; or
 - b. An individual begins receiving adult day health care services or respite care services from an assisted living facility.
2. "Assistant caregiver" means an employee or volunteer who helps a manager or caregiver provide supervisory care services, personal care services, or directed care services to a resident, and does not include a family member of the resident.
3. "Assisted living services" means supervisory care services, personal care services, directed care services, behavioral care, memory care services, or ancillary services provided to a resident by or on behalf of an assisted living facility.
4. "Caregiver" means an individual who provides supervisory care services, personal care services, or directed care services to a resident, and does not include a family member of the resident.
5. "Elopement" means when a resident who is cognitively, physically, mentally, emotionally, or chemically impaired wanders away, walks away, runs away, or otherwise leaves the premises of an assisted living facility authorized to provide directed care services unsupervised or unnoticed, without the knowledge of the licensee's personnel.
6. "Manager" means an individual designated by a governing authority to act on behalf of the governing authority in the on-site management of the assisted living facility.
7. "Medication organizer" means a container that is designed to hold doses of medication and is divided according to date or time increments.
8. "Memory care services" means the same as defined in A.R.S. § 36-405.03(D).
9. "Primary care provider" means a physician, a physician's assistant, or registered nurse practitioner who directs a resident's medical services.
10. "Residency agreement" means a document signed by a resident or the resident's representative and a manager, detailing the terms of residency.
11. "Service plan" means a written description of a resident's need for supervisory care services, personal care services, directed care services, ancillary services, or behavioral health services and the specific assisted living services to be provided to the resident.
12. "Termination of residency" or "terminate residency" means a resident is no longer living in and receiving assisted living services from an assisted living facility.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-802. Supplemental Application Requirements; Exemption

- A. In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as an assisted living facility shall include in a Department-provided format:
 1. Which of the following levels of assisted living services the applicant is requesting authorization to provide:
 - a. Supervisory care services,
 - b. Personal care services, or
 - c. Directed care services; and
 2. Whether the applicant is requesting authorization to provide:
 - a. Adult day health care services, or
 - b. Behavioral health services other than behavioral care.
- B. The Arizona Pioneers' Home is exempt from:
 1. Architectural plans and specifications for a health care institution specified in R9-10-104; and
 2. Physical plant codes and standards for a health care institution specified in R9-10-105(A)(5)(a).

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R.

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1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 869 (April 29, 2022), with an immediate effective date of April 8, 2022 (Supp. 22-2).

R9-10-803. Administration**A. A governing authority shall:**

1. Consist of one or more individuals responsible for the organization, operation, and administration of an assisted living facility;
2. Establish, in writing, an assisted living facility's scope of services;
3. Designate, in writing, a manager who:
 - a. Is 21 years of age or older; and
 - b. Except for the manager of an adult foster care home, has either a:
 - i. Certificate as an assisted living facility manager issued under A.R.S. § 36-446.04(C), or
 - ii. A temporary certificate as an assisted living facility manager issued under A.R.S. § 36-446.06;
4. Adopt a quality management program that complies with R9-10-804;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting manager who has the qualifications established in subsection (A)(3), if the manager is:
 - a. Expected not to be present on the assisted living facility's premises for more than 30 calendar days, or
 - b. Not present on the assisted living facility's premises for more than 30 calendar days;
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the manager and identify the name and qualifications of the new manager;
8. Ensure that a manager or caregiver who is able to read, write, understand, and communicate in English is on an assisted living facility's premises;
9. Ensure compliance with A.R.S. § 36-411; and
10. Ensure the health, safety, or welfare of a resident is not placed at risk of harm.

B. A manager:

1. Is directly accountable to the governing authority of an assisted living facility for the daily operation of the assisted living facility and all services provided by or at the assisted living facility;
2. Has the authority and responsibility to manage the assisted living facility; and
3. Except as provided in subsection (A)(6), designates, in writing, a caregiver who is:
 - a. At least 21 years of age, and
 - b. Present on the assisted living facility's premises and accountable for the assisted living facility when the manager is not present on the assisted living facility premises.

C. A manager shall ensure that policies and procedures are:

1. Established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover job descriptions, duties, and qualifications, including required skills and knowledge, education, and experience for employees and volunteers;
 - b. Cover orientation and in-service education for employees and volunteers;

- c. Include how an employee may submit a complaint related to resident care;
- d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
- e. Except as provided in subsection (M), cover cardiopulmonary resuscitation training for applicable employees and volunteers, including:
 - i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the employee's or volunteer's ability to perform cardiopulmonary resuscitation;
 - 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 that the employee or volunteer has received cardiopulmonary resuscitation training;
- f. Cover first aid training;
- g. Cover how a caregiver will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
- h. Cover staffing and recordkeeping;
- i. Cover resident acceptance and resident rights;
- j. Cover termination of residency, including:
 - i. Termination initiated by the manager of an assisted living facility, and
 - ii. Termination initiated by a resident or the resident's representative;
- k. Cover the provision of assisted living services, including:
 - i. Coordinating the provision of assisted living services,
 - ii. Making vaccination for influenza and pneumonia available to residents according to A.R.S. § 36-406(1)(d), and
 - iii. Obtaining resident preferences for food and the provision of assisted living services;
- l. Cover the provision of respite services or adult day health services, if applicable;
- m. Cover methods by which the assisted living facility is aware of the general or specific whereabouts of a resident, based on the level of assisted living services provided to the resident and the assisted living services the assisted living facility is authorized to provide;
- n. Cover resident medical records, including electronic medical records;
- o. Cover personal funds accounts, if applicable;
- p. Cover specific steps for:
 - i. A resident to file a complaint, and
 - ii. The assisted living facility to respond to a resident's complaint;
- q. Cover health care directives;
- r. Cover assistance in the self-administration of medication, and medication administration;
- s. Cover food services;
- t. Cover contracted services;
- u. Cover equipment inspection and maintenance, if applicable;
- v. Cover infection control; and
- w. Cover a quality management program, including incident report and supporting documentation;

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2. Available to employees and volunteers of the assisted living facility; and
 3. Reviewed at least once every three years and updated as needed.
- D.** A manager shall ensure that the following are conspicuously posted:
1. A list of resident rights;
 2. The assisted living facility's license;
 3. Current phone numbers of:
 - a. The unit in the Department responsible for licensing and monitoring the assisted living facility,
 - b. Adult Protective Services in the Department of Economic Security,
 - c. The State Long-Term Care Ombudsman, and
 - d. The Arizona Center for Disability Law; and
 4. The location at which a copy of the most recent Department inspection report and any plan of correction resulting from the Department inspection may be viewed.
- E.** A manager shall ensure that, unless otherwise stated:
1. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 2. When documentation or information is required by this Chapter to be submitted on behalf of an assisted living facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the assisted living facility.
- F.** If a requirement in this Article states that a manager shall ensure an action or condition or sign a document:
1. A governing authority or licensee may ensure the action or condition or sign the document and retain the responsibility to ensure compliance with the requirement in this Article;
 2. The manager may delegate ensuring the action or condition or signing the document to another individual, but the manager retains the responsibility to ensure compliance with the requirement in the Article; and
 3. If the manager delegates ensuring an action or condition or signing a document, the delegation is documented and the documentation includes the name of the individual to whom the action, condition, or signing is delegated and the effective date of the delegation.
- G.** A manager shall:
1. Not act as a resident's representative and not allow an employee or a family member of an employee to act as a resident's representative for a resident who is not a family member of the employee;
 2. If the assisted living facility administers personal funds accounts for residents and is authorized in writing by a resident or the resident's representative to administer a personal funds account for the resident:
 - a. Ensure that the resident's personal funds account does not exceed \$2,000;
 - b. Maintain a separate record for each resident's personal funds account, including receipts and expenditures;
 - c. Maintain the resident's personal funds account separate from any account of the assisted living facility; and
 - d. Provide a copy of the record of the resident's personal funds account to the resident or the resident's representative at least once every three months;
 3. Notify the resident's representative, family member, public fiduciary, or trust officer if the manager determines that a resident is incapable of handling financial affairs; and
4. Except when a resident's need for assisted living services changes, as documented in the resident's service plan, ensure that a resident receives at least 30 calendar days written notice before any increase in a fee or charge.
- H.** A manager shall permit the Department to interview an employee, a volunteer, a resident, or a resident's representative as part of a compliance survey or a complaint investigation.
- I.** If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was accepted or while the resident is not on the premises and not receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall report the alleged or suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454.
- J.** If a manager has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect or exploitation has occurred on the premises or while a resident is receiving services from an assisted living facility's manager, caregiver, or assistant caregiver, the manager shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Report the suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454;
 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (J)(1); and
 - c. The report in subsection (J)(2);
 4. Maintain the documentation in subsection (J)(3) for at least 12 months after the date of the report in subsection (J)(2);
 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (J)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the manager to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 6. Maintain a copy of the documented information required in subsection (J)(5) for at least 12 months after the date the investigation was initiated.
- K.** A manager shall provide written notification to the Department of a resident's:
1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death;
 2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency services provider; and
 3. Elopement, within 24 hours of the elopement being discovered.
- L.** If a resident is receiving services from a home health agency or hospice service agency, a manager shall ensure that:
1. The resident's medical record contains:

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- a. The name, address, and contact individual, including contact information, of the home health agency or hospice service agency;
- b. Any information provided by the home health agency or hospice service agency; and
- c. A copy of resident follow-up instructions provided to the resident by the home health agency or hospice service agency; and
- 2. Any care instructions for a resident provided to the assisted living facility by the home health agency or hospice service agency are:
 - a. Within the assisted living facility's scope of services,
 - b. Communicated to a caregiver, and
 - c. Documented in the resident's service plan.
- M.** A manager of an assisted living home may establish, in policies and procedures, requirements that a caregiver obtains and provides documentation of cardiopulmonary resuscitation training specific to adults, which includes a demonstration of the caregiver's ability to perform cardiopulmonary resuscitation, from one of the following organizations:
 - 1. American Red Cross,
 - 2. American Heart Association, or
 - 3. National Safety Council.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Former Section R9-10-803 renumbered to R9-10-804; new Section R9-10-803 made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-804. Quality Management

A manager 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 services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident 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 resident 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 resident care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed; new Section R9-10-804 renumbered from R9-10-803 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-805. Contracted Services

A manager shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted as an emergency and (A)(1)(a)(i)(1) amended effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R.

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1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-806. Personnel**A.** A manager shall ensure that:

1. A caregiver:
 - a. Is 18 years of age or older; and
 - b. Provides documentation of:
 - i. Completion of a caregiver training program approved by the Department or the Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers;
 - ii. For supervisory care services, employment as a manager or caregiver of a supervisory care home before November 1, 1998;
 - iii. For supervisory care services or personal care services, employment as a manager or caregiver of a supportive residential living center before November 1, 1998; or
 - iv. For supervisory care services, personal care services, or directed services, one of the following:
 - (1) A nursing care institution administrator's license issued by the Board of Examiners;
 - (2) A nurse's license issued to the individual under A.R.S. Title 32, Chapter 15;
 - (3) Documentation of employment as a manager or caregiver of an unclassified residential care institution before November 1, 1998; or
 - (4) Documentation of sponsorship of or employment as a caregiver in an adult foster care home before November 1, 1998;
2. An assistant caregiver:
 - a. Is 16 years of age or older, and
 - b. Interacts with residents under the supervision of a manager or caregiver;
3. The qualifications, skills, and knowledge required for a caregiver or assistant caregiver:
 - a. Are based on:
 - i. The type of assisted living services, behavioral health services, or behavioral care expected to be provided by the caregiver or assistant caregiver according to the established job description; and
 - ii. The acuity of the residents receiving assisted living services, behavioral health services, or behavioral care from the caregiver or assistant caregiver according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description;
 - ii. The type and duration of education that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services, or behavioral care listed in the established job description; and

iii. The type and duration of experience that may allow the caregiver or assistant caregiver to have acquired the specific skills and knowledge for the caregiver or assistant caregiver to provide the expected assisted living services, behavioral health services or behavioral care listed in the established job description;

4. A caregiver's or assistant caregiver's skills and knowledge are verified and documented:
 - a. Before the caregiver or assistant caregiver provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
 5. An assisted living facility has a manager, caregivers, and assistant caregivers with the qualifications, experience, skills, and knowledge necessary to:
 - a. Provide the assisted living services, behavioral health services, behavioral care, and ancillary services in the assisted living facility's scope of services;
 - b. Meet the needs of a resident; and
 - c. Ensure the health and safety of a resident;
 6. At least one manager or caregiver is present and awake at an assisted living center when a resident is on the premises;
 7. Documentation is maintained for at least 12 months after the last date on the documentation of the caregivers and assistant caregivers working each day, including the hours worked by each;
 8. A manager, a caregiver, and an assistant caregiver, or an employee or a volunteer who has or is expected to have more than eight hours per week of direct interaction with residents, provides evidence of freedom from infectious tuberculosis:
 - a. On or before the date the individual begins providing services at or on behalf of the assisted living facility, and
 - b. As specified in R9-10-113;
 9. Before providing assisted living services to a resident, a caregiver or an assistant caregiver receives orientation that is specific to the duties to be performed by the caregiver or assistant caregiver; and
 10. Before providing assisted living services to a resident, a manager or caregiver provides current documentation of first aid training and cardiopulmonary resuscitation training certification specific to adults.
- B.** A manager of an assisted living home shall ensure that:
1. An individual residing in an assisted living home, who is not a resident, a manager, a caregiver, or an assistant caregiver:
 - a. Either:
 - i. Complies with the fingerprinting requirements in A.R.S. § 36-411, or
 - ii. Interacts with residents only under the supervision of an individual who has a valid fingerprint clearance card; and
 - b. If the individual is 12 years of age or older, provides evidence of freedom from infectious tuberculosis as specified in R9-10-113;
 2. Documentation of compliance with the requirements in subsection (B)(1)(a) and evidence of freedom from infectious tuberculosis, if required under subsection (B)(1)(b), is maintained for an individual residing in the assisted liv-

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ing home who is not a resident, a manager, a caregiver, or an assistant caregiver;

3. As part of the policies and procedures required in R9-10-803(C)(1)(h), a plan is established, documented, and implemented to ensure that the manager or a caregiver is available as back-up to provide assisted living services to a resident if the manager or a caregiver assigned to work is not available or not able to provide the required assisted living services; and
 4. At least the manager or a caregiver is present at an assisted living home when a resident is present in the assisted living home and:
 - a. Except for nighttime hours, the manager or caregiver is awake; and
 - b. If the manager or caregiver is not awake during nighttime hours:
 - i. The manager or caregiver can hear and respond to a resident needing assistance; and
 - ii. If the assisted living home is authorized to provide directed care services, policies and procedures are developed, documented, and implemented to establish a process for checking on a resident receiving directed care services during nighttime hours to ensure the resident's health and safety.
- C. A manager shall ensure that a personnel record for each employee or volunteer:
1. Includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 - c. Documentation of:
 - i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or in policies and procedures;
 - v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - vi. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(8);
 - vii. Cardiopulmonary resuscitation training, if required for the individual in this Article or policies and procedures;
 - viii. First aid training, if required for the individual in this Article or policies and procedures;
 - ix. Compliance with the requirements in A.R.S. § 36-411(A) and (C); and
 - x. The certificate of completion, according to R9-10-126;
 2. Is maintained:
 - a. Throughout the individual's period of providing services in or for the assisted living facility, and

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

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

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-807. Residency and Residency Agreements

- A. Except as provided in R9-10-808(B)(2), a manager shall ensure that a resident provides evidence of freedom from infectious tuberculosis:
 1. Before or within seven calendar days after the resident's date of occupancy, and
 2. As specified in R9-10-113.
- B. A manager shall ensure that before or at the time of acceptance of an individual, the individual submits documentation that is dated within 90 calendar days before the individual is accepted by an assisted living facility and:
 1. If an individual is requesting or is expected to receive supervisory care services, personal care services, or directed care services:
 - a. Includes whether the individual requires:
 - i. Continuous medical services,
 - ii. Continuous or intermittent nursing services, or
 - iii. Restraints; and
 - b. Is dated and signed by a:
 - i. Physician,
 - ii. Registered nurse practitioner,
 - iii. Registered nurse, or
 - iv. Physician assistant; and
 2. If an individual is requesting or is expected to receive behavioral health services, other than behavioral care, in addition to supervisory care services, personal care services, or directed care services from an assisted living facility:
 - a. Includes whether the individual requires continuous behavioral health services, and

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- b. Is signed and dated by a behavioral health professional.
- C. A manager shall not accept or retain an individual if:
- The individual requires continuous:
 - Medical services;
 - Nursing services, unless the assisted living facility complies with A.R.S. § 36-401(C); or
 - Behavioral health services;
 - The primary condition for which the individual needs assisted living services is a behavioral health issue;
 - The services needed by the individual are not within the assisted living facility's scope of services and a home health agency or hospice service agency is not involved in the care of the individual;
 - The assisted living facility does not have the ability to provide the assisted living services needed by the individual; or
 - The individual requires restraints, including the use of bedrails.
- D. Before or at the time of an individual's acceptance by an assisted living facility, a manager shall ensure that there is a documented residency agreement with the assisted living facility that includes:
- The individual's name;
 - Terms of occupancy, including:
 - Date of occupancy or expected date of occupancy,
 - Resident responsibilities, and
 - Responsibilities of the assisted living facility;
 - A list of the services to be provided by the assisted living facility to the resident;
 - A list of the services available from the assisted living facility at an additional fee or charge;
 - For an assisted living home, whether the manager or a caregiver is awake during nighttime hours;
 - The policy for refunding fees, charges, or deposits;
 - The policy and procedure for a resident to terminate residency, including terminating residency because services were not provided to the resident according to the resident's service plan;
 - The policy and procedure for an assisted living facility to terminate residency;
 - The complaint process; and
 - The manager's signature and date signed.
- E. Before or within five working days after a resident's acceptance by an assisted living facility, a manager shall obtain on the documented agreement, required in subsection (D), the signature of one of the following individuals:
- The resident,
 - The resident's representative,
 - The resident's legal guardian, or
 - Another individual who has been designated by the individual under A.R.S. § 36-3221 to make health care decisions on the individual's behalf.
- F. A manager shall:
- Before or at the time of an individual's acceptance by an assisted living facility, provide to the resident or resident's representative a copy of:
 - The residency agreement in subsection (D),
 - Resident's rights, and
 - The policy and procedure on health care directives; and
 - Maintain the original of the residency agreement in subsection (D) in the resident's medical record.
- G. A manager may terminate residency of a resident as follows:
- Without notice, if the resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in an assisted living facility;
 - With a 14-calendar-day written notice of termination of residency:
 - For nonpayment of fees, charges, or deposit; or
 - Under any of the conditions in subsection (C); or
 - With a 30-calendar-day written notice of termination of residency, for any other reason.
- H. A manager shall ensure that the written notice of termination of residency in subsection (G) includes:
- The date of notice;
 - The reason for termination;
 - The policy for refunding fees, charges, or deposits;
 - The deposition of a resident's fees, charges, and deposits; and
 - Contact information for the State Long-Term Care Ombudsman.
- I. A manager shall provide the following to a resident when the manager provides the written notice of termination of residency in subsection (G):
- A copy of the resident's current service plan, and
 - Documentation of the resident's freedom from infectious tuberculosis.
- J. If an assisted living facility issues a written notice of termination of residency as provided in subsection (G) to a resident or the resident's representative because the resident needs services the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide, a manager shall ensure that the written notice of termination of residency includes a description of the specific services that the resident needs that the assisted living facility is either not licensed to provide or is licensed to provide but not able to provide.

Historical Note

Adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-808. Service Plans

- A. Except as required in subsection (B), a manager shall ensure that a resident has a service plan that is established, documented, and implemented that:
- Is completed no later than 14 calendar days after the resident's date of acceptance;
 - Is developed with assistance and review from:
 - The resident or resident's representative,

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- b. The manager, and
 - c. Any individual requested by the resident or the resident's representative;
- 3. Includes the following:
 - a. A description of the resident's medical or health problems, including physical, behavioral, cognitive, or functional conditions or impairments;
 - b. The level of service the resident is expected to receive;
 - c. The amount, type, and frequency of assisted living services and ancillary services being provided to the resident, including medication administration or assistance in the self-administration of medication;
 - d. For a resident who requires intermittent nursing services or medication administration, review by a nurse or medical practitioner;
 - e. For a resident who requires behavioral care:
 - i. Any of the following that is necessary to provide assistance with the resident's psychosocial interactions to manage the resident's behavior:
 - (1) The psychosocial interactions or behaviors for which the resident requires assistance,
 - (2) Psychotropic medications ordered for the resident,
 - (3) Planned strategies and actions for changing the resident's psychosocial interactions or behaviors, and
 - (4) Goals for changes in the resident's psychosocial interactions or behaviors; and
 - ii. Review by a medical practitioner or behavioral health professional; and
 - f. For a resident who will be storing medication in the resident's bedroom or residential unit, how the medication will be stored and controlled;
- 4. Is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f):
 - a. No later than 14 calendar days after a significant change in the resident's physical, cognitive, or functional condition; and
 - b. As follows:
 - i. At least once every 12 months for a resident receiving supervisory care services,
 - ii. At least once every six months for a resident receiving personal care services, and
 - iii. At least once every three months for a resident receiving directed care services; and
- 5. When initially developed and when updated, is signed and dated by:
 - a. The resident or resident's representative;
 - b. The manager;
 - c. If a review is required in subsection (A)(3)(d), the nurse or medical practitioner who reviewed the service plan; and
 - d. If a review is required in subsection (A)(3)(e)(ii), the medical practitioner or behavioral health professional who reviewed the service plan.
- B.** For a resident receiving respite care services, a manager shall ensure that:
 - 1. A written service plan is:
 - a. Based on a determination of the resident's current needs and:
 - i. Is completed no later than three working days after the resident's date of acceptance; or
 - ii. If the resident has a service plan in the resident's medical record that was developed within the previous 12 months, is reviewed and updated based on changes in the requirements in subsections (A)(3)(a) through (f) within three working days after the resident's date of acceptance; and
 - b. If a significant change in the resident's physical, cognitive, or functional condition occurs while the resident is receiving respite care services, updated based on changes in the requirements in subsections (A)(3)(a) through (f) within three working days after the significant change occurs; and
 - 2. If the resident is not expected to be present in the assisted living facility for more than seven calendar days, the resident is not required to comply with the requirements in R9-10-807(A).
- C.** A manager shall ensure that:
 - 1. A caregiver or an assistant caregiver:
 - a. Provides a resident with the assisted living services in the resident's service plan;
 - b. Is only assigned to provide the assisted living services the caregiver or assistant caregiver has the documented skills and knowledge to perform;
 - c. Provides assistance with activities of daily living according to the resident's service plan;
 - d. If applicable, suggests techniques a resident may use to maintain or improve the resident's independence in performing activities of daily living;
 - e. Provides assistance with, supervises, or directs a resident's personal hygiene according to the resident's service plan;
 - f. Encourages a resident to participate in activities planned according to subsection (E); and
 - g. Documents the services provided in the resident's medical record; and
 - 2. A volunteer or an assistant caregiver who is 16 or 17 years of age does not provide:
 - a. Assistance to a resident for:
 - i. Bathing,
 - ii. Toileting, or
 - iii. Moving the resident's body from one surface to another surface;
 - b. Assistance in the self-administration of medication;
 - c. Medication administration; or
 - d. Nursing services.
- D.** A manager of an assisted living facility that is authorized to provide adult day health services shall ensure that the adult day health care services are provided as specified in R9-10-1113.
- E.** A manager shall ensure that:
 - 1. Daily social, recreational, or rehabilitative activities are planned according to residents' preferences, needs, and abilities;
 - 2. A calendar of planned activities is:
 - a. Prepared at least one week in advance of the date the activity is provided,
 - b. Posted in a location that is easily seen by residents,
 - c. Updated as necessary to reflect substitutions in the activities provided, and
 - d. Maintained for at least 12 months after the last scheduled activity;

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3. Equipment and supplies are available and accessible to accommodate a resident who chooses to participate in a planned activity; and
 4. Multiple media sources, such as daily newspapers, current magazines, internet sources, and a variety of reading materials, are available and accessible to a resident to maintain the resident's continued awareness of current news, social events, and other noteworthy information.
- F.** If a resident is not receiving assistance with the resident's psychosocial interactions under the direction of a behavioral health professional or any other behavioral health services at an assisted living facility, the resident is not considered to be receiving behavioral care or behavioral health services from the assisted living facility if the resident:
1. Is prescribed a psychotropic medication, or
 2. Is receiving directed care services and has a primary diagnosis of:
 - a. Dementia,
 - b. Alzheimer's disease-related dementia, or
 - c. Traumatic brain injury.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-809. Transport; Transfer

- A.** Except as provided in subsection (B), a manager shall ensure that:
1. A caregiver or employee coordinates the transport and the services provided to the resident;
 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport, and
 - b. Information from the resident's medical record is provided to a receiving health care institution; and
 3. Documentation includes:
 - a. If applicable, any communication with an individual at a receiving health care institution;
 - b. The date and time of the transport; and
 - c. If applicable, the name of the caregiver accompanying the resident during a transport.
- B.** Subsection (A) does not apply to:
1. Transportation to a location other than a licensed health care institution,

2. Transportation provided for a resident by the resident or the resident's representative,
 3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative, or
 4. A transport to another licensed health care institution in an emergency.
- C.** Except for a transfer of a resident due to an emergency, a manager shall ensure that:
1. A caregiver coordinates the transfer and the services provided to the resident;
 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A caregiver explains risks and benefits of the transfer to the resident or the resident's representative; and
 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the caregiver accompanying the resident during a transfer.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Former Section R9-10-809 renumbered to R9-10-812; new Section R9-10-809 made by final rulemaking at 9 A.A.R. 319, effective March 31, 2003 (Supp. 03-1). R9-10-809(E) reflects a corrected reference to Article 14 from Article 4 (05-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-810. Resident Rights

- A.** A manager shall ensure that, at the time of acceptance, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C).
- B.** A manager shall ensure that:
1. A resident is treated with dignity, respect, and consideration;
 2. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;

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- e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by the assisted living facility's manager, caregivers, assistant caregivers, employees, or volunteers; and
3. A resident or the resident's representative:
- a. Is informed of the following:
 - i. The policy on health care directives, and
 - ii. The resident complaint process;
 - b. Consents to photographs of the resident before the resident is photographed, except that a resident may be photographed when accepted as a resident by an assisted living facility for identification and administrative purposes;
 - c. Except as otherwise permitted by law, provides written consent before the release of information in the resident's:
 - i. Medical record, or
 - ii. Financial records;
 - d. May:
 - i. Request or consent to relocation within the assisted living facility; and
 - ii. Except when relocation is necessary based on a change in the resident's condition as documented in the resident's service plan, refuse relocation within the assisted living facility;
 - e. Has access to the resident's records during normal business hours or at a time agreed upon by the resident or resident's representative and the manager; and
 - f. Is informed of:
 - i. The rates and charges for services before the services are initiated;
 - ii. A change in rates or charges at least 30 calendar days before the change is implemented, unless the change in rates or charges results from a change in services; and
 - iii. A change in services at least 30 calendar days before the change is implemented, unless the resident's service plan changes.
- C. A resident has the following rights:
- 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 - 2. To receive assisted living services that support and respect the resident's individuality, choices, strengths, and abilities;
 - 3. To receive privacy in:
 - a. Care for personal needs;
 - b. Correspondence, communications, and visitation; and
 - c. Financial and personal affairs;
 - 4. To maintain, use, and display personal items unless the personal items constitute a hazard;
 - 5. To choose to participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities;
 - 6. To review, upon written request, the resident's own medical record;

- 7. To receive a referral to another health care institution if the assisted living facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
- 8. To choose to access services from a health care provider, health care institution, or pharmacy other than the assisted living facility where the resident is residing and receiving services or a health care provider, health care institution, or pharmacy recommended by the assisted living facility;
- 9. To participate or have the resident's representative participate in the development of, or decisions concerning, the resident's service plan; and
- 10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Former Section R9-10-810 renumbered to R9-10-813; new Section R9-10-810 made by final rulemaking at 9 A.A.R. 319, effective March 31, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-811. Medical Records

- A. A manager shall ensure that:
- 1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
 - 2. An entry in a resident's medical record is:
 - a. Only recorded by an individual authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 - 3. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 4. A resident's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the resident's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law; and
 - 5. A resident's medical record is protected from loss, damage, or unauthorized use.

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- B.** If an assisted living facility maintains residents' medical records electronically, a manager shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.
- C.** A manager shall ensure that a resident's medical record contains:
1. Resident information that includes:
 - a. The resident's name, and
 - b. The resident's date of birth;
 2. The names, addresses, and telephone numbers of:
 - a. The resident's primary care provider;
 - b. Other persons, such as a home health agency or hospice service agency, involved in the care of the resident; and
 - c. An individual to be contacted in the event of an emergency, significant change in the resident's condition, or termination of residency;
 3. If applicable, the name and contact information of the resident's representative and:
 - a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 4. The date of acceptance and, if applicable, the date of termination of residency;
 5. Documentation of the resident's needs required in R9-10-807(B);
 6. Documentation of general consent and informed consent, if applicable;
 7. Except as allowed in R9-10-808(B)(2), documentation of freedom from infectious tuberculosis as required in R9-10-807(A);
 8. A copy of the resident's health care directive, if applicable;
 9. The resident's signed residency agreement and any amendments;
 10. Resident's service plan and updates;
 11. Documentation of assisted living services provided to the resident;
 12. A medication order from a medical practitioner for each medication that is administered to the resident or for which the resident receives assistance in the self-administration of the medication;
 13. Documentation of medication administered to the resident or for which the resident received assistance in the self-administration of medication that includes:
 - a. The date and time of administration or assistance;
 - b. The name, strength, dosage, and route of administration;
 - c. The name and signature of the individual administering or providing assistance in the self-administration of medication; and
 - d. An unexpected reaction the resident has to the medication;
 14. Documentation of the resident's refusal of a medication, if applicable;
 15. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
 16. If applicable, documentation of a determination by a medical practitioner that evacuation from the assisted living facility during an evacuation drill would cause harm to the resident;
 17. Documentation of notification of the resident of the availability of vaccination for influenza and pneumonia, according to A.R.S. § 36-406(1)(d);
 18. Documentation of the resident's orientation to exits from the assisted living facility required in R9-10-819(B);
 19. If a resident is receiving behavioral health services other than behavioral care, documentation of the determination in R9-10-813(3);
 20. If a resident is receiving behavioral care, documentation of the determination in R9-10-812(3);
 21. If applicable, for a resident who is unable to direct self-care, the information required in R9-10-815(F);
 22. Documentation of any significant change in a resident's behavior, physical, cognitive, or functional condition and the action taken by a manager or caregiver to address the resident's changing needs;
 23. Documentation of the notification required in R9-10-803(G) if the resident is incapable of handling financial affairs; and
 24. If the resident no longer resides and receives assisted living services from the assisted living facility:
 - a. A written notice of termination of residency; or
 - b. If the resident terminated residency, the date the resident terminated residency.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Former Section R9-10-811 renumbered to R9-10-814; new Section R9-10-811 made by final rulemaking at 9 A.A.R. 319, effective March 31, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-812. Behavioral Care

A manager shall ensure that for a resident who requests or receives behavioral care from the assisted living facility, a behavioral health professional or medical practitioner:

1. Evaluates the resident:
 - a. Within 30 calendar days before acceptance of the resident or before the resident begins receiving behavioral care, and

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- b. At least once every six months throughout the duration of the resident's need for behavioral care;
2. Reviews the assisted living facility's scope of services; and
3. Signs and dates a determination stating that the resident's need for behavioral care can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989 (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989 (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed; new Section R9-10-812 renumbered from R9-10-809 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-813. Behavioral Health Services

If an assisted living facility is authorized to provide behavioral health services other than behavioral care, a manager shall ensure that:

1. Policies and procedures are established, documented, and implemented that cover when general consent and informed consent are required and by whom general consent and informed consent may be given;
2. The behavioral health services:
 - a. Are provided under the direction of a behavioral health professional; and
 - b. Comply with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
 - ii. For an assessment, in R9-10-1011(B); and
3. For a resident who requests or receives behavioral health services from the assisted living facility, a behavioral health professional:
 - a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for behavioral health services;
 - b. Reviews the assisted living facility's scope of services; and
 - c. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

Historical Note

New Section renumbered from R9-10-810 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective Octo-

ber 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-814. Personal Care Services

- A. A manager of an assisted living facility authorized to provide personal care services shall not accept or retain a resident who:
 1. Is unable to direct self-care;
 2. Except as specified in subsection (B), is confined to a bed or chair because of an inability to ambulate even with assistance; or
 3. Except as specified in subsection (C), has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.
- B. A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who is confined to a bed or chair because of an inability to ambulate even with assistance if:
 1. The condition is a result of a short-term illness or injury; or
 2. The following requirements are met at the onset of the condition or when the resident is accepted by the assisted living facility:
 - a. The resident or resident's representative requests that the resident be accepted by or remain in the assisted living facility;
 - b. The resident's primary care provider or other medical practitioner:
 - i. Examines the resident at the onset of the condition, or within 30 calendar days before acceptance, and at least once every six months throughout the duration of the resident's condition;
 - ii. Reviews the assisted living facility's scope of services; and
 - iii. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility; and
 - c. The resident's service plan includes the resident's increased need for personal care services.
- C. A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner, if the requirements in subsection (B)(2) are met.
- D. A manager of an assisted living facility authorized to provide personal care services may accept or retain a resident who:
 1. Is receiving nursing services from a home health agency or a hospice service agency; or
 2. Requires intermittent nursing services if:
 - a. The resident's condition for which nursing services are required is a result of a short-term illness or injury, and
 - b. The requirements of subsection (B)(2) are met.
- E. A manager shall ensure that a bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available and accessible in a bedroom or residential unit being used by a resident receiving personal care services.
- F. In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving personal care services includes:

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1. Skin maintenance to prevent and treat bruises, injuries, pressure sores, and infections;
 2. Offering sufficient fluids to maintain hydration;
 3. Incontinence care that ensures that a resident maintains the highest practicable level of independence when toileting; and
 4. If applicable, the determination in subsection (B)(2)(b)(iii).
- G.** A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving personal care services unless the resident has an order from the resident's primary care provider or another medical practitioner for the non-prescription medication.

Historical Note

New Section renumbered from R9-10-811 and amended by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-815. Directed Care Services

- A.** A manager shall ensure that a resident's representative is designated for a resident who is unable to direct self-care.
- B.** A manager of an assisted living facility authorized to provide directed care services shall not accept or retain a resident who, except as provided in R9-10-814(B)(2):
1. Is confined to a bed or chair because of an inability to ambulate even with assistance; or
 2. Has a stage 3 or stage 4 pressure sore, as determined by a registered nurse or medical practitioner.
- C.** In addition to the requirements in R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving directed care services includes:
1. The requirements in R9-10-814(F)(1) through (3);
 2. If applicable, the determination in R9-10-814(B)(2)(b)(iii);
 3. Cognitive stimulation and activities to maximize functioning;
 4. Strategies to ensure a resident's personal safety;
 5. Encouragement to eat meals and snacks;
 6. Documentation:
 - a. Of the resident's weight, or
 - b. From a medical practitioner stating that weighing the resident is contraindicated;
 7. Coordination of communications with the resident's representative, family members, and, if applicable, other individuals identified in the resident's service plan; and
 8. If the resident is receiving memory care services:
 - a. Identification of specialized environmental features to support memory care services, such as secure areas to prevent wandering and spaces designed for cognitive stimulation and engagement;
 - b. Strategies for providing person-centered care that aligns with the principles of dementia-friendly environments, including familiar surroundings, optimized sensory stimulation, and meaningful activities; and
 - c. Strategies for administering medications as ordered.
- D.** A manager shall ensure that an employee does not provide non-prescription medication to a resident receiving directed

care services unless the resident has an order from a medical practitioner for the non-prescription medication.

- E.** A manager shall ensure that:
1. A bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies is available in a bedroom being used by a resident receiving directed care services; or
 2. An assisted living facility has implemented another means to alert a caregiver or assistant caregiver to a resident's needs or emergencies.
- F.** A manager of an assisted living facility authorized to provide directed care services shall ensure that:
1. Policies and procedures are established, documented, and implemented that ensure the safety of a resident who may wander;
 2. There is a means of exiting the facility for a resident who does not have a key, special knowledge for egress, or the ability to expend increased physical effort that meets one of the following:
 - a. Provides access to an outside area that:
 - i. Allows the resident to be at least 30 feet away from the facility that is secure, and
 - ii. Monitors or alerts employees of the egress of a resident from the facility;
 - b. Provides access to an outside area:
 - i. From which a resident may exit to a location at least 30 feet away from the facility that is secure, and
 - ii. Monitors or alerts employees of the egress of a resident from the facility; or
 - c. Uses a mechanism that meets the Special Egress-Control Devices provisions in the International Building Code incorporated by reference in R9-10-104.01; and
 3. A caregiver or an assistant caregiver complies with the requirements for incidents in R9-10-804 when a resident who is unable to direct self-care wanders into an area not designated by the governing authority for use by the resident.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-816. Memory Care Services

- A.** If an assisted living facility is authorized to provide directed care services, a manager shall ensure that:
1. Policies and procedures for memory care services are established, documented, and implemented to cover the following:
 - a. Skills and knowledge necessary for the personnel member to provide the expected memory care services;
 - b. Interventions used for behavior management;

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- c. Systems to accommodate visitors, staff, and residents who do not need controlled egress;
 - d. The requirements in R9-10-815(C)(8) regarding the prevention of unsafe wandering or exit seeking, which may include the use of tracking systems;
 - e. Promotion of nutrition and hydration care;
 - f. Evacuation and emergency procedures specific to residents receiving memory care services, that include the requirements in R9-10-819(A)(5);
 - g. Prevention techniques of elopement and responding to elopement incidents promptly and effectively;
 - h. Monitoring residents receiving memory care services in outdoor areas on the premises;
 - i. Specialized environmental features to support memory care that include:
 - i. Secure areas to prevent wandering and spaces designed for cognitive stimulation and engagement; and
 - ii. Strategies for providing person-centered care that aligns with the principles of dementia-friendly environments, including familiar surroundings, optimized sensory stimulation, and meaningful activities; and
 - j. Specialized accommodations and progressive support for activities of daily living tailored to persons living with dementia following evidence-based best practices;
2. Activities that match the resident's cognitive ability, memory, attention span, language, reasoning ability, and physical function;
 3. For a resident who requests or receives memory care services from the assisted living facility, a medical practitioner:
 - a. Evaluates the resident within 30 calendar days before acceptance of the resident and at least once every six months throughout the duration of the resident's need for memory care services;
 - b. Reviews the assisted living facility's scope of services; and
 - c. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility;
 4. There is staffing to ensure adequate supervision and care for residents receiving memory care services;
 5. In an assisted living facility where residents are housed in two or more detached buildings, or if a building has distinct and segregated areas, a designated caregiver must be awake and available in each building and each segregated area at all times; and
 6. If applicable, staffing is increased to compensate for the evaluated care and service needs of residents at move-in or for the changing physical or cognitive needs of the residents.
- B.** A manager shall ensure that staff obtain a certificate of completion, as specified in R9-10-126, including the minimum eight hours of initial memory care services training within the first 30 days of hire or provide a copy of a certificate of completion, as specified in R9-10-126, obtained within the preceding 12 months from the date of hire. If a staff member or contractor has not worked at an assisted living facility that is licensed to provide directed care services for a period of 12 months, the staff member or contractor must complete the minimum eight hours of initial memory care services training within 30 days after the date of hire, rehire, or returning to work.
- C.** In addition to the minimum eight hours of initial memory care services training, a manager shall complete a minimum of four hours of memory care services training specific to assisted living facility managers.
 - D.** Each resident receiving memory care services must have a service plan that meets the requirements specified in R9-10-815(C).
 - E.** Service planning for residents receiving memory care services shall be person-centered involving comprehensive assessments that consider the resident's medical history, preference, and social context, and should actively include input from the resident and the resident's representative. Service planning for residents receiving memory care services shall be individualized, regularly reviewed according to R9-10-808, and adjusted to meet the changing needs of residents as their condition progresses.
 - F.** The assisted living facility shall only admit or retain residents whose cognitive and physical care needs can be safely managed within the area or areas in an assisted living facility where memory care services are provided.
 - G.** An assisted living facility authorized to provide directed care services and is providing memory care services shall incorporate evidence-based specialized environmental features that:
 1. Use clear, easy-to-understand signage and visual cues to help residents navigate their surroundings;
 2. Reduce environmental factors that may cause confusion or distress, such as loud noises or overly bright lighting;
 3. Prevent residents from accessing materials, furnishings, equipment, activities, or treatments that may pose a health or safety risk;
 4. Support resident movement and engagement;
 5. Promote independence and overall well-being;
 6. Ensure easy access and intuitive wayfinding; and
 7. Facilitate engagement and encourage participation in meaningful daily tasks and activities.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-817. Medication Services**A.** A manager shall ensure that:

1. Policies and procedures for medication services include:
 - a. Procedures for preventing, responding to, and reporting a medication error;
 - b. Procedures for responding to and reporting an unexpected reaction to a medication;
 - c. Procedures to ensure that a resident's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the resident's needs;
 - d. Procedures for:

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- i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
 - ii. Monitoring a resident who self-administers medication;
- e. Procedures for assisting a resident in procuring medication;
- f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
- g. Procedures for administering medication to residents receiving memory care services; and
- 2. If a verbal order for a resident's medication is received from a medical practitioner by the assisted living facility:
 - a. The manager or a caregiver takes the verbal order from the medical practitioner;
 - b. The verbal order is documented in the resident's medical record; and
 - c. A written order verifying the verbal order is obtained from the medical practitioner within 14 calendar days after receiving the verbal order.
- B.** If an assisted living facility provides medication administration, a manager shall ensure that:
 - 1. Medication is stored by the assisted living facility;
 - 2. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner, registered nurse, or pharmacist;
 - b. Include a process for documenting an individual authorized, according to the definition of "administer" in A.R.S. § 32-1901, by a medical practitioner to administer medication under the direction of the medical practitioner;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record; and
 - 3. A medication administered to a resident:
 - a. Is administered by an individual under the direction of a medical practitioner;
 - b. Is administered in compliance with a medication order; and
 - c. Is documented in the resident's medical record.
- C.** If an assisted living facility provides assistance in the self-administration of medication, a manager shall ensure that:
 - 1. A resident's medication is stored by the assisted living facility;
 - 2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container or medication organizer for the resident;
 - c. Observing the resident while the resident removes the medication from the container or medication organizer;
 - d. Except when a resident uses a medication organizer, verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label;
 - ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; and
 - iii. The resident is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label;
 - e. For a resident using a medication organizer, verifying that the resident is taking the medication in the medication organizer according to the schedule specified on the medical practitioner's order; or
 - f. Observing the resident while the resident takes the medication;
- 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or nurse; and
- 4. Assistance in the self-administration of medication provided to a resident:
 - a. Is in compliance with an order; and
 - b. Is documented in the resident's medical record.
- D.** A manager shall ensure that:
 - 1. A current drug reference guide is available for use by personnel members; and
 - 2. A current toxicology reference guide is available for use by personnel members.
- E.** A manager shall ensure that a resident's medication organizer is only filled by:
 - 1. The resident;
 - 2. The resident's representative;
 - 3. A family member of the resident;
 - 4. A personnel member of a home health agency or hospice service agency; or
 - 5. The manager or a caregiver who has been designated and is under the direction of a medical practitioner, according to subsection (B)(2)(b).
- F.** When medication is stored by an assisted living facility, a manager shall ensure that:
 - 1. Medication is stored in a separate locked room, closet, cabinet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and
 - 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of residents who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
- G.** A manager shall ensure that a caregiver immediately reports a medication error or a resident's unexpected reaction to a medication to the medical practitioner who ordered the medication or, if the medical practitioner who ordered the medication is not available, another medical practitioner.
- H.** If medication is stored by a resident in the resident's bedroom or residential unit, a manager shall ensure that:
 - 1. The medication is stored according to the resident's service plan; or

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

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). R9-10-817 renumbered to R9-10-818; new Section R9-10-817 made by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-818. Food Services**A.** A manager shall ensure that:

1. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one calendar day before the first meal on the food menu is served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the assisted living facility are served according to posted menus;
3. If the assisted living facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the assisted living facility, a copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the assisted living facility;
4. The assisted living facility is able to store, refrigerate, and reheat food to meet the dietary needs of a resident;
5. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2015>;
6. A resident is provided a diet that meets the resident's nutritional needs as specified in the resident's service plan;
7. Water is available and accessible to residents at all times, unless otherwise stated in a medical practitioner's order; and
8. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the provision of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the resident.

B. If the assisted living facility offers therapeutic diets, a manager shall ensure that:

1. A current therapeutic diet manual is available for use by employees, and
2. The therapeutic diet is provided to a resident according to a written order from the resident's primary care provider or another medical practitioner.

C. A manager 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. Food is prepared:
 - a. Using methods that conserve nutritional value, flavor, and appearance; and
 - b. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
 4. Potentially hazardous food is maintained as follows:
 - a. Foods requiring refrigeration are maintained at 41° F or below; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 165° F;
 5. A refrigerator used by an assisted living facility to store food or medication contains a thermometer, accurate to plus or minus 3° F, placed 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.
- D.** A manager of an assisted living center shall ensure that:
1. The assisted living center has a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
 2. A copy of the assisted living center's food establishment license or permit is maintained.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). R9-10-818 renumbered to R9-10-819; new Section R9-10-818 renumbered from R9-10-817 by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-819. Emergency and Safety Standards**A.** A manager shall ensure that:

1. A disaster plan is developed, documented, maintained in a location accessible to caregivers and assistant caregivers, and, if necessary, implemented that includes:
 - a. When, how, and where residents will be relocated;

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- b. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
 - c. A plan to ensure each resident's medication will be available to administer to the resident during a disaster; and
 - d. A plan for obtaining food and water for individuals present in the assisted living facility or the assisted living facility's relocation site during a disaster;
 - 2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
 - 3. Documentation of the disaster plan review required in subsection (A)(2) includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each employee or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 - 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 - 5. An evacuation drill for employees and residents:
 - a. Is conducted at least once every six months; and
 - b. Includes all individuals on the premises except for:
 - i. A resident whose medical record contains documentation that evacuation from the assisted living facility would cause harm to the resident, and
 - ii. Sufficient caregivers to ensure the health and safety of residents not evacuated according to subsection (A)(5)(b)(i);
 - 6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and residents to evacuate the assisted living facility;
 - c. If applicable:
 - i. An identification of residents needing assistance for evacuation, and
 - ii. An identification of residents who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
 - 7. If the assisted living facility is authorized to provide directed care services, an elopement drill for employees:
 - a. Conduct an elopement drill every six months on each shift and document the date, time, and description of each drill; and
 - b. Immediately investigate any elopement and notify the designated family member or members, legal guardian, or other responsible person within 24 hours.
 - 8. An evacuation path is conspicuously posted in each hallway of each floor of the assisted living facility.
- B.** A manager shall ensure that:
- 1. A resident receives orientation to the exits from the assisted living facility and the route to be used when evacuating the assisted living facility within 24 hours after the resident's acceptance by the assisted living facility, and
 - 2. The resident's orientation is documented.
- C.** A manager shall ensure that a first-aid kit is maintained in the assisted living facility in a location accessible to caregivers and assistant caregivers.
- D.** When a resident has an accident, emergency, or injury that results in the resident needing medical services, a manager shall ensure that a caregiver or an assistant caregiver:
- 1. Immediately notifies the resident's emergency contact and primary care provider; and
 - 2. Documents the following:
 - a. The date and time of the accident, emergency, or injury;
 - b. A description of the accident, emergency, or injury;
 - c. The names of individuals who observed the accident, emergency, or injury;
 - d. The actions taken by the caregiver or assistant caregiver;
 - e. The individuals notified by the caregiver or assistant caregiver; and
 - f. Any action taken to prevent the accident, emergency, or injury from occurring in the future.
- E.** A manager of an assisted living center shall ensure that:
- 1. Unless the assisted living center has documentation of having received an exception from the Department before October 1, 2013, in the areas of the assisted living center providing personal care services or directed care services:
 - a. A fire alarm system is installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, and is in working order; and
 - b. A sprinkler system is installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, and is in working order;
 - 2. For the areas of the assisted living center providing only supervisory care services:
 - a. A fire alarm system and a sprinkler system meeting the requirements in subsection (E)(1) are installed and in working order, or
 - b. The assisted living center complies with the requirements in subsection (F);
 - 3. A fire inspection is conducted by a local fire department or the State Fire Marshal before licensing and according to the time-frame established by the local fire department or the State Fire Marshal;
 - 4. Any repairs or corrections stated on the fire inspection report are made; and
 - 5. Documentation of a current fire inspection is maintained.
- F.** A manager of an assisted living home shall ensure that:
- 1. A fire extinguisher that is labeled as rated at least 2A-10-BC by the Underwriters Laboratories is mounted and maintained in the assisted living home;
 - 2. A disposable fire extinguisher is replaced when its indicator reaches the red zone;
 - 3. A rechargeable fire extinguisher:
 - a. Is serviced at least once every 12 months, and
 - b. Has a tag attached to the fire extinguisher that specifies the date of the last servicing and the identification of the person who serviced the fire extinguisher;
 - 4. Except as provided in subsection (G):
 - a. A smoke detector is:
 - i. Installed in each bedroom, hallway that adjoins a bedroom, storage room, laundry room,

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- attached garage, and room or hallway adjacent to the kitchen, and other places recommended by the manufacturer;
 - ii. Either battery operated or, if hard-wired into the electrical system of the assisted living home, has a back-up battery;
 - iii. In working order; and
 - iv. Tested at least once a month; and
 - b. Documentation of the test required in subsection (F)(4)(a)(iv) is maintained for at least 12 months after the date of the test;
 - 5. An appliance, light, or other device with a frayed or spliced electrical cord is not used at the assisted living home; and
 - 6. An electrical cord, including an extension cord, is not run under a rug or carpeting, over a nail, or from one room to another at the assisted living home.
- G. A manager of an assisted living home may use a fire alarm system and a sprinkler system to ensure the safety of residents if the fire alarm system and sprinkler system:
 - 1. Are installed and in working order; and
 - 2. Meet the requirements in subsection (E)(1).

Historical Note

New Section made by final rulemaking at 9 A.A.R. 319, effective March 14, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1). R9-10-819 renumbered to R9-10-820; new Section R9-10-819 renumbered from R9-10-818 and amended by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-820. Environmental Standards

- A. A manager shall ensure that:
 - 1. The premises and equipment used at the assisted living facility are:
 - a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
 - b. Free from a condition or situation that may cause a resident or other individual to suffer physical injury;
 - 2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
 - 3. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
 - 4. Heating and cooling systems maintain the assisted living facility at a temperature between 70° F and 84° F at all times, unless individually controlled by a resident;
 - 5. Common areas:
 - a. Are lighted to ensure the safety of residents, and
 - b. Have lighting sufficient to allow caregivers and assistant caregivers to monitor resident activity;
 - 6. Hot water temperatures are maintained between 95° F and 120° F in areas of an assisted living facility used by residents;
 - 7. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents and the cleaning and sanitation requirements in this Article;
 - 8. A resident has access to a laundry service or a washing machine and dryer in the assisted living facility;
 - 9. Soiled linen and soiled clothing stored by the assisted living facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
 - 10. Oxygen containers are secured in an upright position;
 - 11. Poisonous or toxic materials stored by the assisted living facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents;
 - 12. Combustible or flammable liquids and hazardous materials stored by the assisted living facility are stored in the original labeled containers or safety containers in a locked area inaccessible to residents;
 - 13. Equipment used at the assisted living 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 - 14. If pets or animals are allowed in the assisted living facility, pets or animals are:
 - a. Controlled to prevent endangering the residents and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or cat, vaccinated against rabies;
 - 15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
 - 16. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to applicable state laws and rules.
- B. If a swimming pool is located on the premises, a manager shall ensure that:
 - 1. On a day that a resident uses the swimming pool, an employee:
 - a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
 - i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
 - ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
 - iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
 - b. Records the results of the water quality tests in a log that includes the date tested and test result;
 - 2. Documentation of the water quality test is maintained for at least 12 months after the date of the test; and
 - 3. A swimming pool is not used by a resident if a water quality test shows that the swimming pool water does not comply with subsection (B)(1)(a).

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Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). R9-10-820 renumbered to R9-10-821; new Section R9-10-820 renumbered from R9-10-819, by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

R9-10-821. Physical Plant Standards

- A.** A manager shall ensure that an assisted living center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that:
 1. Are applicable to the level of services planned to be provided or being provided; and
 2. Were in effect on the date the assisted living facility submitted architectural plans and specifications to the Department for approval, according to R9-10-104.
- B.** A manager shall ensure that:
 1. The premises and equipment are sufficient to accommodate:
 - a. The services stated in the assisted living facility's scope of services; and
 - b. An individual accepted as a resident by the assisted living facility;
 2. A common area for use by residents is provided that has sufficient space and furniture to accommodate the recreational and socialization needs of residents;
 3. A dining area has sufficient space and tables and chairs to accommodate the needs of the residents;
 4. At least one bathroom is accessible from a common area and:
 - a. May be used by residents and visitors;
 - b. Provides privacy when in use; and
 - c. Contains the following:
 - i. At least one working sink with running water,
 - ii. At least one working toilet that flushes and has a seat,
 - iii. Toilet tissue for each toilet,
 - iv. Soap in a dispenser accessible from each sink,
 - v. Paper towels in a dispenser or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A window that opens or another means of ventilation;
 5. An outside activity space is provided and available that:
 - a. Is on the premises,
 - b. Has a hard-surfaced section for wheelchairs, and
 - c. Has an available shaded area;
 6. Exterior doors are equipped with ramps or other devices to allow use by a resident using a wheelchair or other assistive device; and
 7. The key to the door of a lockable bathroom, bedroom, or residential unit is available to a manager, caregiver, and assistant caregiver.
- C.** A manager shall ensure that:
 1. For every eight residents there is at least one working toilet that flushes and has a seat and one sink with running water;
 2. For every eight residents there is at least one working bathtub or shower; and
 3. A resident bathroom provides privacy when in use and contains:
 - a. A mirror;
 - b. Toilet tissue for each toilet;
 - c. Soap accessible from each sink;
 - d. Paper towels in a dispenser or a mechanical air hand dryer for a bathroom that is not in a residential unit and used by more than one resident;
 - e. A window that opens or another means of ventilation;
 - f. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
 - g. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers.
- D.** A manager shall ensure that:
 1. Each resident is provided with a sleeping area in a residential unit or a bedroom;
 2. For an assisted living home, a resident's sleeping area is on the ground floor of the assisted living home unless:
 - a. The resident is able to direct self-care;
 - b. The resident is ambulatory without assistance; and
 - c. There are at least two unobstructed, usable exits to the outside from the sleeping area that the resident is capable of using;
 3. Except as provided in subsection (E), no more than two individuals reside in a residential unit or bedroom;
 4. A resident's sleeping area:
 - a. Is not used as a common area;
 - b. Is not used as a passageway to a common area, another sleeping area, or common bathroom unless the resident's sleeping area:
 - i. Was used as a passageway to a common area, another sleeping area, or common bathroom before October 1, 2013; and
 - ii. Written consent is obtained from the resident or the resident's representative;
 - c. Is constructed and furnished to provide unimpeded access to the door;
 - d. Has floor-to-ceiling walls with at least one door;
 - e. Has access to natural light through a window or a glass door to the outside; and
 - f. Has a window or door that can be used for direct egress to outside the building;
 5. If a resident's sleeping area is in a bedroom, the bedroom has:
 - a. For a private bedroom, at least 80 square feet of floor space, not including a closet or bathroom;
 - b. For a shared bedroom, at least 60 square feet of floor space for each individual occupying the shared bedroom, not including a closet or bathroom; and
 - c. A door that opens into a hallway, common area, or outdoors;
 6. If a resident's sleeping area is in a residential unit, the residential unit has:
 - a. Except as provided in subsection (E)(2), at least 220 square feet of floor space, not including a closet or bathroom, for one individual residing in the residential unit and an additional 100 square feet of floor space, not including a closet or bathroom, for each additional individual residing in the residential unit;
 - b. An individually keyed entry door;

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- c. A bathroom that provides privacy when in use and contains:
 - i. A working toilet that flushes and has a seat;
 - ii. A working sink with running water;
 - iii. A working bathtub or shower;
 - iv. Lighting;
 - v. A mirror;
 - vi. A window that opens or another means of ventilation;
 - vii. Grab bars for the toilet and, if applicable, the bathtub or shower and other assistive devices, if required to provide for resident safety; and
 - viii. Nonporous surfaces for shower enclosures and slip-resistant surfaces in bathtubs and showers;
- d. A resident-controlled thermostat for heating and cooling;
- e. A kitchen area equipped with:
 - i. A working sink and refrigerator,
 - ii. A cooking appliance that can be removed or disconnected,
 - iii. Space for food preparation, and
 - iv. Storage for utensils and supplies; and
- f. If not furnished by a resident:
 - i. An armchair, and
 - ii. A table where a resident may eat a meal; and
- 7. If not furnished by a resident, each sleeping area has:
 - a. A bed, at least 36 inches in width and 72 inches in length, consisting of at least a frame and mattress that is clean and in good repair;
 - b. Clean linen, including a mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, a bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for the resident;
 - c. Sufficient light for reading;
 - d. Storage space for clothing;
 - e. Individual storage space for personal effects; and
 - f. Adjustable window covers that provide resident privacy.
- E. A manager may allow more than two individuals to reside in a residential unit or bedroom if:
 - 1. There is at least 60 square feet for each individual living in the bedroom;
 - 2. There is at least 100 square feet for each individual living in the residential unit; and
 - 3. The manager has documentation that the assisted living facility has been operating since before November 1, 1998, with more than two individuals living in the residential unit or bedroom.
- F. If there is a swimming pool on the premises of the assisted living facility, a manager shall ensure that:
 - 1. Unless the assisted living facility has documentation of having received an exception from the Department before October 1, 2013, the swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (F)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use;
 - 2. A life preserver or shepherd's crook is available and accessible in the swimming pool area; and
 - 3. Pool safety requirements are conspicuously posted in the swimming pool area.
- G. A manager shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (F)(1) is covered and locked when not in use.

Historical Note

New Section R9-10-821 renumbered from R9-10-820, by final rulemaking at 31 A.A.R. 2085 (June 27, 2025), with a delayed effective date of June 30, 2025 (Supp. 25-2).

ARTICLE 9. OUTPATIENT SURGICAL CENTERS**R9-10-901. Definitions**

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

- 1. "Inpatient care" means postsurgical services provided in a hospital.
- 2. "Outpatient surgical services" means anesthesia and surgical services provided to a patient in an outpatient surgical center.
- 3. "Surgical suite" means an area of an outpatient surgical center that includes one or more operating rooms, one or more procedure rooms, and one or more recovery rooms.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 3792, effective October 4, 2003 (Supp. 03-3). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-902. Administration

- A. A governing authority shall:
 - 1. Consist of one or more individuals responsible for the organization, operation, and administration of an outpatient surgical center;
 - 2. Establish, in writing:
 - a. An outpatient surgical center's scope of services, and
 - b. Qualifications for an administrator;
 - 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
 - 4. Grant, deny, suspend, or revoke clinical privileges of a physician and other members of the medical staff and delineate, in writing, the clinical privileges of each medical staff member, according to the medical staff bylaws;
 - 5. Adopt a quality management plan according to R9-10-903;

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6. Review and evaluate the effectiveness of the quality management plan at least once every 12 months;
 7. Designate in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on an outpatient surgical center's premises for more than 30 calendar days, or
 - b. Not present on an outpatient surgical center's premises for more than 30 calendar days; and
 8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.
- B. An administrator:**
1. Is directly accountable to the governing authority of an outpatient surgical center for the daily operation of the outpatient surgical center and for all services provided by or at the outpatient surgical center;
 2. Has the authority and responsibility to manage the outpatient surgical center; and
 3. Except as provided in subsection (A)(7), designates, in writing, an individual who is present on an outpatient surgical center's premises and accountable for the outpatient surgical center when the administrator is not present on the outpatient surgical center's premises.
- C. An administrator shall ensure that:**
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to patient care;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Include a method to identify a patient to ensure that the patient receives services as ordered;
 - f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
 - g. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The outpatient surgical center to respond to a patient complaint;
 - h. Cover health care directives;
 - i. Cover medical records, including electronic medical records;
 - j. Cover a quality management program, including incident reports and supporting documentation; and
 - k. Cover contracted services;
 2. Policies and procedures for medical services and nursing services provided by an outpatient surgical center are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient screening, admission, transfer, and discharge;
 - b. Cover the provision of medical services, nursing services, and health-related services in the outpatient surgical center's scope of services;
 - c. Include when general consent and informed consent are required;
 - d. Cover dispensing, administering, and disposing of medications;
 - e. Cover prescribing a controlled substance to minimize substance abuse by a patient;
 - f. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 - g. Cover infection control;
 - h. Cover environmental services that affect patient care; and
 - i. Cover prevention of surgical smoke exposure in compliance with A.R.S. § 36-434.01, if applicable;
 3. Policies and procedures are:
 - a. Available to personnel members, employees, volunteers, and students of the outpatient surgical center; and
 - b. Reviewed at least once every three years and updated as needed;
 4. A pharmacy maintained by the outpatient surgical center is licensed according to A.R.S. Title 32, Chapter 18;
 5. Pathology services are provided by a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Act of 1967;
 6. If the outpatient surgical center meets the definition of "abortion clinic" in A.R.S. § 36-449.01, abortions and related services are provided in compliance with the requirements in Article 15 of this Chapter; and
 7. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient surgical center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient surgical center.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-903. 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 services provided to patients;

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

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-904. Contracted Services

An administrator shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-905. Personnel

A. An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health

- services listed in the established job description,
- ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
- iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;

- 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
- 3. Sufficient personnel members are present on an outpatient surgical center's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the outpatient surgical center's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient;
- 4. A personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with patients, provides evidence of freedom from infectious tuberculosis:
 - a. On or before the date the individual begins providing services at or on behalf of the outpatient surgical center, and
 - b. As specified in R9-10-113;
- 5. A plan to provide orientation, specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
- 6. A personnel member completes orientation before providing physical health services or behavioral health services;
- 7. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
- 8. A plan to provide in-service education specific to the job duties of a personnel member is developed, documented, and implemented; and
- 9. A personnel member's in-service education 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 in-service education.

B. An administrator shall ensure that a personnel member:

- 1. Is 18 years of age or older; and
- 2. Is certified in cardiopulmonary resuscitation within the first month of employment or volunteer service, and maintains current certification in cardiopulmonary resuscitation.

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

- 1. The individual's name, date of birth, and contact telephone number;

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2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
3. Documentation of:
 - a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - f. Cardiopulmonary resuscitation training, if required for the individual according to subsection (B);
 - g. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (A)(4); and
 - h. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training.

D. An administrator shall ensure that personnel records are:

1. Maintained:
 - a. Throughout the individual's period of providing services in or for the outpatient surgical center, and
 - b. For at least 24 months after the last date the individual provided services in or for the outpatient surgical center; and
2. For a personnel member who has not provided physical health services or behavioral health services at or for the outpatient surgical center during the previous 12 months, provided to the Department within 72 hours after the Department's request.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 3792, effective October 4, 2003 (Supp. 03-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-906. Medical Staff

A governing authority shall ensure that:

1. The medical staff approve bylaws for the conduct of medical staff activities according to medical staff bylaws and governing authority requirements;
2. The medical staff physicians conduct medical peer review according to A.R.S. Title 36, Chapter 4, Article 5 and submit recommendations to the governing authority for approval; and
3. The medical staff establish written policies and procedures that define the extent of emergency treatment to be performed in the outpatient surgical center.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

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R9-10-907. Admission

- A.** A medical staff member shall only admit patients to the outpatient surgical center who:
 1. Do not require planned inpatient care, and
 2. Are discharged from the outpatient surgical center within 24 hours.
- B.** Within 30 calendar days before a patient is admitted to an outpatient surgical center, a medical staff member shall complete a medical history and physical examination of the patient.
- C.** The individual who is responsible for performing a patient's surgical procedure shall document the preoperative diagnosis and the surgical procedure to be performed in the patient's medical record.
- D.** An administrator shall ensure that the following documents are in a patient's medical record before the patient's surgery:
 1. A medical history and the physical examination required in subsection (B),
 2. A preoperative diagnosis and the results of any laboratory tests or diagnostic procedures relative to the surgery and the condition of the patient,
 3. Evidence of informed consent by the patient or patient's representative for the surgical procedure and care of the patient,
 4. Health care directives, and
 5. Physician orders.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-908. Transfer

Except for a transfer of a patient due to an emergency, an administrator shall ensure that:

1. A personnel member coordinates the transfer and the services provided to the patient;
2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information in the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9

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A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 3792, effective October 4, 2003 (Supp. 03-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-909. Patient Rights**A.** An administrator shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
 - b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by the outpatient surgical center's medical staff, personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and the associated risks and possible complications of the proposed psychotropic medication or surgical procedure;
 - d. Is informed of the following:
 - i. Policies and procedures on health care directives, and
 - ii. The patient complaint process;
 - e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient surgical center for identification and administrative purposes; and
 - f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or

- ii. Financial records.

C. A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient surgical center is not authorized or not able to provide physical health services needed by the patient;
6. To participate, or have the patient's representative participate, in the development of or decisions concerning treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, a patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-910. Medical Records**A.** An administrator shall ensure that:

1. A medical record is established and maintained for a patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
 - a. Recorded only by an individual authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical staff member according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical staff member issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
 - c. As permitted by law; and
6. A patient's medical record is protected from loss, damage, or unauthorized use.

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- B.** If an outpatient surgical center maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
 - a. The patient's name;
 - b. The patient's address;
 - c. The patient's date of birth; and
 - d. Any known allergies, including medication allergies;
 2. The admitting medical practitioner;
 3. An admitting diagnosis;
 4. Documentation of general consent and informed consent for treatment by the patient or the patient's representative, except in an emergency;
 5. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 6. The date of admission and, if applicable, date of discharge;
 7. Documentation of medical history and results of a physical examination;
 8. A copy of patient's health care directive, if applicable;
 9. Orders;
 10. Progress notes;
 11. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 12. Documentation of outpatient surgical center services provided to the patient;
 13. A discharge summary, if applicable;
 14. Documentation of receipt of written discharge instructions by the patient or patient's representative;
 15. If applicable:
 - a. Laboratory reports,
 - b. Radiologic report, and
 - c. Diagnostic reports;
 16. The anesthesia report, required in R9-10-911(C)(2);
 17. The operative report of the surgical procedure, required in R9-10-911(C)(1); and
 18. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and
 - f. Any adverse reaction a patient has to the medication.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-911. Surgical Services

- A.** An administrator shall ensure that:
1. A current listing of surgical procedures offered by an outpatient surgical center is maintained on the outpatient surgical center's premises, and
 2. A chronological register of surgical procedures performed in the outpatient surgical center is maintained for at least 24 months after the date of the last entry.
- B.** An administrator shall ensure that a roster of medical staff members who have clinical privileges at the outpatient surgical center is available to the medical staff, specifying the privileges and limitations of each medical staff member on the roster.
- C.** An administrator shall ensure that the individual responsible for:
1. Performing a surgical procedure completes an operative report of the surgical procedure and any necessary discharge instructions according to medical staff bylaws and policies and procedures, and
 2. Administering anesthesia during a surgical procedure completes an anesthesia report and any necessary discharge instructions according to medical staff bylaws and policies and procedures.
- D.** An administrator shall ensure that a physician medically discharges a patient from surgery.
- E.** An administrator shall ensure that a physician or an anesthesia provider licensed pursuant to Title 32, Chapter 13, 15, or 17, discharges a patient from the recovery room.
- F.** An administrator shall ensure that one of the following remains on the outpatient surgical center's premises until all patients are discharged from the recovery room:
1. A physician; or
 2. An individual authorized under A.R.S. Title 32, Chapter 13, 15, or 17 to administer anesthesia.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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R9-10-912. Nursing Services

An administrator shall appoint a registered nurse as the director of nursing who:

1. Is responsible for the management of the outpatient surgical center's nursing services;
2. Ensures that policies and procedures are established, documented, and implemented for nursing services provided in the outpatient surgical center;
3. Ensures that the outpatient surgical center is staffed with sufficient nursing personnel, based on the number of patients, the health care needs of the patients, and the outpatient surgical center's scope of services;
4. Participates in quality management activities;
5. Designates a registered nurse, in writing, to manage an outpatient surgical center's nursing services when the director of nursing is not present on the outpatient surgical center's premises;
6. Ensures that a nurse who is not directly assisting the surgeon is responsible for the functioning of an operating room while a surgical procedure is being performed in the operating room;
7. Ensures that a registered nurse is present in the:
 - a. Recovery room when a patient is present in the recovery room, and
 - b. Outpatient surgical center until all patients are discharged; and
8. Ensures that a nurse documents in a patient's medical record that the patient or the patient's representative has received written discharge instructions.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-913. Behavioral Health Services

If an outpatient surgical center is authorized to provide behavioral health services, an administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented that cover when informed consent is required and by whom informed consent may be given; and
2. The behavioral health services:
 - a. Are provided under the direction of a behavioral health professional; and
 - b. Comply with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians, in R9-10-115; and
 - ii. For an assessment, in R9-10-1011(B).

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemak-

ing at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-914. Medication Services

A. An administrator shall ensure that policies and procedures for medication services:

1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient including:
 - 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:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose; and
 - c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs; and
2. 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. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a patient:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the patient's medical record.

C. 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; and
3. If pharmaceutical services are provided on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - i. Develop a drug formulary,
 - ii. Update the drug formulary at least once every 12 months,
 - iii. Develop medication usage and medication substitution policies and procedures, and
 - iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the

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- ordering medical staff member specifically orders otherwise;
 - b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. 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
 - d. A copy of the pharmacy license is provided to the Department upon request.
- D.** When medication is stored at an outpatient surgical center, an administrator shall ensure that:
- 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and
 - 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication;
 - d. Storing, inventorying, and dispensing controlled substances; and
 - e. If applicable, donated medicine according to A.R.S. § 32-1909.
- E.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the outpatient surgical center's director of nursing.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-915. Infection Control

An administrator shall ensure that:

- 1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the outpatient surgical center;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the outpatient surgical center;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the outpatient surgical center; and
 - d. Documenting infection control activities including:
 - i. The collection and analysis of infection control data,

- ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
- 2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
 - 3. Policies and procedures are established, documented, and implemented that cover:
 - a. Compliance with the requirements in 9 A.A.C. 6 for reporting and control measures for communicable diseases and infestations;
 - b. Handling and disposal of biohazardous medical waste;
 - c. Sterilization, disinfection, distribution, and storage of medical equipment and supplies;
 - d. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
 - e. Training personnel members, employees, and volunteers in infection control practices; and
 - f. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
 - 4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 - 5. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination,
 - b. Bagged at the site of use, and
 - c. Maintained separate from clean linen and clothing; and
 - 6. A personnel member, employee, or volunteer washes hands or uses a hand disinfection product after patient contact and after handling soiled linen, soiled clothing, or potentially infectious material.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-916. Emergency and Safety Standards

A. An administrator shall ensure that policies and procedures for providing medical emergency treatment to a patient are established, documented, and implemented and include:

- 1. A list of the medications, supplies, and equipment required on the premises for the medical emergency treatment provided by the outpatient surgical center;
- 2. A system to ensure medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
- 3. A requirement that a cart or a container is available for medical emergency treatment that contains medications, supplies, and equipment specified in policies and procedures;
- 4. A method to verify and document that the contents of the cart or container are available for medical emergency treatment; and

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5. A method for ensuring a patient may be transferred to a hospital or other health care institution to receive treatment for a medical emergency that the outpatient surgical center is not authorized or not able to provide.
- B. An administrator shall ensure that medical emergency treatment is provided to a patient admitted to the outpatient surgical center according to policies and procedures.
- C. An administrator shall ensure that:
 1. A disaster plan is developed, documented, maintained in a location accessible to medical staff and employees, and, if necessary, implemented that includes:
 - a. Procedures to be followed in the event of a fire or threat to patient safety;
 - b. Assigned personnel responsibilities;
 - c. Instructions for the evacuation or transfer of patients;
 - d. Maintenance of patient medical records; and
 - e. A plan to provide any other services related to patient care to meet the patients' needs;
 2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (C)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, medical staff member, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 5. An evacuation drill for employees is conducted at least once every six months for employees on the premises;
 6. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees to evacuate the outpatient surgical center;
 - c. Any problems encountered in conducting the evacuation drill; and
 - d. Recommendations for improvement, if applicable; and
 7. An evacuation path is conspicuously posted on each hallway of each floor of the outpatient surgical center and every room where patients may be present.
- D. An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.
- E. An administrator shall:
 1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the fire inspection report, and
 3. Maintain documentation of a current fire inspection.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section amended by exempt rulemak-

ing at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-917. Environmental Standards

- A. An administrator shall ensure that:
 1. An outpatient surgical center's premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness or infection; and
 - b. Free from a condition or situation that may cause a patient or an individual to suffer physical injury;
 2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
 3. Equipment used at the outpatient surgical center to provide care to a patient 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 5. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
 6. Heating and cooling systems maintain the outpatient surgical center at a temperature between 70° F and 84° F at all times;
 7. Common areas:
 - a. Are lighted to assure the safety of patients, and
 - b. Have lighting sufficient to allow personnel members to monitor patient activity; and
 8. 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.
- B. An administrator shall ensure that an outpatient surgical center has a functional emergency power source.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

R9-10-918. Physical Plant Standards

- A. An administrator shall ensure that the outpatient surgical center complies with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, that were in effect on the date the outpatient surgical center submitted the application packet including the notarized attestation of architectural plans according to R9-10-104.

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- B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the outpatient surgical center's scope of services, and
 2. An individual accepted as a patient by the outpatient surgical center.
- C.** An administrator shall ensure that:
1. There are two recovery beds for each operating room, for up to four operating rooms, whenever general anesthesia is administered;
 2. One additional recovery bed is available for each additional operating room; and
 3. Recovery beds are located in a space that provides for a minimum of 70 square feet per bed, allowing three feet or more between beds and between the sides of a bed and the wall.
- D.** An administrator may provide chairs in the recovery room area that allow a patient to recline for patients who have not received general anesthesia.
- E.** An administrator shall ensure that the following are available in the surgical suite:
1. Oxygen and the means of administration;
 2. Mechanical ventilator assistance equipment including airways, manual breathing bag, and suction apparatus;
 3. Cardiac monitor;
 4. Defibrillator; and
 5. Cardiopulmonary resuscitation drugs as determined by the policies and procedures.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1). New Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-919. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1). New Section made by final rulemaking at 9 A.A.R. 338, effective March 16, 2003 (Supp. 03-1). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-920. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-921. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-922. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-923. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-924. Repealed**Historical Note**

Adopted effective June 2, 1983 (Supp. 82-5). Former Section R9-10-924 repealed, new Section R9-10-924 adopted effective November 6, 1985 (Supp. 85-6). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-925. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

Attachment 1. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

Attachment 2. Repealed**Historical Note**

Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective November 6, 1985 (Supp. 85-6).

Editor's Note: The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1). Subsequently, those Sections were repealed by final rulemaking (Supp. 99-2).

ARTICLE 10. OUTPATIENT TREATMENT CENTERS**R9-10-1001. Definitions**

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

1. "Emergency room services" means medical services provided to a patient in an emergency.
2. "Pain management services" means medical services, nursing services, or health-related services provided to a patient to reduce or relieve the patient's chronic pain.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

R9-10-1002. Supplemental Application and Documentation Submission Requirements

- A.** In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for a license as an outpatient treatment center shall submit, in a Department-provided format:

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1. The days and hours of clinical operation and, if different from the days and hours of administrative operation, the days and hours of administrative operation; and
 2. A request to provide one or more of the following services:
 - a. Behavioral health services and, if applicable;
 - i. Behavioral health observation/stabilization services,
 - ii. Children's behavioral health services,
 - iii. Court-ordered evaluation,
 - iv. Court-ordered treatment,
 - v. Counseling,
 - vi. Crisis services,
 - vii. Opioid treatment services,
 - viii. Pre-petition screening,
 - ix. Respite services,
 - x. Respite services for children on the premises,
 - xi. DUI education,
 - xii. DUI screening,
 - xiii. DUI treatment, or
 - xiv. Misdemeanor domestic violence offender treatment;
 - b. Diagnostic imaging services;
 - c. Clinical laboratory services;
 - d. Dialysis services;
 - e. Emergency room services;
 - f. Pain management services;
 - g. Physical health services;
 - h. Rehabilitation services;
 - i. Sleep disorder services; or
 - j. Urgent care services provided in a freestanding urgent care center setting.
- B.** In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority of an:
1. Affiliated outpatient treatment center applying for a license for the affiliated outpatient treatment center shall submit, in a Department-provided format, the following information for each counseling facility for which the affiliated outpatient treatment center is providing administrative support:
 - a. Name, and
 - b. Either:
 - i. The license number assigned to the counseling facility by the Department; or
 - ii. If the counseling facility is not currently licensed, the:
 - (1) Counseling facility's street address, and
 - (2) Date the counseling facility submitted to the Department an application for a health care institution license; and
 2. Outpatient treatment center, applying for a license that includes a request for authorization to provide respite services for children on the premises, shall include the requested respite capacity.

C. A licensee of an affiliated outpatient treatment center shall submit to the Department the information required in subsection (B)(1) with the relevant fees required in R9-10-106(C) or (D), as applicable.

D. A licensee of an outpatient treatment center authorized to provide respite services for children on the premises shall submit to the Department with the relevant fees in R9-10-106(C) or (D), as applicable:

 1. The respite capacity, and
 2. The specific 10 continuous hours per day during which the outpatient treatment center provides respite services on the premises.

E. A licensee of an outpatient treatment center authorized to operate as a collaborating outpatient treatment center shall submit to the Department with the relevant fees in R9-10-106(C) or (D), as applicable:

 1. The information and documentation required in R9-10-1031(D)(1); and
 2. A floor plan that shows:
 - a. Each colocator's proposed treatment area, and
 - b. The areas of the collaborating outpatient treatment center shared by a colocator and collaborating outpatient treatment center.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1003. Administration

- A.** If an outpatient treatment center is operating under a single group license issued to a hospital according to A.R.S. § 36-422(F) or (G), the hospital's governing authority is the governing authority for the outpatient treatment center.
- B.** A governing authority shall:
1. Consist of one or more individuals accountable for the organization, operation, and administration of an outpatient treatment center;
 2. Establish, in writing:
 - a. An outpatient treatment center's scope of services, and
 - b. Qualifications for an administrator;
 3. Designate, in writing, an administrator who has the qualifications established in subsection (B)(2)(b);
 4. Adopt a quality management program according to R9-10-1004;
 5. Review and evaluate the effectiveness of the quality management program in R9-10-1004 at least once every 12 months;
 6. Designate, in writing, an acting administrator who has the qualifications established in subsection (B)(2)(b) if the administrator is:
 - a. Expected not to be present on an outpatient treatment center's premises for more than 30 calendar days, or
 - b. Not present on an outpatient treatment center's premises for more than 30 calendar days; and
 7. Except as provided in subsection (B)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in an administrator and identify the name and qualifications of the new administrator.
- C.** An administrator:
1. Is directly accountable to the governing authority for the daily operation of the outpatient treatment center and all services provided by or at the outpatient treatment center;

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2. Has the authority and responsibility to manage the outpatient treatment center; and
3. Except as provided in subsection (B)(6), designates, in writing, an individual who is present on the outpatient treatment center's premises and accountable for the outpatient treatment center when the administrator is not available.

D. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a patient;
 - d. Cover the requirements in Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training including:
 - i. The method and content of cardiopulmonary resuscitation training which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation,
 - 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 that an individual has received cardiopulmonary resuscitation training;
 - f. Cover first aid training;
 - g. Include a method to identify a patient to ensure the patient receives the services ordered for the patient;
 - h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
 - i. Cover health care directives;
 - j. Cover medical records, including electronic medical records;
 - k. Cover quality management, including incident report and supporting documentation; and
 - l. Cover contracted services;
2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient screening, admission, assessment, transport, transfer, discharge plan, and discharge;
 - b. Cover the provision of medical services, nursing services, behavioral health services, health-related services, and ancillary services;
 - c. Include when general consent and informed consent are required;
 - d. Cover obtaining, administering, storing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
 - e. Cover prescribing a controlled substance to minimize substance abuse by a patient;

- f. Cover infection control;
- g. Cover telehealth, if applicable;
- h. Cover environmental services that affect patient care;
- i. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. An outpatient treatment center to respond to a complaint;
- j. Cover smoking tobacco products on an outpatient treatment center's premises; and
- k. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;

3. Outpatient treatment center policies and procedures are:
 - a. Reviewed at least once every three years and updated as needed, and
 - b. Available to personnel members and employees;
4. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of an outpatient treatment center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the outpatient treatment center;
5. The following are conspicuously posted:
 - a. The current license for the outpatient treatment center issued by the Department;
 - b. The name, address, and telephone number of the Department;
 - c. A notice that a patient may file a complaint with the Department about the outpatient treatment center;
 - d. One of the following:
 - i. A schedule of rates according to A.R.S. § 36-436.01(C), or
 - ii. A notice that the schedule of rates required in A.R.S. § 36-436.01(C) is available for review upon request;
 - e. A list of patient rights;
 - f. A map for evacuating the facility; and
 - g. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(D), with patient information redacted, are available; and
6. Patient follow-up instructions are:
 - a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the outpatient treatment center unless the patient leaves against a personnel member's advice; and
 - b. Documented in the patient's medical record.

E. If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from an outpatient treatment center's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:

1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
2. For a patient under 18 years of age, according to A.R.S. § 13-3620.

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F. If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from an outpatient treatment center's employee or personnel member, an administrator shall:

1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
2. Report the suspected abuse, neglect, or exploitation of the patient as follows:
 - a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

G. If an outpatient treatment center is an affiliated outpatient treatment center, an administrator shall ensure that the outpatient treatment center complies with the requirements for an affiliated outpatient treatment center in 9 A.A.C. 10, Article 19.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1004. 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 services provided to patients;
 - 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 change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1005. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1006. Personnel

An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected

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- physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
- 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
- 3. Sufficient personnel members are present on an outpatient treatment center's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the outpatient treatment center's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient;
- 4. A personnel member only provides physical health services or behavioral health services the personnel member is qualified to provide;
- 5. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;
- 6. A personnel member completes orientation before providing medical services, nursing services or health-related services to a patient;
- 7. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
- 8. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;
- 9. A personnel member's in-service education is documented, to include:
 - a. The personnel member's name,
 - b. The date of the in-service education, and
 - c. The subject or topics covered in the in-service education;
- 10. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;
- 11. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service, and if applicable, the ending date;
 - c. Documentation of:
 - i. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education as required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - vi. The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable; and
 - vii. Cardiopulmonary resuscitation training, if the individual is required to have cardiopulmonary resuscitation training according to this Article or policies and procedures; and
- 12. The record in subsection (A)(11) is:
 - a. Maintained while an individual provides services for or at the outpatient treatment center and for at least 24 months after the last date the employee or volunteer provided services for or at the outpatient treatment center; and
 - b. If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1007. Transport; Transfer

- A.** Except as provided in subsection (B), an administrator shall ensure that:
 - 1. A personnel member coordinates the transport and the services provided to the patient;
 - 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before and after the transport,
 - b. Information from the patient's medical record is provided to a receiving health care institution,
 - c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative; and
 - d. A personnel member communicates or documents why the personnel member did not communicate with an individual at a receiving health care institution;
 - 3. The patient's medical record includes documentation of:
 - a. Communication or lack of communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transport.
- B.** Subsection (A) does not apply to:
 - 1. Transportation to a location other than a licensed health care institution,
 - 2. Transportation provided for a patient by the patient or the patient's representative,

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3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative, or
4. A transport to another licensed health care institution in an emergency.
- C. Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
 1. A personnel member coordinates the transfer and the services provided to the patient;
 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
 3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.
- h. Except as allowed in R9-10-1012(B), restraint or seclusion;
- i. Retaliation for submitting a complaint to the Department or another entity; or
- j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
 - d. Is informed of the following:
 - i. The outpatient treatment center's policy on health care directives, and
 - ii. The patient complaint process;
 - e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
 - f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.
- C. A patient has the following rights:
 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
 3. To receive privacy in treatment and care for personal needs;
 4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
 6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
 7. To participate or refuse to participate in research or experimental treatment; and
 8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1008. Patient Rights

- A. An administrator shall ensure that:
 1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
 2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
 - b. Where patient rights are posted as required in subsection (A)(1).
- B. An administrator shall ensure that:
 1. A patient is treated with dignity, respect, and consideration;
 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

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R9-10-1009. Medical Records**A.** An administrator shall ensure that:

1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
 - c. As permitted by law;
6. Policies and procedures include the maximum time-frame to retrieve a patient's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

B. If an outpatient treatment center maintains patients' medical records electronically, an administrator shall ensure that:

1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a 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. Except as specified in A.A.C. R9-6-1005, the patient's name and address;
 - b. The patient's date of birth; and
 - c. Any known allergies, including medication allergies;
2. A diagnosis or reason for outpatient treatment center services;
3. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
4. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care

- power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
- ii. Is a legal guardian, a copy of the court order establishing guardianship;

5. Documentation of medical history and, if applicable, results of a physical examination;
6. Orders;
7. Assessment;
8. Treatment plans;
9. Interval notes;
10. Progress notes;
11. Documentation of outpatient treatment center services provided to the patient;
12. The name of each individual providing treatment or a diagnostic procedure;
13. Disposition of the patient upon discharge;
14. Documentation of the patient's follow-up instructions provided to the patient;
15. A discharge summary;
16. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Sleep disorder reports,
 - d. Diagnostic reports, and
 - e. Consultation reports;
17. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual, other than actions taken while providing behavioral health observation/stabilization services; and
18. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication;
 - f. Any adverse reaction a patient has to the medication; and
 - g. For prepacked or sample medication provided to the patient for self-administration, the name, strength, dosage, amount, route of administration, and expiration date.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1010. Medication Services

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- A.** If an outpatient treatment center provides medication administration or assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication services:
1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient including:
 - 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:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a patient's medication regimen is reviewed by a medical practitioner and meets the patient's needs;
 - d. Procedures for documenting medication administration and assistance in the self-administration of medication;
 - e. Procedures for assisting a patient in obtaining medication; and
 - f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 2. 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.** If an outpatient treatment center provides medication administration, an administrator shall ensure that:
1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
 3. A medication administered to a patient is:
 - a. Administered in compliance with an order, and
 - b. Documented in the patient's medical record.
- C.** If an outpatient treatment center provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A patient's medication is stored by the outpatient treatment center;
 2. The following assistance is provided to a patient:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the patient;
 - c. Observing the patient while the patient removes the medication from the container;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a patient is:
 - a. In compliance with an order, and
 - b. Documented in the patient's medical record.
- D.** 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 ARS 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.
- E.** When medication is stored at an outpatient treatment center, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions on the medication container; and
 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;

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- b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
 - e. If applicable, donated medicine according to A.R.S. § 32-1909.
 - F. An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the outpatient treatment center's clinical director.
- Historical Note**
- New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).
- R9-10-1011. Behavioral Health Services**
- A. An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:
 - 1. The outpatient treatment center does not provide a behavioral health service the outpatient treatment center is not authorized to provide;
 - 2. The behavioral health services provided by or at the outpatient treatment center:
 - a. Are provided under the direction of a behavioral health professional; and
 - b. Comply with the requirements:
 - i. For behavioral health paraprofessionals and behavioral health technicians in R9-10-115, and
 - ii. For an assessment, in subsection (B);
 - 3. A personnel member who provides behavioral health services is at least 18 years old; and
 - 4. If an outpatient treatment center provides behavioral health services to a patient who is less than 18 years of age, the owner and an employee or a volunteer comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.
 - B. An administrator of an outpatient treatment center that is authorized to provide behavioral health services shall ensure that:
 - 1. Except as provided in subsection (B)(2), a behavioral health assessment for a patient is completed before treatment for the patient is initiated;
 - 2. If a behavioral health assessment that complies with the requirements in this Section is received from a behavioral health provider other than the outpatient treatment center or the outpatient treatment center has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission:
 - a. The patient's assessment information is reviewed and updated if additional information that affects the patient's assessment is identified, and
 - b. The review and update of the patient's assessment information is documented in the patient's medical record within 48 hours after the review is completed;
 - 3. If a behavioral health assessment is conducted by a:
 - a. Behavioral health technician or a registered nurse, within 72 hours a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the patient; or
 - b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the behavioral health services needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the behavioral health services needed by the patient;
 - 4. A behavioral health assessment:
 - a. Documents a patient's:
 - i. Presenting issue;
 - ii. Substance abuse history;
 - iii. Co-morbidity;
 - iv. Medical condition and history;
 - v. Legal history, including:
 - (1) Custody,
 - (2) Guardianship, and
 - (3) Pending litigation;
 - vi. Criminal justice record;
 - vii. Family history;
 - viii. Behavioral health treatment history; and
 - ix. 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. The behavioral health services, physical health services, or ancillary services that will be provided to the patient;
 - iii. Prescribing medication to treat or manage a mental health or substance abuse condition; and
 - iv. The signature and date signed of the personnel member conducting the behavioral health assessment; and
 - c. Is documented in patient's medical record;
 - 5. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
 - 6. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
 - 7. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;
 - 8. Documentation of the request in subsection (B)(6) and the opportunity in subsection (B)(7) is in the patient's medical record;
 - 9. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;
 - 10. If information in subsection (B)(4)(a) is obtained about a patient after the patient's behavioral health assessment is

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completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;

11. Counseling is:
 - a. Offered as described in the outpatient treatment center's scope of services,
 - b. Provided according to the frequency and number of hours identified in the patient's assessment, and
 - c. Provided by a behavioral health professional or a behavioral health technician;
 12. A personnel member providing counseling that addresses a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
 13. Each counseling session is documented in the patient's medical record to include:
 - a. The date of the counseling session;
 - b. The amount of time spent in the counseling session;
 - c. Whether the counseling was individual counseling, family counseling, or group counseling;
 - d. The treatment goals addressed in the counseling session; and
 - e. The signature of the personnel member who provided the counseling and the date signed.
- C. An administrator of an outpatient treatment center authorized to provide behavioral health services may request to provide any of the following to individuals required to attend by a referring court:
1. DUI screening,
 2. DUI education,
 3. DUI treatment, or
 4. Misdemeanor domestic violence offender treatment.
- D. An administrator of an outpatient treatment center authorized to provide the services in subsection (C):
1. Shall comply with the requirements for the specific service in 9 A.A.C. 20, and
 2. May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1011 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1011 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1012. Behavioral Health Observation/Stabilization Services

- A. An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:
1. Behavioral health observation/stabilization services are available 24 hours a day, every calendar day;
 2. Behavioral health observation/stabilization services are provided in a designated area that:
 - a. Is used exclusively for behavioral health observation/stabilization services;
 - b. Has the space for a patient to receive privacy in treatment and care for personal needs; and
 - c. For every 15 observation chairs or less, has at least 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 or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A means of ventilation;
 3. If the outpatient treatment center is authorized to provide behavioral health observation/stabilization services to individuals under 18 years of age:
 - a. There is a separate designated area for providing behavioral health observation/stabilization services to individuals under 18 years of age that:
 - i. Meets the requirements in subsection (B)(2), and
 - ii. Has floor to ceiling walls that separate the designated area from other areas of the outpatient treatment center;
 - b. A registered nurse is present 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;
 4. A medical practitioner is available;
 5. If the medical practitioner present at the outpatient treatment center is a registered nurse practitioner or a physician assistant, a physician is on-call;
 6. A registered nurse is present and provides direction for behavioral health observation/stabilization services in the designated area;
 7. A nurse monitors each patient at the intervals determined according to subsection (A)(12) and documents the monitoring in the patient's medical record;
 8. An individual who arrives at the designated area for behavioral health observation/stabilization services in the outpatient treatment center is screened within 30 minutes, by a qualified person who is on the premises, after entering the designated area to determine whether the individual is in need of immediate physical health services;
 9. If a screening indicates that an individual needs immediate physical health services that the outpatient treatment center is:
 - a. Able to provide according to the outpatient treatment center's scope of services, the individual is examined by a medical practitioner within 30 minutes after being screened; or

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- b. Not able to provide, the individual is transferred to a health care institution capable of meeting the individual's immediate physical health needs;
10. If a screening indicates that an individual needs behavioral health observation/stabilization services and the outpatient treatment center has the capabilities to provide the behavioral health observation/stabilization services, the individual is admitted to the designated area for behavioral health observation/stabilization services and may remain in the designated area and receive observation/stabilization services for up to 23 hours and 59 minutes;
11. Before a patient is discharged from the designated area for behavioral health observation/stabilization services, a medical practitioner determines whether the patient will be:
 - a. If the behavioral health observation/stabilization services are provided in a health care institution that also provides inpatient services and is capable of meeting the patient's needs, admitted to the health care institution as an inpatient;
 - b. Transferred to another health care institution capable of meeting the patient's needs;
 - c. Provided a referral to another entity capable of meeting the patient's needs; or
 - d. Discharged and provided patient follow-up instructions;
12. When a patient is admitted to a designated area for behavioral health observation/stabilization services, an assessment of the patient includes the interval for monitoring the patient based on the patient's medical condition, behavior, suspected drug or alcohol abuse, and medication status to ensure the health and safety of the patient;
13. If a patient is not being admitted as an inpatient to a health care institution, before discharging the patient from a designated area for behavioral health observation/stabilization services, a personnel member:
 - a. Identifies the specific needs of the patient after discharge necessary to assist the patient to function independently;
 - b. Identifies any resources, including family members, community social services, peer support services, and Regional Behavioral Health Agency staff, that may be available to assist the patient; and
 - c. Documents the information in subsection (A)(13)(a) and the resources in subsection (A)(13)(b) in the patient's medical record;
14. When a patient is discharged from a designated area for behavioral health observation/stabilization services, a personnel member:
 - a. Provides the patient with discharge information that includes:
 - i. The identified specific needs of the patient after discharge, and
 - ii. Resources that may be available for the patient; and
 - b. Contacts any resources identified as required in subsection (A)(13)(b);
15. Except as provided in subsection (A)(16), a patient is not re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge from a designated area for behavioral health observation/stabilization services;
16. A patient may be re-admitted to the outpatient treatment center for behavioral health observation/stabilization services within two hours after the patient's discharge if:
 - a. It is at least one hour since the time of the patient's discharge;
 - b. A law enforcement officer or the patient's case manager accompanies the patient to the outpatient treatment center;
 - c. Based on a screening of the patient, it is determined that re-admission for behavioral health observation/stabilization is necessary for the patient; and
 - d. The name of the law enforcement officer or the patient's case manager and the reasons for the determination in subsection (A)(16)(c) are documented in the patient's medical record;
17. A patient admitted for behavioral health observation/stabilization services is provided:
 - a. An observation chair; or
 - b. A separate piece of equipment for the patient to use to sit or recline that:
 - i. Is at least 12 inches from the floor; and
 - ii. Has sufficient space around the piece of equipment to allow a personnel member to provide behavioral health services and physical health services, including emergency services, to the patient;
18. If an individual is not admitted for behavioral health observation/stabilization services because there is not an observation chair available for the individual's use, a personnel member provides support to the individual to access the services or resources necessary for the individual's health and safety, which may include:
 - a. Admitting the individual to the outpatient treatment center to provide behavioral health services other than behavioral health observation/stabilization services;
 - b. Establishing a method to notify the individual when there is an observation chair available;
 - c. Referring or providing transportation to the individual to another health care institution;
 - d. Assisting the individual to contact the individual's support system; and
 - e. If the individual is enrolled with a Regional Behavioral Health Authority, contacting the appropriate person to request assistance for the individual;
19. Personnel members 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;
20. The log required in subsection (A)(19) is maintained for at least 12 months after the date of documentation in the log;
21. An observation chair or, as provided in subsection (A)(17)(b), a piece of equipment used by a patient to sit or recline is visible to a personnel member;
22. Except as provided in subsection (A)(23), a patient admitted to receive behavioral health observation/stabilization services is visible to a personnel member;
23. A patient admitted to receive behavioral health observation/stabilization services may use the bathroom and not

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be visible to a personnel member, if the personnel member:

- a. Determines that the patient is capable of using the bathroom unsupervised,
- b. Is aware of the patient's location, and
- c. Is able to intervene in the patient's actions to ensure the patient's health and safety; and

24. An observation chair:

- a. Effective until July 1, 2015, has space around the observation chair that allows a personnel member to provide behavioral health services and physical health services, including emergency services, to a patient in the observation chair; and
- b. Effective on July 1, 2015, 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.

B. An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall:

1. Have a room used for seclusion that complies with requirements for seclusion rooms in R9-10-316, and
2. Comply with the requirements for restraint and seclusion in R9-10-316.

C. An administrator of an outpatient treatment center that is authorized to provide behavioral health observation/stabilization services shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover the process for:
 - i. Evaluating a patient previously admitted to the designated area to determine whether the patient is ready for admission to an inpatient setting or discharge, including when to implement the process;
 - ii. Contacting other health care institutions that provide behavioral health observation/stabilization services to determine if the patient could be admitted for behavioral health observation/stabilization services in another health care institution, including when to implement the process; and
 - iii. Ensuring that sufficient personnel members, space, and equipment are available to provide behavioral health observation/stabilization services; and
 - b. Establish a maximum capacity of the number of patients for whom the outpatient treatment center is capable of providing behavioral health observation/stabilization services;
2. The outpatient treatment center does not:
 - a. Exceed the maximum capacity established by the outpatient treatment center in subsection (C)(1)(b); or
 - b. Admit an individual if the outpatient treatment center does not have personnel members, space, and equipment available to provide behavioral health observation/stabilization services to the individual; and
3. Effective on July 1, 2015:

- a. If an admission of an individual causes the outpatient treatment center to exceed the outpatient treatment center's licensed occupancy, the individual is only admitted for behavioral health observation/stabilization services after:
 - (i.) A behavioral health professional reviews the individual's screening and determines the admission is an emergency; and
 - (ii.) Documents the determination in the individual's medical record; and
- b. The outpatient treatment center's quality management program's plan, required in R9-10-1004(1), includes a method to identify and document each occurrence of exceeding licensed occupancy, to evaluate the occurrences of exceeding licensed occupancy, and to review the actions taken to reduce future occurrences of exceeding licensed occupancy.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1012 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1012 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1013. Court-ordered Evaluation

An administrator of an outpatient treatment center that is authorized to provide court-ordered evaluation shall comply with the requirements for court-ordered evaluation in A.R.S. Title 36, Chapter 5, Article 4.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1013 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1013 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, §

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13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1014. Court-ordered Treatment

An administrator of an outpatient treatment center that is authorized to provide court-ordered treatment shall comply with the requirements for court-ordered treatment in A.R.S. Title 36, Chapter 5, Article 5.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1014 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1014 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1015. Clinical Laboratory Services

An administrator of an outpatient treatment center that is authorized to provide clinical laboratory services shall ensure that:

1. If clinical laboratory services are provided on the premises or at another location, the clinical laboratory services are provided by a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the U.S. Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. 263a, as amended by Public Law 100-578, October 31, 1988; and
2. A clinical laboratory test result is documented in a patient's medical record including:
 - a. The name of the clinical laboratory test;
 - b. The patient's name;
 - c. The date of the clinical laboratory test;
 - d. The results of the clinical laboratory test; and
 - e. If applicable, any adverse reaction related to or as a result of the clinical laboratory test.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1015 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1015 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222,

effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1016. Crisis Services

- A. An administrator of an outpatient treatment center that is authorized to provide crisis services shall comply with the requirements for behavioral health services in R9-10-1011.
- B. An administrator of an outpatient treatment center that is authorized to provide crisis services shall ensure that:
 1. Crisis services are available during clinical hours of operation;
 2. A behavioral health technician, qualified to provide crisis services according to the outpatient treatment center's policies and procedures, is present in the outpatient treatment center during clinical hours of operation; and
 3. The following individuals, qualified to provide crisis services according to policies and procedures, are available during clinical hours of operation:
 - a. A behavioral health professional,
 - b. A medical practitioner, and
 - c. A registered nurse.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1016 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1016 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1017. Diagnostic Imaging Services

An administrator of an outpatient treatment center that is authorized to provide diagnostic imaging services shall:

1. Designate an individual to provide direction for diagnostic imaging services who is a:
 - a. Radiologic technologist, certified under A.R.S. Title 32, Chapter 28, Article 2, who has at least 12 months experience in an outpatient treatment center;
 - b. Physician; or
 - c. Radiologist; and
2. Ensure that:
 - a. Diagnostic imaging services are provided in compliance with A.R.S. Title 30, Chapter 4 and 9 A.A.C. 7;
 - b. Written documentation of compliance with subsection (2)(a) is maintained;
 - c. Diagnostic imaging services are provided to a patient according to an order that includes:
 - i. The patient's name,

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- ii. The name of the ordering individual,
- iii. The diagnostic imaging procedure ordered, and
- iv. The reason for the diagnostic imaging procedure;
- d. A medical staff member or radiologist interprets the diagnostic image; and
- e. A diagnostic imaging patient report is completed that includes:
 - i. The patient's name,
 - ii. The date of the procedure, and
 - iii. A physician's or radiologist's interpretation of the diagnostic image.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1017 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1017 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by final rulemaking at 14 A.A.R. 294, effective March 8, 2008 (Supp. 08-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1018. Dialysis Services

A. In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:

1. "Caregiver" means an individual designated by a patient or a patient's representative to perform self-dialysis in the patient's stead.
2. "Chief clinical officer" means a physician appointed to provide direction for dialysis services provided by an outpatient treatment center.
3. "Long-term care plan" means a written plan of action for a patient with kidney failure that is developed to achieve long-term optimum patient outcome.
4. "Modality" means a method of treatment for kidney failure, including transplant, hemodialysis, and peritoneal dialysis.
5. "Nutritional assessment" means an analysis of a patient's weight, height, lifestyle, medication, mobility, food and fluid intake, and diagnostic procedures to identify conditions and behaviors that indicate whether the patient's nutritional needs are being met.
6. "Patient care plan" means a written document for a patient receiving dialysis that identifies the patient's needs for medical services, nursing services, and health-related services and the process by which the medical services, nursing services, or health-related services will be provided to the patient.

7. "Peritoneal dialysis" means the process of using the peritoneal cavity for removing waste products by fluid exchange.
 8. "Psychosocial evaluation" means an analysis of an individual's mental and social conditions to determine the individual's need for social work services.
 9. "Reprocessing" means cleaning and sterilizing a dialyzer previously used by a patient so that the dialyzer can be reused by the same patient.
 10. "Self-dialysis" means dialysis performed by a patient or a caregiver on the patient's body.
 11. "Social worker" means an individual licensed according to A.R.S. Title 32, Chapter 33 to engage in the "practice of social work" as defined in A.R.S. § 32-3251.
 12. "Stable means" that a patient's blood pressure, temperature, pulse, respirations, and diagnostic procedure results are within medically recognized acceptable ranges or consistent with the patient's usual medical condition so that medical intervention is not indicated.
 13. "Transplant surgeon" means a physician who:
 - a. Is board eligible or board certified in general surgery or urology by a professional credentialing board, and
 - b. Has at least 12 months of training or experience performing renal transplants and providing care for patients with renal transplants.
- B. A governing authority of an outpatient treatment center that is authorized to provide dialysis services shall:
1. Ensure that the administrator appointed as required in R9-10-1003(B)(3) has at least 12 months of experience in an outpatient treatment center providing dialysis services; and
 2. Appoint a chief clinical officer to direct the dialysis services provided by or at the outpatient treatment center who is a physician who:
 - a. Is board eligible or board certified in internal medicine or pediatrics by a professional credentialing board, and
 - b. Has at least 12 months of experience or training in providing dialysis services.
- C. An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:
1. In addition to the policies and procedures required in R9-10-1003(D), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Long-term care plans and patient care plans,
 - b. Assigning a patient an identification number,
 - c. Personnel members' response to a patient's adverse reaction during dialysis, and
 - d. Personnel members' response to an equipment malfunction during dialysis;
 2. A personnel member complies with the requirements in A.R.S. § 36-423 and R9-10-114 for hemodialysis technicians and hemodialysis technician trainees, if applicable;
 3. A personnel member completes basic cardiopulmonary resuscitation training specific to the age of the patients receiving dialysis from the outpatient treatment center:
 - a. Before providing dialysis services, and
 - b. At least once every 12 months after the initial date of employment or volunteer service;
 4. A personnel member wears a name badge that displays the individual's first name, job title, and professional license or certification; and

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5. At least one registered nurse or medical practitioner is on the premises while a patient receiving dialysis services is on the premises.
- D. An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that:
 1. The premises of the outpatient treatment center where dialysis services are provided complies with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01, that were in effect on the date listed on the building permit or zoning clearance submitted, as required by R9-10-104, as part of the application including the notarized attestation of architectural plans and specifications submitted before initial approval of the inclusion of dialysis services in the outpatient treatment center's scope of services;
 2. Before a modification of the premises of an outpatient treatment center where dialysis services are provided is made, an application including the notarized attestation of architectural plans and specifications of the outpatient treatment center required in R9-10-104(A):
 - a. Is submitted to the Department; and
 - b. Demonstrates compliance with the applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01, in effect on the date:
 - i. Listed on the building permit or zoning clearance submitted as part of the application including the notarized attestation of architectural plans and specifications for the modification, or
 - ii. The application including the notarized attestation of architectural plans and specifications of the modification of the outpatient treatment center required in R9-10-104(A) is submitted to the Department; and
 3. A modification of the outpatient treatment center complies with applicable physical plant health and safety codes and standards for outpatient treatment centers providing dialysis services, incorporated by reference in R9-10-104.01 in effect on the date:
 - a. Listed on the building permit or zoning clearance submitted as part of the application including the notarized attestation of architectural plans and specifications for the modification, or
 - b. The application including the notarized attestation of architectural plans and specifications required in R9-10-104(A) is submitted to the Department.
- E. An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that for a patient receiving dialysis services:
 1. The dialysis services provided to the patient meet the needs of the patient;
 2. A physician:
 - a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
 - b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;
 3. If the patient's medical history and physical examination required in subsection (E)(2) is not performed by the patient's nephrologist, the patient's nephrologist, within 30 calendar days after the date of the medical history and physical examination:
 - a. Reviews and authenticates the patient's medical history and physical examination, documents concurrence with the medical history and physical examination, and includes information specific to nephrology; or
 - b. Performs a medical history and physical examination that includes information specific to nephrology;
 4. The patient's nephrologist or the nephrologist's designee:
 - a. Performs a medical history and physical examination on the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center, and
 - b. Documents monthly notes related to the patient's progress in the patient's medical record;
 5. A registered nurse responsible for the nursing services provided to the patient receiving dialysis services:
 - a. Reviews with the patient the results of any diagnostic tests performed on the patient;
 - b. Assesses the patient's medical condition before the patient begins receiving hemodialysis and after the patient has received hemodialysis;
 - c. If the patient returns to another health care institution after receiving dialysis services at the outpatient treatment center, provides an oral or written notice of information related to the patient's medical condition to the registered nurse responsible for the nursing services provided to the patient at the health care institution or, if there is not a registered nurse responsible, the individual responsible for the medical services, nursing services, or health-related services provided to the patient at the health care institution;
 - d. Informs the patient's nephrologist of any changes in the patient's medical condition or needs; and
 - e. Documents in the patient's medical record:
 - i. Any notice provided as required in subsection (E)(5)(c), and
 - ii. Monthly notes related to the patient's progress;
 6. If the patient is not stable, before dialysis is provided to the patient, a nephrologist is notified of the patient's medical condition and dialysis is not provided until the nephrologist provides direction;
 7. The patient:
 - a. Is under the care of a nephrologist;
 - b. Is assigned a patient identification number according to the policy and procedure in subsection (C)(1)(b);
 - c. Is identified by a personnel member before beginning dialysis;
 - d. Receives the dialysis services ordered for the patient by a medical practitioner;
 - e. Is monitored by a personnel member while receiving dialysis at least once every 30 minutes; and
 - f. If the outpatient treatment center reprocesses and reuses dialyzers, is informed that the outpatient treatment center reprocesses and reuses dialyzers before beginning hemodialysis;
 8. Equipment used for hemodialysis is inspected and tested according to the manufacturer's recommendations or the outpatient treatment center's policies and procedures before being used to provide hemodialysis to a patient;

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9. The equipment inspection and testing required in subsection (E)(8) is documented in the patient's medical record;
 10. Supplies and equipment used for dialysis services for the patient are used, stored, and discarded according to manufacturer's recommendations;
 11. If hemodialysis is provided to the patient, a personnel member:
 - a. Inspects the dialyzer before use to ensure that the:
 - i. External surface of the dialyzer is clean;
 - ii. Dialyzer label is intact and legible;
 - iii. Dialyzer, blood port, and dialysate port are free from leaks and cracks or other structural damage; and
 - iv. Dialyzer is free of visible blood and other foreign material;
 - b. Verifies the order for the dialyzer to ensure the correct dialyzer is used for the correct patient;
 - c. Verifies the duration of dialyzer storage based on the type of germicide used or method of sterilization or disinfection used;
 - d. If the dialyzer has been reprocessed and is being reused, verifies that the label on the dialyzer includes:
 - i. The patient's name and the patient's identification number,
 - ii. The number of times the dialyzer has been used in patient treatments,
 - iii. The date of the last use of the dialyzer by the patient, and
 - iv. The date of the last reprocessing of the dialyzer;
 - e. If the patient's name is similar to the name of another patient receiving dialysis in the same outpatient treatment center, informs other personnel members, employees, and volunteers, of the similar names to ensure that the name or other identifying information on the label corresponds to the correct patient; and
 - f. Ensures that a patient's vascular access is visible to a personnel member during dialysis;
 12. A patient receiving dialysis is visible to a nurse at a location used by nurses to coordinate patients and treatment;
 13. If the patient has an adverse reaction during dialysis, a personnel member responds by implementing the policy and procedure required in subsection (C)(1)(c);
 14. If the equipment used during the patient's dialysis malfunctions, a personnel member responds by implementing the policy and procedure required in subsection (C)(1)(d); and
 15. After a patient's discharge from an outpatient treatment center, the nephrologist responsible for the dialysis services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
 - a. A description of the patient's medical condition and the dialysis services provided to the patient, and
 - b. The signature of the nephrologist.
- F.** If an outpatient treatment center provides support for self-dialysis services, an administrator shall ensure that:
1. A patient or the patient's caregiver is:
 - a. Instructed to use the equipment to perform self-dialysis by a personnel member trained to provide the instruction, and
 - b. Monitored in the patient's home to assess the patient's or patient caregiver's ability to use the equipment to perform self-dialysis;
 2. Instruction provided to a patient as required in subsection (F)(1)(a) and monitoring in the patient's home as required in subsection (F)(1)(b) is documented in the patient's medical record;
 3. All supplies for self-dialysis necessary to meet the needs of the patient are provided to the patient;
 4. All equipment necessary to meet the needs of the patient's self-dialysis is provided for the patient and maintained by the outpatient treatment center according to the manufacturer's recommendations;
 5. The water used for hemodialysis is tested and treated according to the requirements in subsection (N);
 6. Documentation of the self-dialysis maintained by the patient or the patient's caregiver is:
 - a. Reviewed to ensure that the patient is receiving continuity of care, and
 - b. Placed in the patient's medical record; and
 7. If a patient uses self-dialysis and self-administers medication:
 - a. The medical practitioner responsible for the dialysis services provided to the patient reviews the patient's diagnostic laboratory tests;
 - b. The patient and the patient's caregiver are informed of any potential:
 - i. Side effects of the medication; and
 - ii. Hazard to a child having access to the medication and, if applicable, a syringe used to inject the medication; and
 - c. The patient or the patient's caregiver is:
 - i. Taught the route and technique of administration and is able to administer the medication, including injecting the medication;
 - ii. Taught and able to perform sterile techniques if the patient or the patient's caregiver will be injecting the medication;
 - iii. Provided with instructions for the administration of the medication, including the specific route and technique the patient or the patient's caregiver has been taught to use;
 - iv. Able to read and understand the directions for using the medication;
 - v. Taught and able to self-monitor the patient's blood pressure; and
 - vi. Informed how to store the medication according to the manufacturer's instructions.
- G.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a social worker is employed by the outpatient treatment center to meet the needs of a patient receiving dialysis services including:
1. Conducting an initial psychosocial evaluation of the patient within 30 calendar days after the patient's admission to the outpatient treatment center;
 2. Participating in reviewing the patient's need for social work services;
 3. Recommending changes in treatment based on the patient's psychosocial evaluation;
 4. Assisting the patient and the patient's representative in obtaining and understanding information for making decisions about the medical services provided to the patient;

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5. Identifying community agencies and resources and assisting the patient and the patient's representative to utilize the community agencies and resources;
 6. Documenting monthly notes related to the patient's progress in the patient's medical record; and
 7. Conducting a follow-up psychosocial evaluation of the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center.
- H.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a registered dietitian is employed by the outpatient treatment center to assist a patient receiving dialysis services to meet the patient's nutritional and dietetic needs including:
1. Conducting an initial nutritional assessment of the patient within 30 calendar days after the patient's admission to the outpatient treatment center;
 2. Consulting with the patient's nephrologist and recommending a diet to meet the patient's nutritional needs;
 3. Providing advice to the patient and the patient's representative regarding a diet prescribed by the patient's nephrologist;
 4. Monitoring the patient's adherence and response to a prescribed diet;
 5. Reviewing with the patient any diagnostic test performed on the patient that is related to the patient's nutritional or dietetic needs;
 6. Documenting monthly notes related to the patient's progress in the patient's medical record; and
 7. Conducting a follow-up nutritional assessment of the patient at least once every 12 months after the date of the patient's admission to the outpatient treatment center.
- I.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a long-term care plan for each patient:
1. Is developed by a team that includes at least:
 - a. The chief clinical officer of the outpatient treatment center;
 - b. If the chief clinical officer is not a nephrologist, the patient's nephrologist;
 - c. A transplant surgeon or the transplant surgeon's designee;
 - d. A registered nurse responsible for nursing services provided to the patient;
 - e. A social worker;
 - f. A registered dietitian; and
 - g. The patient or patient's representative, if the patient or patient's representative chooses to participate in the development of the long-term care plan;
 2. Identifies the modality of treatment and dialysis services to be provided to the patient;
 3. Is reviewed and approved by the chief clinical officer;
 4. Is signed and dated by each personnel member participating in the development of the long-term care plan;
 5. Includes documentation signed by the patient or the patient's representative that the patient or the patient's representative was provided an opportunity to participate in the development of the long-term care plan;
 6. Is signed and dated by the patient or the patient's representative; and
 7. Is reviewed at least once every 12 months by the team in subsection (I)(1) and updated according to the patient's needs.
- J.** An administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a patient care plan for each patient:
1. Is developed by a team that includes at least:
 - a. The patient's nephrologist;
 - b. A registered nurse responsible for nursing services provided to the patient;
 - c. A social worker;
 - d. A registered dietitian; and
 - e. The patient or the patient's representative, if the patient or patient's representative chooses to participate in the development of the patient care plan;
 2. Includes an assessment of the patient's need for dialysis services;
 3. Identifies treatment and treatment goals;
 4. Is signed and dated by each personnel member participating in the development of the patient care plan;
 5. Includes documentation signed by the patient or the patient's representative that the patient or the patient's representative was provided an opportunity to participate in the development of the patient care plan;
 6. Is signed and dated by the patient or the patient's representative;
 7. Is implemented;
 8. Is evaluated by:
 - a. The registered nurse responsible for the dialysis services provided to the patient,
 - b. The registered dietitian providing services to the patient related to the patient's nutritional or dietetic needs, and
 - c. The social worker providing services to the patient related to the patient's psychosocial needs;
 9. Includes documentation of interventions, resolutions, and outcomes related to treatment goals; and
 10. Is reviewed and updated according to the needs of the patient:
 - a. At least once every six months for a patient whose medical condition is stable, and
 - b. At least once every 30 calendar days for a patient whose medical condition is not stable.
- K.** In addition to the requirements in R9-10-1009(C), an administrator of an outpatient treatment center that is authorized to provide dialysis services shall ensure that a medical record for each patient contains:
1. An annual medical history;
 2. An annual physical examination;
 3. Monthly notes related to the patient's progress by a medical practitioner, registered dietitian, social worker, and registered nurse;
 4. If applicable, documentation of:
 - a. The equipment inspection and testing required in subsection (E)(9), and
 - b. The self-dialysis required in subsection (F)(2); and
 5. If applicable, documentation of the patient's discharge.
- L.** For a patient who received dialysis services, an administrator shall ensure that after the patient's discharge from an outpatient treatment center that is authorized to provide dialysis services, the nephrologist responsible for the dialysis services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
1. A description of the patient's medical condition and the dialysis services provided to the patient, and
 2. The signature of the nephrologist.

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- M.** If an outpatient treatment center reuses dialyzers or other dialysis supplies, an administrator shall ensure that the outpatient treatment center complies with the guidelines adopted by the Association for the Advancement of Medical Instrumentation in Reprocessing of Hemodialyzers, ANSI/AAMI RD47:2008/(R)2013, incorporated by reference, available through <http://my.aami.org/store/>, on file with the Department, and including no future editions or amendments.
- N.** A chief clinical officer shall ensure that the quality of water used in dialysis conforms to the guidelines adopted by the Association for the Advancement of Medical Instrumentation in Dialysis Water and Dialysate Recommendations: A User Guide, incorporated by reference, available through <http://my.aami.org/store/>, on file with the Department, and including no future editions or amendments.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1018 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1018 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1019. Emergency Room Services

An administrator of an outpatient treatment center that is authorized to provide emergency room services shall ensure that:

1. Emergency room services are:
 - a. Available on the premises:
 - i. At all times, and
 - ii. To stabilize an individual's emergency medical condition; and
 - b. Provided:
 - i. In a designated area, and
 - ii. Under the direction of a physician;
2. Clinical laboratory services are available on the premises;
3. Diagnostic imaging services are available on the premises;
4. An area designated for emergency room services complies with the physical plant codes and standards for a freestanding emergency care facility in R9-10-104.01;
5. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that specify requirements for the use of a room used for seclusion that meets the requirements in R9-10-217(D);
6. A physician is present in an area designated for emergency room services;

7. A registered nurse is present in an area designated for emergency room services and provides direction for nursing services in the designated area;
8. The outpatient treatment center has a documented transfer agreement with a general hospital;
9. Emergency room services are provided to an individual, including a woman in active labor, requesting medical services in an emergency;
10. If emergency room services cannot be provided at the outpatient treatment center, measures and procedures are implemented to minimize the risk to the patient until the patient is transferred to the general hospital with which the outpatient treatment center has a transfer agreement as required in subsection (8);
11. There is a chronological log of emergency room services provided to a patient that includes:
 - a. The patient's name;
 - b. The date, time, and mode of arrival; and
 - c. The disposition of the patient, including discharge or transfer; and
12. The chronological log required in subsection (11) is maintained:
 - a. In the designated area for emergency room services for at least 12 months after the date the emergency room services were provided; and
 - b. By the outpatient treatment center for a total of at least 24 months after the date the emergency room services were provided.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1019 adopted as an emergency now adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1019 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-1020. Opioid Treatment Services

- A.** A governing authority of an outpatient treatment center that is authorized to provide opioid treatment services shall:
 1. Ensure that the outpatient treatment center obtains certification by the Substance Abuse and Mental Health Services Administration before providing opioid treatment,
 2. Maintain a current Substance Abuse and Mental Health Services Administration certificate for the outpatient treatment center on the premises, and
 3. Ensure that the administrator appointed as required in R9-10-1003(B)(3) is named on the Substance Abuse and Mental Health Services Administration certificate as the

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individual responsible for the opioid treatment services provided by or at the outpatient treatment center.

B. An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that:

1. In addition to the policies and procedures required in R9-10-1003(D), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Include the criteria for receiving opioid treatment services and address:
 - i. Comprehensive maintenance treatment consisting of dispensing or administering an opioid agonist treatment medication at stable dosage levels to a patient for a period in excess of 21 calendar days and providing medical and health-related services to the patient, and
 - ii. Detoxification treatment that occurs over a continuous period of more than 30 calendar days;
 - b. Include the criteria and procedures for discontinuing opioid treatment services;
 - c. Address the needs of specific groups of patients, such as patients who:
 - i. Are pregnant;
 - ii. Are children;
 - iii. Have chronic or acute medical conditions such as HIV infection, hepatitis, diabetes, tuberculosis, or cardiovascular disease;
 - iv. Have a mental disorder;
 - v. Abuse alcohol or other drugs; or
 - vi. Are incarcerated or detained;
 - d. Contain a method of patient identification to ensure the patient receives the opioid treatment services ordered;
 - e. Contain methods to assess whether a patient is receiving concurrent opioid treatment services from more than one health care institution;
 - f. Contain methods to ensure that the opioid treatment services provided to a patient by or at the outpatient treatment center meet the patient's needs;
 - g. Include relapse prevention procedures;
 - h. Include for laboratory testing:
 - i. Criteria for the assessment of a patient's opioid agonist blood levels,
 - ii. Procedures for specimen collection and processing to reduce the risk of fraudulent results, and
 - iii. Procedures for conducting random drug testing of patients receiving an opioid agonist treatment medication;
 - i. Include procedures for the response of personnel members to a patient's adverse reaction during opioid treatment; and
 - j. Include criteria for dispensing one or more doses of an opioid agonist treatment medication to a patient for use off the premises and address:
 - i. Who may authorize dispensing,
 - ii. Restrictions on dispensing, and
 - iii. Information to be provided to a patient or the patient's representative before dispensing;
2. A physician provides direction for the opioid treatment services provided at the outpatient treatment center;

3. If a patient requires administration of an opioid agonist treatment medication as a result of chronic pain, the patient:

- a. Receives consultation with or a referral for consultation with a physician or registered nurse practitioner who specializes in chronic pain management, and
- b. Is not admitted for opioid treatment services:
 - i. Unless the patient is physically addicted to an opioid drug, as manifested by the symptoms of withdrawal in the absence of the opioid drug; and
 - ii. A medical practitioner at the outpatient treatment center coordinates with the physician or registered nurse practitioner who is providing chronic pain management to the patient; and

4. In addition to the requirements in R9-10-1009(C), a medical record for each patient contains:

- a. If applicable, documentation of the dispensing of doses of an opioid agonist treatment medication to the patient for use off the premises; and
- b. If applicable, documentation of the patient's discharge from receiving opioid treatment services.

C. An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that for a patient receiving opioid treatment services:

1. The opioid treatment services provided to the patient meet the needs of the patient;
2. A physician or a medical practitioner under the direction of a physician:
 - a. Performs a medical history and physical examination on the patient within 30 calendar days before admission or within 48 hours after admission, and
 - b. Documents the medical history and physical examination in the patient's medical record within 48 hours after admission;
3. Before receiving opioid treatment, the patient is informed of the following:
 - a. The progression of opioid addiction and the patient's apparent stage of opioid addiction;
 - b. The goal and benefits of opioid treatment;
 - c. The signs and symptoms of overdose and when to seek emergency assistance;
 - d. The characteristics of opioid agonist treatment medication, including common side-effects and potential interaction effects with other drugs;
 - e. The requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;
 - f. Confidentiality requirements;
 - g. Drug screening and urinalysis procedures;
 - h. Requirements for dispensing to a patient one or more doses of an opioid agonist treatment medication for use by the patient off the premises;
 - i. Testing and treatment available for HIV and other communicable diseases; and
 - j. The patient complaint process;
4. Documentation of the provision of the information specified in subsection (C)(3) is included in the patient's medical record;
5. The patient receives a dose of an opioid agonist treatment medication only on the order of a medical practitioner;
6. The patient begins detoxification treatment only at the request of the patient or according to the outpatient treat-

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ment center's policy and procedure for discontinuing opioid treatment services required in subsection (B)(1)(b);

7. If the patient has an adverse reaction during opioid treatment, a personnel member and, if appropriate, a medical practitioner responds by implementing the policy and procedure required in subsection (B)(1)(i);
 8. Before the patient's discharge from opioid treatment services, the patient is provided with patient follow-up instructions that:
 - a. Include information that may reduce the risk of relapse; and
 - b. May include a referral for counseling, support groups, or medication for depression or sleep disorders; and
 9. After the patient's discharge from opioid treatment services provided by or at the outpatient treatment center, the medical practitioner responsible for the opioid treatment services provided to the patient documents the patient's discharge in the patient's medical record within 30 calendar days after the patient's discharge and includes:
 - a. A description of the patient's medical condition and the opioid treatment services provided to the patient, and
 - b. The signature of the medical practitioner.
- D.** An administrator of an outpatient treatment center that is authorized to provide opioid treatment services shall ensure that an assessment for each patient receiving opioid treatment services:
1. Includes, in addition to the information in R9-10-1010(B):
 - a. An assessment of the patient's need for opioid treatment services,
 - b. An assessment of the patient's medical conditions that may be affected by opioid treatment,
 - c. An assessment of other medications being taken by the patient and conditions that may be affected by opioid treatment, and
 - d. A plan to prevent relapse;
 2. Identifies the treatment to be provided to the patient and treatment goals; and
 3. Specifies whether the patient may receive an opioid agonist treatment medication for use off the premises and, if so, the number of doses that may be dispensed.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1020 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1020 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1021. Pain Management Services

A medical director of an outpatient treatment center that is authorized to provide pain management services shall ensure that:

1. Pain management services are provided under the direction of:
 - a. A physician; or
 - b. A nurse practitioner licensed according to A.R.S. Title 32, Chapter 15 with advanced pain management certification from a nationally recognized accreditation or certification entity;
2. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise;
3. If a controlled substance is used to provide pain management services:
 - a. A medical practitioner discusses the risks and benefits of using a controlled substance with a patient;
 - b. If the controlled substance is an opioid, the outpatient treatment center complies with the requirements in R9-10-2006; and
 - c. The following information is included in a patient's medical record:
 - i. The patient's history of substance use disorder,
 - ii. Documentation of the discussion in subsection (3)(a),
 - iii. The nature and intensity of the patient's pain, and
 - iv. The objectives used to determine whether the patient is being successfully treated; and
4. If an injection or a nerve block is used to provide pain management services:
 - a. Before the injection or nerve block is initially used on a patient, an evaluation of the patient is performed by a physician or nurse anesthetist;
 - b. An injection or nerve block is administered by a physician or nurse anesthetist; and
 - c. The following information is included in a patient's medical record:
 - i. The evaluation of the patient required in subsection (4)(a),
 - ii. A record of the administration of the injection or nerve block, and
 - iii. Any resuscitation measures taken; and
5. An outpatient treatment center that meets the definition of a pain management clinic in A.R.S. § 36-448.01 and complies with 9 Article 20 of this Chapter.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1021 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1021 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final

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rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

R9-10-1022. Physical Health Services

An administrator of an outpatient treatment center that is authorized to provide physical health services shall ensure that:

1. Medical services provided at or by the outpatient treatment center are provided under A.R.S. § 36-401(A)(33),
2. Nursing services provided at or by the outpatient treatment center are provided under the direction of a registered nurse, and
3. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1022 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1022 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1023. Pre-petition Screening

An administrator of an outpatient treatment center that is authorized to provide pre-petition screening shall comply with the requirements for pre-petition screening in A.R.S. Title 36, Chapter 5, Article 4.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1023 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1023 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1024. Rehabilitation Services

An administrator shall ensure that if an outpatient treatment center is authorized to provide:

1. Occupational therapy services, an occupational therapist provides direction for the occupational therapy services provided at or by the outpatient treatment center;

2. Physical therapy services, a physical therapist provides direction for the physical therapy services provided at or by the outpatient treatment center; or
3. Speech-language pathology services, a speech-language pathologist provides direction for the speech-language pathology services provided at or by the outpatient treatment center.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). New Section R9-10-1024 adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1024 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1025. Respite Services

- A. In addition to the definitions in A.R.S. § 36-401, R9-10-101, and R9-10-1001, the following definitions apply in this Section:
 1. "Emergency safety response" has the same meaning as in R9-10-701.
 2. "Outing" means travel by a child, who is receiving respite services provided by an outpatient treatment center, to a location away from the outpatient treatment center premises or, if applicable, the child's residence for a specific activity.
 3. "Parent" means a child's:
 - a. Mother or father, or
 - b. Legal guardian.
- B. An administrator of an outpatient treatment center that is authorized to provide respite services shall ensure that:
 1. Respite services are not provided in a personnel member's residence unless the personnel member's residence is licensed as a behavioral health respite home;
 2. Except for an outpatient treatment center that is authorized to provide respite services for children on the premises, respite services are provided:
 - a. In a patient's residence; or
 - b. Up to 10 continuous hours in a 24-hour time period while the individual who is receiving the respite services is:
 - i. Supervised by a personnel member;
 - ii. Awake;
 - iii. Except as stated in subsection (B)(3), provided food;
 - iv. Allowed to rest;
 - v. Provided an opportunity to use the toilet and meet the individual's hygiene needs; and
 - vi. Participating in activities in the community but is not in a licensed health care institution or child care facility; and
 3. If a child is provided respite services according to subsection (B)(2)(b), the child is provided the appropriate meals or snacks in subsection (J)(1) for the amount of time the

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child is receiving respite services from the outpatient treatment center.

- C. If an outpatient treatment center that is authorized to provide respite services for children includes outings in the outpatient treatment center's scope of services, an administrator shall ensure that:
1. Before a personnel member takes a child receiving respite services on an outing, written permission is obtained from the child's parent that includes:
 - a. The child's name;
 - b. A description of the outing;
 - c. The name of the outing destination, if applicable;
 - d. The street address and, if available, the telephone number of the outing destination;
 - e. Either:
 - i. The date or dates of the outing; or
 - ii. The time period, not to exceed 12 months, during which the permission is given;
 - f. The projected time of departure from the outpatient treatment center or, if applicable, the child's residence;
 - g. The projected time of arrival back at the outpatient treatment center or, if applicable, the child's residence; and
 - h. The dated signature of the child's parent;
 2. Each motor vehicle used on an outing by a personnel member for a child receiving respite services from the outpatient treatment center:
 - a. Is maintained in a mechanically safe condition;
 - b. Is free from hazards;
 - c. Has an operational heating system;
 - d. Has an operational air-conditioning system; and
 - e. Is equipped with:
 - i. A first-aid kit that meets the requirements in subsection (S)(1), and
 - ii. Two large, clean towels or blankets;
 3. On an outing, a child does not ride in a truck bed, camper, or trailer attached to a motor vehicle;
 4. The Department is notified within 24 hours after a motor vehicle accident that involves a child who is receiving respite services while riding in the motor vehicle on an outing; and
 5. A personnel member who drives a motor vehicle with children receiving respite services from the outpatient treatment center in the motor vehicle:
 - a. Requires that each door be locked before the motor vehicle is set in motion and keeps the doors locked while the motor vehicle is in motion;
 - b. Does not permit a child to be seated in front of a motor vehicle's air bag;
 - c. Requires that a child remain seated and entirely inside the motor vehicle while the motor vehicle is in motion;
 - d. Requires that a child is secured, as required in A.R.S. § 28-907 or A.R.S. § 28-909, before the motor vehicle is set in motion and while the motor vehicle is in motion;
 - e. Assists a child into or out of the motor vehicle away from moving traffic at curbside or in a driveway, parking lot, or other location designated for this purpose;
 - f. Carries drinking water in an amount sufficient to meet the needs of each child on the outing and a sufficient number of cups or other drinking receptacles so that each child can drink from a different cup or receptacle; and
 - g. Accounts for each child while on the outing.
- D. An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. Respite services are only provided on the premises for up to 10 continuous hours per day between the hours of 6:00 a.m. and 10:00 p.m.;
 2. The specific 10 continuous hours per day during which the outpatient treatment center provides respite services on the premises is stated in the outpatient treatment center's hours of operation that is submitted as part of the outpatient treatment center's license application and according to R9-10-1002(D);
 3. A personnel member, who is expected to provide respite services eight or more hours a week, complies with the requirements for tuberculosis screening in R9-10-113;
 4. At least one personnel member who has current training in first aid and cardiopulmonary resuscitation is available on the premises when a child is receiving respite services on the premises;
 5. At least one personnel member who has completed training in crisis intervention according to R9-10-716(F) is available on the premises when a child is receiving respite services on the premises;
 6. A personnel member does not use or possess any of the following items when a child receiving respite services is on the premises:
 - a. A controlled substance as listed in A.R.S. Title 36, Chapter 27, Article 2, except where used as a prescription medication in the manner prescribed;
 - b. A dangerous drug as defined in A.R.S. § 13-3401, except where used as a prescription medication in the manner prescribed;
 - c. A prescription medication as defined in A.R.S. § 32-1901, except where used in the manner prescribed; or
 - d. A firearm as defined in A.R.S. § 13-105;
 7. An unannounced fire and emergency evacuation drill is conducted at least once a month, and at different times of the day, and each personnel member providing respite services for children on the premises and each child receiving respite services on the premises participates in the fire and emergency evacuation drill;
 8. Each fire and emergency evacuation drill is documented, and the documentation is maintained for at least 12 months after the date of the fire and emergency evacuation drill;
 9. Before a child receives respite services on the premises of the outpatient treatment center, in addition to the requirements in R9-10-1009, the following information is obtained and maintained in the child's medical record:
 - a. The name, home address, city, state, zip code, and contact telephone number of each parent of the child;
 - b. The name and contact telephone number of at least two additional individuals authorized by the child's parent to collect the child from the outpatient treatment center;
 - c. The name and contact telephone number of the child's health care provider;

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- d. The written authorization for emergency medical care of the child when the parent cannot be contacted at the time of an emergency;
 - e. The name of the individual to be contacted in case of injury or sudden illness of the child;
 - f. If applicable, a description of any dietary restrictions or needs due to a medical condition or diagnosed food sensitivity or allergy;
 - g. A written record completed by the child's parent or health care provider noting the child's susceptibility to illness, physical conditions of which a personnel member should be aware, and any specific requirements for health maintenance; and
10. Documentation is obtained and maintained in the child's medical record each time the child receives respite services on the premises that includes:
- a. The date and time of each admission to and discharge from receiving respite services; and
 - b. A signature, which contains at least a first initial of a first name and the last name of the child's parent or other individual designated by the child's parent, each time the child is admitted or discharged from receiving respite services on the premises;
11. Policies and procedures are developed, documented, and implemented to ensure that the identity of an individual is known to a personnel member or is verified with picture identification before the personnel member discharges a child to the individual;
12. A child is not discharged to an individual other than the child's parent or other individual designated according to subsection (D)(9)(b), except:
- a. When the child's parent authorizes the administrator by telephone or electronic means to release the child to an individual not so designated, and
 - b. The administrator can verify the telephone or electronic authorization using a means of verification that has been agreed to by the administrator and the child's parent and documented in the child's medical record; and
13. The number of personnel members providing respite services for children on the premises is determined by the needs of the children present, with a minimum of at least:
- a. One personnel member providing supervision for every five children receiving respite services on the premises; and
 - b. Two personnel members on the premises when a child is receiving respite services on the premises.
- E.** If swimming activities are conducted at a swimming pool for a child receiving respite services on the premises of an outpatient treatment center, an administrator shall ensure that there is an individual at the swimming pool on the premises who has current lifeguard certification that includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation. If the individual is a personnel member, the personnel member cannot be counted in the personnel member-to-children ratio required by subsection (D)(13).
- F.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that in each area designated for providing respite services:
- 1. Drinking water is provided sufficient for the needs of and accessible to each child in both indoor and outdoor areas;
 - 2. Indoor areas used by children are decorated with age-appropriate articles such as bulletin boards, pictures, and posters;
 - 3. Storage space is provided for indoor and outdoor toys, materials, and equipment in areas accessible to children;
 - 4. Clean clothing is available to a child when the child needs a change of clothing;
 - 5. At least one indoor area in the outpatient treatment center where respite services are provided for children is equipped with at least one cot or mat, a sheet, and a blanket, where a child can rest quietly away from the other children;
 - 6. Except as provided in subsection (AA)(2)(a), outdoor or large muscle development activities are scheduled to allow not less than 75 square feet for each child occupying the outdoor area or indoor area substituted for outdoor area at any time;
 - 7. The premises, including the buildings, are maintained free from hazards;
 - 8. Toys and play equipment, required in this Section, are maintained:
 - a. Free from hazards, and
 - b. In a condition that allows the toy or play equipment to be used for the original purpose of the toy or play equipment;
 - 9. Temperatures are maintained between 70° F and 84° F in each room or indoor area used by children;
 - 10. Except when a child is napping or sleeping or for a child who has a sensory issue documented in the child's behavioral health assessment, each room or area used by a child is maintained at a minimum of 30 foot candles of illumination;
 - 11. When a child is napping or sleeping in a room, the room is maintained at a minimum of five foot candles of illumination;
 - 12. Each child's toothbrush, comb, washcloth, and cloth towel that are provided for the child's use by the child's parent are maintained in a clean condition and stored in an identified space separate from those of other children;
 - 13. Except as provided in subsection (F)(14), the following are stored separate from food storage areas and are inaccessible to a child:
 - a. All materials and chemicals labeled as a toxic or flammable substance;
 - b. All substances that have a child warning label and may be a hazard to a child; and
 - c. Lawn mowers, ladders, toilet brushes, plungers, and other equipment that may be a hazard to a child;
 - 14. Hand sanitizers:
 - a. When being stored, are stored separate from food storage areas and are inaccessible to children; and
 - b. When being provided for use, are accessible to children; and
 - 15. Except when used as part of an activity, the following are stored in an area inaccessible to a child:
 - a. Garden tools, such as a rake, trowel, and shovel; and
 - b. Cleaning equipment and supplies, such as a mop and mop bucket.
- G.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that a personnel member:
- 1. Supervises each child at all times;
 - 2. Does not smoke or use tobacco;

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- a. In any area where respite services may be provided for a child, or
 - b. When transporting or transferring a child;
 3. Except for a child who can change the child's own clothing, changes a child's clothing when wet or soiled;
 4. Empties clothing soiled with feces into a toilet without rinsing;
 5. Places a child's soiled clothing in a plastic bag labeled with the child's name, stores the clothing in a container used for this purpose, and sends the clothing home with the child's parent;
 6. Prepares and posts in each indoor area, before the first child arrives to receive respite services that day, a current schedule of age-appropriate activities that meet the needs of the children receiving respite services that day, including the times the following are provided:
 - a. Meals and snacks,
 - b. Naps,
 - c. Indoor activities,
 - d. Outdoor or large muscle development activities,
 - e. Quiet and active activities,
 - f. Personnel member-directed activities,
 - g. Self-directed activities, and
 - h. Activities that develop small muscles;
 7. Provides activities and opportunities, consistent with a child's behavioral health assessment, for each child to:
 - a. Gain a positive self-concept;
 - b. Develop and practice social skills;
 - c. Acquire communication skills;
 - d. Participate in large muscle physical activity;
 - e. Develop habits that meet health, safety, and nutritional needs;
 - f. Express creativity;
 - g. Learn to respect cultural diversity of children and staff;
 - h. Learn self-help skills; and
 - i. Develop a sense of responsibility and independence;
 8. Implements the schedule in subsection (G)(6);
 9. If an activity on the schedule in subsection (G)(6) is not implemented, writes on the schedule the activity that was not implemented and what activity was substituted;
 10. Ensures that each indoor area has a supply of age-appropriate toys, materials, and equipment, necessary to implement the schedule required in subsection (G)(6), in a quantity sufficient for the number of children receiving respite services at the outpatient treatment center that day, including:
 - a. Art and crafts supplies;
 - b. Books;
 - c. Balls;
 - d. Puzzles, blocks, and toys to enhance manipulative skills;
 - e. Creative play toys;
 - f. Musical instruments; and
 - g. Indoor and outdoor equipment to enhance large muscle development;
 11. Does the following when a parent permits or asks a personnel member to apply personal products, such as petroleum jelly, diaper rash ointments, sun screen or sun block preparations, toothpaste, and baby diapering preparations on the parent's child:
 - a. Obtains the child's personal products and written approval for use of the personal products from the child's parent;
 - b. Labels the personal products with the child's name; and
 - c. Keeps the personal products inaccessible to children; and
 12. Monitors a child for overheating or overexposure to the sun.
- H.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises and includes in the outpatient treatment center's scope of respite services for children wearing diapers shall ensure that there is a diaper changing space in the area designated for providing respite services for children that contains:
1. A nonabsorbent, sanitizable diaper changing surface that is:
 - a. Seamless and smooth, and
 - b. Kept clear of items not required for diaper changing;
 2. A hand-washing sink adjacent to the diaper changing surface, for a personnel member's use when changing diapers and for washing a child during or after diapering, that provides:
 - a. Running water,
 - b. Soap from a dispenser, and
 - c. Single-use paper hand towels from a dispenser;
 3. At least one waterproof, sanitizable container with a waterproof liner and a tight-fitting lid for soiled diapers; and
 4. At least one waterproof, sanitizable container with a waterproof liner and a tight-fitting lid for soiled clothing.
- I.** In a diaper changing space, an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. A diaper changing procedure is established, documented, and implemented that states that a child's diaper is changed as soon as it is soiled and that a personnel member when diapering:
 - a. Washes and dries the child, using a separate wash cloth and towel only once for each child;
 - b. If applicable, applies the child's individual personal products labeled with the child's name;
 - c. Uses single-use non-porous gloves;
 - d. Washes the personnel member's own hands with soap and running water according to the requirements in R9-10-1028(5);
 - e. Washes each child's hands with soap and running water after each diaper change; and
 - f. Cleans, sanitizes, and dries the diaper changing surface following each diaper change; and
 2. A personnel member:
 - a. Removes disposable diapers and disposable training pants from a diaper changing space as needed or at least twice every 24 hours to a waste receptacle outside the building; and
 - b. Does not:
 - i. Permit a bottle, formula, food, eating utensil, or food preparation in a diaper changing space;
 - ii. Draw water for human consumption from the hand-washing sink adjacent to a diaper changing surface, required in subsection (H)(2); or
 - iii. If responsible for food preparation, change diapers until food preparation duties have been completed for the day.
- J.** Except as provided in subsection (K)(3), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:

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1. Serve the following meals or snacks to a child receiving respite services on the premises:
 - a. For the following periods of time:
 - i. Two to four hours, one or more snacks;
 - ii. Four to eight hours, one or more snacks and one or more meals; and
 - iii. More than eight hours, two snacks and one or more meals;
 - b. Make breakfast available to a child receiving respite services on the premises before 8:00 a.m.;
 - c. Serve lunch to a child who is receiving respite services on the premises between 11:00 a.m. through 1:00 p.m.; and
 - d. Serve dinner to a child who is receiving respite services on the premises from 5:00 p.m. through 7:00 p.m. and who will remain on the premises after 7:00 p.m.;
 2. Ensure that a meal or snack provided by the outpatient treatment center meets the meal pattern requirements in Table 10.1; and
 3. If the outpatient treatment center provides a meal or snack to a child:
 - a. Make a second serving of a food component of a provided snack or meal available to a child who requests a second serving, and
 - b. Substitute a food that is equivalent to a specific food component if a requested second serving of a specific food component is not available.
- K.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:
1. May serve food provided for a child by the child's parent;
 2. If a child's parent does not provide a sufficient number of meals or snacks to meet the requirements in subsection (J)(1), shall supplement, according to the requirements in Table 10.1, the meals or snacks provided by the child's parent; and
 3. If applicable, shall serve food to a child at the times and in quantities consistent with the information documented according to subsection (D)(9)(f) for the child and the child's behavioral health assessment, to meet the child's dietary and nutritional needs.
- L.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises that has a respite capacity of more than 10 shall obtain a food establishment license or permit according to the requirements in 9 A.A.C. 8, Article 1, and, if applicable, maintain documentation of the current food establishment license or permit.
- M.** If an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises serves food to a child receiving respite services on the premises that is not prepared by the outpatient treatment center or provided by the child's parent, the administrator shall ensure that the food was prepared by a food establishment, as defined according to A.A.C. R9-8-101.
- N.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. Children, except infants and children who cannot wash their own hands, wash their hands with soap and running water before and after handling or eating food;
 2. A personnel member:
 - a. Washes the hands of an infant or a child who cannot wash the child's own hands before and after the infant or child handles or eats food, using:
 - i. A washcloth,
 - ii. A single-use paper towel, or
 - iii. Soap and running water; and
 - b. If using a washcloth, uses each washcloth on only one child and only one time before it is laundered or discarded;
 3. Non-single-use utensils and equipment used in preparing, eating, or drinking food are:
 - a. After each use:
 - i. Washed in an automatic dishwasher and air dried or heat dried; or
 - ii. Washed in hot soapy water, rinsed in clean water, sanitized, and air dried or heat dried; and
 - b. Stored in a clean area protected from contamination;
 4. Single-use utensils and equipment are disposed of after being used;
 5. Perishable foods are covered and stored in a refrigerator at a temperature of 41° F or less;
 6. A refrigerator at the outpatient treatment center maintains a temperature of 41° F or less, as shown by a thermometer kept in the refrigerator at all times;
 7. A freezer at the outpatient treatment center maintains a temperature of 0° F or less, as shown by a thermometer kept in the freezer at all times; and
 8. Foods are prepared as close as possible to serving time and, if prepared in advance, are either:
 - a. Cold held at a temperature of 45° F or less or hot held at a temperature of 130° F or more until served, or
 - b. Cold held at a temperature of 45° F or less and then reheated to a temperature of at least 165° F before being served.
- O.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises:
1. May allow a personnel member to separate a child who is receiving respite services on the premises from other children for unacceptable behavior for no longer than three minutes after the child has regained self-control, but not more than 10 minutes without the personnel member interacting with the child, consistent with the child's behavioral health assessment;
 2. Shall ensure that:
 - a. A personnel member, consistent with the child's behavioral health assessment:
 - i. Defines and maintains consistent and reasonable guidelines and limitations for a child's behavior;
 - ii. Teaches, models, and encourages orderly conduct, personal control, and age-appropriate behavior; and
 - iii. Explains to a child why a particular behavior is not allowed, suggests an alternative, and assists the child to become engaged in an alternative activity;
 - b. An emergency safety response is:
 - i. Only used:
 - (1) By a personnel member trained according to R9-10-716(F)(1) to use an emergency safety response,
 - (2) For the management of a child's violent or

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- self-destructive behavior, and
 - (3) When less restrictive interventions have been determined to be ineffective; and
 - ii. Discontinued at the earliest possible time, but no longer than five minutes after the emergency safety response is initiated;
 - c. If an emergency safety response was used for a child, a personnel member, when the child is discharged to the child's parent:
 - i. Notifies the child's parent of the use of the emergency safety response for the child and the behavior, event, or environmental factor that caused the need for the emergency safety response; and
 - ii. Documents in the child's medical record that the child's parent was notified of the use of the emergency safety response;
 - d. Within 24 hours after an emergency safety response is used for a child receiving respite services on the premises, the following information is entered into the child's medical record:
 - i. The date and time the emergency safety response was used;
 - ii. The name of each personnel member who used an emergency safety response;
 - iii. The specific emergency safety response used;
 - iv. The behavior, event, or environmental factor that caused the need for the emergency safety response; and
 - v. Any injury that resulted from the use of the emergency safety response;
 - e. Within 10 working days after an emergency safety response is used for a child receiving respite services on the premises, a behavioral health professional reviews the information in subsection (O)(2)(d) and documents the review in the child's medical record;
 - f. After the review required in subsection (O)(2)(e), the following information is entered into the child's medical record:
 - i. Actions taken or planned to prevent the need for a subsequent use of an emergency safety response for the child,
 - ii. A determination of whether the child is appropriately placed at the outpatient treatment center providing respite services for children on the premises, and
 - iii. Whether the child's treatment plan was reviewed or needs to be reviewed and amended to ensure that the child's treatment plan is meeting the child's treatment needs;
 - g. Emergency safety response training is documented according to the requirements in R9-10-716(F)(2); and
 - h. Materials used for emergency safety response training are maintained according to the requirements in R9-10-716(F)(3); and
3. A personnel member does not use or permit:
 - a. A method of discipline that could cause harm to the health, safety, or welfare of a child;
 - b. Corporal punishment;
 - c. Abusive language;
 - d. Discipline associated with:
 - i. Eating, napping, sleeping, or toileting;
 - ii. Medication; or
 - iii. Mechanical restraint; or
 - e. Discipline administered to any child by another child.
- P.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:
1. Provide each child who naps or sleeps on the premises with a separate cot or mat and ensure that:
 - a. A cot or mat used by the child accommodates the child's height and weight;
 - b. A personnel member covers each cot or mat with a clean sheet that is laundered when soiled, or at least once every seven days and before use by a different child;
 - c. A clean blanket or sheet is available for each child;
 - d. A rug, carpet, blanket, or towel is not used as a mat; and
 - e. Each cot or mat is maintained in a clean and repaired condition;
 2. Not use bunk beds or waterbed mattresses for a child receiving respite services;
 3. Provide an unobstructed passageway at least 18 inches wide between each row of cots or mats to allow a personnel member access to each child;
 4. Ensure that if a child naps or sleeps while receiving respite services at the outpatient treatment center, the administrator:
 - a. Does not permit the child to lie in direct contact with the floor while napping or sleeping;
 - b. Prohibits the operation of a television in a room where the child is napping or sleeping; and
 - c. Requires that a personnel member remain awake while supervising the napping or sleeping child; and
 5. Ensure that storage space is provided on the premises for cots, mats, sheets, and blankets, that is:
 - a. Accessible to an area used for napping or sleeping; and
 - b. Separate from food service and preparation areas, toilet rooms, and laundry rooms.
- Q.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall, in the area of the premises where the respite services are provided:
1. Maintain the premises and furnishings:
 - a. Free of insects and vermin,
 - b. In a clean condition, and
 - c. Free from odor; and
 2. Ensure that:
 - a. Floor coverings are:
 - i. Clean; and
 - ii. Free from:
 - (1) Dampness,
 - (2) Odors, and
 - (3) Hazards;
 - b. Toilet bowls, lavatory fixtures, and floors in toilet rooms and kitchens are cleaned and sanitized as often as necessary to maintain them in a clean and sanitized condition or at least once every 24 hours;
 - c. Each toilet room used by children receiving respite services on the premises contains, within easy reach of children:
 - i. Mounted toilet tissue;
 - ii. A sink with running water;
 - iii. Soap contained in a dispenser; and

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- iv. Disposable, single-use paper towels, in a mounted dispenser, or a mechanical hand dryer;
 - d. Personnel members wash their hands with soap and running water after toileting;
 - e. A child's hands are washed with soap and running water after toileting;
 - f. Except for a cup or receptacle used only for water, food waste is stored in a covered container and the container is clean and lined with a plastic bag;
 - g. Food waste and other refuse is removed from the area of the premises where respite services are provided for children at least once every 24 hours or more often as necessary to maintain a clean condition and avoid odors;
 - h. A personnel member or a child does not draw water for human consumption from a toilet room hand-washing sink;
 - i. Toys, materials, and equipment are maintained in a clean condition;
 - j. Plumbing fixtures are maintained in a clean and working condition; and
 - k. Chipped or cracked sinks and toilets are replaced or repaired.
- R.** If laundry belonging to an outpatient treatment center providing respite services for children on the premises is done on the premises, an administrator shall:
1. Not use a kitchen or food storage area for sorting, handling, washing, or drying laundry;
 2. Locate the laundry equipment in an area that is separate from areas used by children and inaccessible to children;
 3. Not permit a child to be in a laundry room or use a laundry area as a passageway for children; and
 4. Ensure that laundry soiled by vomitus, urine, feces, blood, or other body fluid is stored, cleaned, and sanitized separately from other laundry.
- S.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that there is a first aid kit in the designated area of the outpatient treatment center where respite services are provided that:
1. Contains first aid supplies in a quantity sufficient to meet the needs of the children receiving respite services, including the following:
 - a. Sterile bandages including:
 - i. Self-adhering bandages of assorted sizes,
 - ii. Sterile gauze pads, and
 - iii. Sterile gauze rolls;
 - b. Antiseptic solution or sealed antiseptic wipes;
 - c. A pair of scissors;
 - d. Self-adhering tape;
 - e. Single-use, non-porous gloves; and
 - f. Reclosable plastic bags of at least one-gallon size; and
 2. Is accessible to personnel members but inaccessible to children receiving respite services on the premises.
- T.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall:
1. Prepare and date a written fire and emergency plan that contains:
 - a. The location of the first aid kit;
 - b. The names of personnel members who have first aid training;
 - c. The names of personnel members who have cardio-pulmonary resuscitation training;
 - d. The directions for:
 - i. Initiating notification of a child's parent by telephone or other equally expeditious means within 60 minutes after a fire or emergency; and
 - ii. Providing written notification to the child's parent within 24 hours after a fire or emergency; and
 - e. The outpatient treatment center's street address and the emergency telephone numbers for the local fire department, police department, ambulance service, and poison control center;
2. Maintain the plan required in subsection (T)(1) in the area designated for providing respite services;
 3. Post the plan required in subsection (T)(1) in any indoor area where respite services are provided that does not have an operable telephone service or two-way voice communication system that connects the indoor area where respite services are provided with an individual who has direct access to an in-and-out operable telephone services; and
 4. Update the plan in subsection (T)(1) at least once every 12 months after the date of initial preparation of the plan or when any information changes.
- U.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall in the area designated for providing respite services:
1. Post, near a room's designated exit, a building evacuation plan that details the designated exits from the room and the facility where the outpatient treatment center is located; and
 2. Maintain and use a communication system that contains:
 - a. A direct-access, in-and-out, operating telephone service in the area where respite services are provided; or
 - b. A two-way voice communication system that connects the area where respite services are provided with an individual who has direct access to an in-and-out, operating telephone service.
- V.** If, while receiving respite services at an outpatient treatment center authorized to provide respite services for children on the premises, a child has an accident, injury, or emergency that, based on an evaluation by a personnel member, requires medical treatment by a health care provider, an administrator shall ensure that a personnel member:
1. Notifies the child's parent immediately after the accident, injury, or emergency;
 2. Documents:
 - a. A description of the accident, injury, or emergency, including the date, time, and location of the accident, injury, or emergency;
 - b. The method used to notify the child's parent; and
 - c. The time the child's parent was notified; and
 3. Maintains the documentation required in subsection (V)(2) for at least 12 months after the date the child last received respite services on the outpatient treatment center's premises.
- W.** If a parent of a child who received respite services at an outpatient treatment center authorized to provide respite services for children on the premises informs a personnel member that the child's parent obtained medical treatment for the child from a health care provider for an accident, injury, or emergency the

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child had while on the premises, an administrator shall ensure that a personnel member:

1. Documents any information about the child's accident, injury, or emergency received from the child's parent; and
 2. Maintains the documentation required in subsection (W)(1) for at least 12 months after the date the child last received respite services on the outpatient treatment center's premises.
- X.** If a child exhibits signs of illness or infestation at an outpatient treatment center authorized to provide respite services for children on the premises, an administrator shall ensure that a personnel member:
1. Immediately separates the child from other children,
 2. Immediately notifies the child's parent by telephone or other expeditious means to arrange for the child's discharge from the outpatient treatment center,
 3. Documents the notification required in subsection (X)(2), and
 4. Maintains documentation of the notification required in subsection (X)(3) for at least 12 months after the date of the notification.
- Y.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall comply with the following physical plant requirements:
1. Toilets and hand-washing sinks are available to children in the area designated for providing respite services or on the premises as follows:
 - a. At least one flush toilet and one hand-washing sink for 10 or fewer children;
 - b. At least two flush toilets and two hand-washing sinks for 11 to 25 children; and
 - c. At least one flush toilet and one hand-washing sink for each additional 20 children;
 2. A hand-washing sink provides running water with a drain connected to a sanitary sewer as defined in A.R.S. § 45-101;
 3. A glass mirror, window, or other glass surface that is located within 36 inches of the floor is made of safety glass that has been manufactured, fabricated, or treated to prevent the glass from shattering or flying when struck or broken, or is shielded by a barrier to prevent impact by or physical injury to a child; and
 4. There is at least 30 square feet of unobstructed indoor space for each child who may be receiving respite services on the premises, which excludes floor space occupied by:
 - a. The interior walls;
 - b. A kitchen, a bathroom, a closet, a hallway, a stair, an entryway, an office, an area designated for isolating a child from other children, a storage room, or a room or floor space designated for the sole use of personnel members;
 - c. Room space occupied by desks, file cabinets, storage cabinets, or hand-washing sinks for a personnel member's use; or
 - d. Indoor area that is substituted for required outdoor area.
- Z.** An administrator of an outpatient treatment center authorized to provide respite services for children on the premises shall ensure that, in addition to the policies and procedures required in this Article, policies and procedures are established, documented, and implemented for the children's use of a toilet and hand-washing sink that ensure the children's health and safety and include:
1. Supervision requirements for children using the toilet, based on a child's age, gender, and behavioral health issue; and
 2. If the outpatient treatment center does not have a toilet and hand-washing sink available for the exclusive use of children receiving respite services, a method to ensure that an individual, other than a child receiving respite services or a personnel member providing respite services, is not present in the toilet and hand-washing sink area when a child receiving respite services is present in the toilet and hand-washing sink area.
- AA.** To provide activities that develop large muscles and an opportunity to participate in structured large muscle physical activities, an administrator of an outpatient treatment center authorized to provide respite services for children on the premises shall:
1. Provide at least 75 square feet of outdoor area per child for at least 50% of the outpatient treatment center's respite capacity; or
 2. Comply with one of the following:
 - a. If no child receives respite services on the premises for more than four hours per day, provide at least 50 square feet of indoor area for each child, based on the outpatient treatment center's respite capacity;
 - b. If a child receives respite services on the premises for more than four hours but less than six hours per day, provide at least 75 square feet of indoor area per child for at least 50% of the outpatient treatment center's respite capacity, in addition to the indoor area required in subsection (Y)(4); or
 - c. Provide at least 37.5 square feet of outdoor area and 37.5 square feet of indoor area per child for at least 50% of the outpatient treatment center's respite capacity, in addition to the activity area required in subsection (Y)(4).
- BB.** If an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises is substituting indoor area for outdoor area, the administrator shall:
1. Designate, on the site plan and the floor plan submitted with the license application or a request for an intended change or modification, the indoor area that is being substituted for an outdoor area; and
 2. In the indoor area substituted for outdoor area, install and maintain a mat or pad designed to provide impact protection in the fall zone of indoor swings and climbing equipment.
- CC.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. An outdoor area used by children receiving respite services:
 - a. Is enclosed by a fence:
 - i. A minimum of 4.0 feet high,
 - ii. Secured to the ground, and
 - iii. With either vertical or horizontal open spaces on the fence or gate that do not exceed 4.0 inches;
 - b. Is maintained free from hazards, such as exposed concrete footings and broken toys; and
 - c. Has gates that are kept closed while a child is in the outdoor area;

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2. The following is provided and maintained within the fall zones of swings and climbing equipment in an outdoor area:
 - a. A shock-absorbing unitary surfacing material manufactured for such use in outdoor activity areas; or
 - b. A minimum depth of 6.0 inches of a nonhazardous, resilient material such as fine loose sand or wood chips;
 3. Hard surfacing material such as asphalt or concrete is not installed or used under swings or climbing equipment unless used as a base for shock-absorbing unitary surfacing material;
 4. A swing or climbing equipment is not located in the fall zone of another swing or climbing equipment; and
 5. A shaded area for each child occupying an outdoor area at any time of the day is provided.
- DD.** An administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall install and maintain a portable, pressurized fire extinguisher that meets, at a minimum, a 2A-10-BC rating of the Underwriters Laboratories in an outpatient treatment center's kitchen and any other location required for Existing Health Care Occupancies in National Fire Protection Association 101, Life Safety Code, incorporated by reference in R9-10-104.01.
- EE.** In addition to the requirements in R9-10-1029(F), an administrator of an outpatient treatment center that is authorized to provide respite services for children on the premises shall ensure that:
1. Combustible material, such as paper, boxes, or rags, is not permitted to accumulate inside or outside the premises;
 2. An unvented or open-flame space heater or portable heater is not used on the premises;
 3. A gas valve on an unused gas outlet is removed and capped where it emerges from the wall or floor;
 4. Heating and cooling equipment is inaccessible to a child;
 5. Fans are mounted and inaccessible to a child;
 6. Toilet rooms are ventilated to the outside of the building, either by a screened window open to the outside air or by an exhaust fan and duct system that is operated when the toilet room is in use;
 7. A toilet room with a door that opens to the exterior of a building is equipped with a self-closing device that keeps the door closed except when an individual is entering or exiting; and
 8. A toilet room door does not open into a kitchen or laundry.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1025 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1025 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Sequential numbering corrections made under subsection R9-10-1025(G) at the request of the Department of Health Services on June 27, 2016; file number M16-185 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

Table 10.1 Meal Pattern Requirements for Children

Meal Pattern Requirements for Children			
Food Components	Ages 1 through 2 years	Ages 3 through 5 years	Ages 6 and older
Breakfast:			
1. Milk, fluid	1/2 cup	3/4 cup	1 cup
2. Vegetable, fruit, or full-strength juice	1/4 cup	1/2 cup	1/2 cup
3. Bread and bread alternates (whole grain or enriched):			
Bread	1/2 slice	1/2 slice	1 slice
or cornbread, rolls, muffins, or biscuits	1/2 serving	1/2 serving	1 serving
or cold dry cereal (volume or weight, whichever is less)	1/4 cup	1/3 cup	3/4 cup
or cooked cereal, pasta, noodle products, or cereal grains	1/4 cup	1/4 cup	1/2 cup
Lunch or Supper:			
1. Milk, fluid	1/2 cup	3/4 cup	1 cup
2. Vegetable and/or fruit (2 or more kinds)	1/4 cup total	1/2 cup total	3/4 cup total
3. Bread and bread alternates (whole grain or enriched):			
Bread	1/2 slice	1/2 slice	1 slice
or cornbread, rolls, muffins, or biscuits	1/2 serving	1/2 serving	1 serving
or cold dry cereal (volume or weight, whichever is less)	1/4 cup	1/3 cup	3/4 cup
or cooked cereal, pasta, noodle products, or cereal grains	1/4 cup	1/4 cup	1/2 cup
4. Meat or meat alternates:			
Lean meat, fish, or poultry (edible portion as served)	1 oz.	1 1/2 oz.	2 oz.
or cheese	1 oz.	1 1/2 oz.	2 oz.

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Table 10.1 Meal Pattern Requirements for Children (Continued)

Meal Pattern Requirements for Children			
Food Components	Ages 1 through 2 years	Ages 3 through 5 years	Ages 6 and older
or egg	1/2 egg	3/4 egg	1 egg
or cooked dry beans or peas*	1/4 cup	3/8 cup	1/2 cup
or peanut butter, soy nut butter, or other nut or seed butters	2 tbsp.**	3 tbsp.**	4 tbsp.**
or peanuts, soy nuts, tree nuts, or seeds			
or an equivalent quantity of any combination of the above meat/meat alternates	1/2 oz.**	3/4 oz.**	1 oz.**
or yogurt	4 oz.	6 oz.	8 oz.
Lunch or Supper:			
1. Milk, fluid	1/2 cup	1/2 cup	1 cup
2. Vegetable and/or fruit (2 or more kinds)	1/2 cup	1/2 cup	3/4 cup
3. Bread and bread alternates (whole grain or enriched):			
Bread	1/2 slice	1/2 slice	1 slice
or cornbread, rolls, muffins, or biscuits	1/2 serving	1/2 serving	1 serving
or cold dry cereal (volume or weight, whichever is less)	1/4 cup	1/3 cup	3/4 cup
or cooked cereal, pasta, noodle products, or cereal grains	1/4 cup	1/4 cup	1/2 cup
4. Meat or meat alternates:			
Lean meat, fish, or poultry (edible portion as served)	1/2 oz.	1/2 oz.	1 oz.
or cheese	1/2 oz.	1/2 oz.	1 oz.
or egg	1/2 egg	1/2 egg	1/2 egg
or cooked dry beans or peas*	1/8 cup	1/8 cup	1/4 cup
or peanut butter, soy nut butter, or other nut or seed butters	1 tbsp.	1 tbsp.	2 tbsp.
or peanuts, soy nuts, tree nuts, or seeds	1/2 oz.	1/2 oz.	1 oz.
or an equivalent quantity of any combination of the above meat/meat alternates			
or yogurt	2 oz.	2 oz.	4 oz.
* In the same meal service, dried beans or dried peas may be used as a meat alternate or as a vegetable; however, such use does not satisfy the requirement for both components.			
** At lunch and supper, no more than 50% of the requirement shall be met with nuts, seeds, or nut butters. Nuts, seeds, or nut butters shall be combined with another meat or meat alternative to fulfill the requirement. Two tablespoons of nut butter or one ounce of nuts or seeds equals one ounce of meat.			
*** Juice may not be served when milk is served as the only other component.			

Historical Note

Table 10.1 made by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2).

R9-10-1026. Sleep Disorder Services

An administrator of an outpatient treatment center that is authorized to provide sleep disorder services shall ensure that:

1. A physician provides direction for the sleep disorder services provided by the outpatient treatment center;
2. At least one of the following is present on the premise of the outpatient treatment center:
 - a. A polysomnographic technician certified by the Board of Registered Polysomnographic Technologists (BRPT),
 - b. A polysomnographic technician accepted by the BRPT to sit for the BRPT certification examination, or
 - c. A respiratory therapist;
3. There is at least one patient testing room having a minimum of 140 square feet and no dimension less than 10 feet;
4. There is a bathroom available for use by a patient that contains:
 - a. A working sink with running water,
 - b. A working toilet that flushes and has a seat,
 - c. Toilet tissue,
 - d. Soap for hand washing,
 - e. Paper towels or a mechanical air hand dryer,
 - f. Lighting, and
 - g. A means of ventilation;
5. A personnel member certified in cardiopulmonary resuscitation is available on the outpatient treatment center's premise; and
6. Equipment for the delivery of continuous positive airway pressure and bi-level positive airway pressure, including remote control of the airway pressure, is available on the premises of the outpatient treatment center.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1026 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing

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R9-10-1026 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1027. Urgent Care Services Provided in a Freestanding Urgent Care Setting

An administrator of an outpatient treatment center that is authorized to provide urgent care services in a freestanding urgent care setting shall ensure that:

1. In addition to the policies and procedures required in R9-10-1003(D)(1), policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Basic life support training and pediatric basic life support training including:
 - i. Method and content of training,
 - ii. Qualifications of individuals providing the training, and
 - iii. Documentation that verifies a medical practitioner has received the training; and
 - b. A workplace violence prevention plan according to A.R.S. § 36-420.03.
2. A medical practitioner is on the premises during hours of clinical operation to provide the medical services, nursing services, and health-related services included in the outpatient treatment center's scope of services;
3. If a physician is not on the premises during hours of operation, a notice stating this fact is conspicuously posted in the waiting room according to A.R.S. § 36-432;
4. If a patient's death occurs at the outpatient treatment center, a written report is submitted to the Department as required in A.R.S. § 36-445.04;
5. A medical practitioner completes basic life support training and pediatric basic life support training:
 - a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center, and
 - b. At least once every 24 months after the initial date of employment;
6. Except as provided in subsection (5), a personnel member completes basic adult and pediatric cardiopulmonary resuscitation training:
 - a. Before providing medical services, nursing services, or health-related services at the outpatient treatment center; and
 - b. At least once every 24 months after the initial date of employment or volunteer service; and
7. In addition to the requirements in R9-10-1006(11), a medical practitioner's record includes documentation of completion of basic life support training and pediatric basic life support training.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1027 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed

by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1027 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1028. Infection Control

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to the outpatient treatment center's policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the outpatient treatment center;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the outpatient treatment center;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the outpatient treatment center; and
 - d. Documentation of infection control activities including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. If applicable:
 - i. Handling and disposal of biohazardous medical waste;
 - ii. Isolation of a patient;
 - iii. Sterilization and disinfection of medical equipment and supplies;
 - iv. Use of personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable; and
 - v. Collection, storage, and cleaning of soiled linens and clothing;
 - b. Cleaning an individual's hands when the individual's hands are visibly soiled;
 - c. Training of personnel members, employees, and volunteers in infection control practices; and
 - d. Work restrictions for a personnel member, employee, or volunteer with a communicable disease or infected skin lesion;

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4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures; and
5. A personnel member, employee, or volunteer washes his or her hands with soap and water or uses a hand disinfection product before and after each patient contact and after handling soiled linen, soiled clothing, or a potentially infectious material.

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1028 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1028 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1029. Emergency and Safety Standards

- A.** An administrator shall ensure that policies and procedures for providing emergency treatment are established, documented, and implemented that protect the health and safety of patients and include:
 1. A list of the medications, supplies, and equipment required on the premises for the emergency treatment provided by the outpatient treatment center;
 2. A system to ensure medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
 3. A requirement that a cart or a container is available for emergency treatment that contains the medication, supplies, and equipment specified in the outpatient treatment center's policies and procedures; and
 4. A method to verify and document that the contents of the cart or container are available for emergency treatment.
- B.** An administrator shall ensure that emergency treatment is provided to a patient admitted to the outpatient treatment center according to the outpatient treatment center's policies and procedures.
- C.** An administrator shall ensure that:
 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members, and, if necessary, implemented that includes:
 - a. Procedures for protecting the health and safety of patients and other individuals on the premises;
 - b. Assigned responsibilities for each personnel member, employee, or volunteer;
 - c. Instructions for the evacuation of patients and other individuals on the premises; and
 - d. Arrangements to provide medical services, nursing services, and health-related services to meet patients' needs;
 2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;

3. An evacuation drill is conducted on each shift at least once every 12 months;
 4. A disaster plan review required in subsection (C)(2) or an evacuation drill required in subsection (C)(3) is documented as follows:
 - a. The date and time of the evacuation drill or disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the evacuation drill or disaster plan review;
 - c. A critique of the evacuation drill or disaster plan review; and
 - d. If applicable, recommendations for improvement;
 5. Documentation required in subsection (C)(4) is maintained for at least 12 months after the date of the evacuation drill or disaster plan review; and
 6. An evacuation path is conspicuously posted on each hallway of each floor of the outpatient treatment center.
- D.** An administrator shall ensure that an outpatient treatment center has either:
 1. Both of the following that are tested and serviced at least once every 12 months:
 - a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and
 - b. A sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order; or
 2. The following:
 - a. A smoke detector installed in each hallway of the outpatient treatment center that is:
 - i. Maintained in an operable condition;
 - ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and
 - iii. Tested monthly; and
 - b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
 - i. Is available at the outpatient treatment center;
 - ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;
 - iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
 - iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person.
 - E.** An administrator shall ensure that documentation of a test required in subsection (D) is maintained for at least 12 months after the date of the test.
 - F.** An administrator shall ensure that:
 1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit signs;
 2. Except as provided in subsection (G), a corridor in the outpatient treatment center is at least 44 inches wide;

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3. Corridors and exits are kept clear of any obstructions;
 4. A patient can exit through any exit during hours of operation;
 5. An extension cord is not used instead of permanent electrical wiring;
 6. Each electrical outlet and electrical switch has a cover plate that is in good repair;
 7. If applicable, a sign is placed at the entrance of a room or an area indicating that oxygen is in use; and
 8. Oxygen and medical gas containers:
 - a. Are maintained in a secured, upright position; and
 - b. Are stored in a room with a door:
 - i. In a building with sprinklers, at least five feet from any combustible materials; or
 - ii. In a building without sprinklers, at least 20 feet from any combustible materials.
- G.** If an outpatient treatment center licensed before October 1, 2013 has a corridor less than 44 inches wide, an administrator shall ensure that:
1. The corridor is wide enough to allow for:
 - a. Unobstructed movement of patients within the outpatient treatment center, and
 - b. The safe evacuation of patients from the outpatient treatment center; and
 2. The corridor is used only as a passageway.
- H.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the fire inspection report, and
 3. Maintain documentation of a current fire inspection.
- Historical Note**
- Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1029 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1029 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).
- R9-10-1030. Physical Plant, Environmental Services, and Equipment Standards**
- A.** An administrator shall ensure that:
1. An outpatient treatment center's premises are:
 - a. Sufficient to provide the outpatient treatment center's scope of services;
 - b. Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and
 2. Free from a condition or situation that may cause an individual to suffer physical injury;
- B.** If an outpatient treatment center collects urine or stool specimens from a patient, except as provided in subsection (B), or is authorized to provide respite services for children on the premises, the outpatient treatment center has at least one bathroom on the premises that:
- a. 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 means of ventilation; and
 - b. Is for the exclusive use of the outpatient treatment center;
- C.** A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
- D.** A tobacco smoke-free environment is maintained on the premises;
- E.** A refrigerator used to store a medication is:
- a. Maintained in working order, and
 - b. Only used to store medications;
- F.** Equipment at the outpatient treatment center is:
- a. Sufficient to provide the outpatient treatment center's scope of services;
 - b. Maintained in working condition;
 - c. Used according to the manufacturer's recommendations; and
 - d. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures; and
- G.** Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of testing, calibration, or repair.
- H.** An outpatient treatment center may have a bathroom used for the collection of a patient's urine or stool that is not for the exclusive use of the outpatient treatment center if:
1. The bathroom is located in the same contiguous building as the outpatient treatment center's premises,
 2. The bathroom is of a sufficient size to support the outpatient treatment center's scope of services, and
 3. There is a documented agreement between the licensee and the owner of the building stating that the bathroom complies with the requirements in this Section and allowing the Department access to the bathroom to verify compliance.
- I.** If an outpatient treatment center has a bathroom that is not for the exclusive use of the outpatient treatment center as allowed in subsection (B), an administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to:
 - a. Protect the health and safety of an individual using the bathroom; and
 - b. Ensure that the bathroom is cleaned and sanitized to prevent, minimize, and control illness and infection;
 2. Documented instructions are provided to a patient that cover:
 - a. Infection control measures when a patient uses the bathroom, and
 - b. The safe return of a urine or stool specimen to the outpatient treatment center;

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- j. A statement that the associated licensed provider will:
 - i. Document the following each time another colocator provides emergency health care services in the associated licensed provider's treatment area:
 - (1) The name of the colocator;
 - (2) If different from the name of the colocator, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (E)(1)(j)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
 - k. A statement that the associated licensed provider will:
 - i. Document the following each time the associated licensed provider provides emergency health care services in another colocator's treatment area:
 - (1) If different from the name of the associated licensed provider, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (2) The name of the colocator;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (E)(1)(k)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
 - l. An attestation that the associated licensed provider will comply with the written agreement;
 - m. The signature of the associated licensed provider's governing authority according to A.R.S. § 36-422(B) and the date signed; and
 - n. The signature of the collaborating outpatient treatment center's governing authority according to A.R.S. § 36-422(B) and the date signed; and
2. A copy of the associated licensed provider's scope of services, including whether the associated licensed provider plans to provide behavioral health services for children.
- F. An administrator of a collaborating outpatient treatment center shall have a written agreement with each exempt health care provider that includes:
- 1. In a Department-provided format:
 - a. The exempt health care provider's name;
 - b. The exempt health care provider license type and license number;
 - c. Whether the exempt health care provider plans to share medical records with the collaborating outpatient treatment center;
 - d. If the exempt health care provider plans to share medical records with the collaborating outpatient treatment center, specific information about which party will obtain a patient's:
 - i. General consent or informed consent, as applicable;
 - ii. Consent to allow a colocator access to the patient's medical record; and
 - iii. Advance directives;
 - e. How the exempt health care provider will transport or transfer a patient to another colocator within the collaborating outpatient treatment center;
 - f. How the exempt health care provider will ensure controlled substances stored in the exempt health care provider's designated premises are not diverted;
 - g. How the exempt health care provider will ensure environmental services in the exempt health care provider's licensed premises will not affect patient care in the collaborating outpatient treatment center;
 - h. How the exempt health care provider and any staff of the exempt health care provider will respond to a patient's sudden, intense, or out-of-control behavior, in the exempt health care provider's treatment area, to prevent harm to the patient or another individual in the collaborating outpatient treatment center;
 - i. A statement that, if any of the colocators include children's behavioral health services in the colocator's statement of services, the exempt health care provider will ensure that all employees and staff of the exempt health care provider comply with the fingerprint clearance card requirements A.R.S. § 36-425.03;
 - j. A statement that the exempt health care provider will:
 - i. Document the following each time another colocator provides emergency health care services in the exempt health care provider's treatment area:
 - (1) The name of the colocator;
 - (2) If different from the name of the colocator, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (F)(1)(j)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
 - k. A statement that the exempt health care provider will:

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- i. Document the following each time the exempt health care provider provides emergency health care services in another colocator's treatment area:
 - (1) If different from the name of the exempt health care provider, the name of the physician, physician assistant, registered nurse practitioner, or behavioral health professional providing the emergency health care services;
 - (2) The name of the colocator;
 - (3) A description of the emergency health care services provided; and
 - (4) The date and time the emergency health care services were provided;
 - ii. Maintain the documentation in subsection (F)(1)(k)(i) for at least 12 months after the emergency health care services were provided; and
 - iii. Submit a copy of the documentation to the collaborating outpatient treatment center within 48 hours after the provision of the emergency health care services;
- l. An attestation that the exempt health care provider will comply with the written agreement;
 - m. The signature of the exempt health care provider and the date signed; and
 - n. The signature of the collaborating outpatient treatment center's governing authority according to A.R.S. § 36-422(B) and the date signed; and
2. A copy of the exempt health care provider's scope of services, including whether the exempt health care provider plans to provide behavioral health services for children.
- G.** As part of the policies and procedures required in this Article, an administrator of a collaborating outpatient treatment center shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient based on the scopes of services of all colocators that:
1. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for nontreatment personnel who may provide services in the areas of the collaborating outpatient treatment center's premises shared with a colocator;
 2. Cover orientation and in-service education for nontreatment personnel who may provide services in the areas of the collaborating outpatient treatment center's premises shared with a colocator;
 3. Cover cardiopulmonary resuscitation training, including:
 - a. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - b. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - c. The time-frame for renewal of cardiopulmonary resuscitation training; and
 - d. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
 4. Cover first aid training;
 5. Cover patient screening, including a method to ensure that, if a patient identifies a specific colocator, the patient is directed to the identified colocator;
 6. Cover the provision of emergency treatment to protect the health and safety of a patient or individual present in an area of the collaborating outpatient treatment center's premises shared with a colocator according to the requirements for emergency treatment policies and procedures in R9-10-1029(A);
 7. If medication is stored in an area of the collaborating outpatient treatment center's premises shared with a colocator, cover obtaining, storing, accessing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;
 8. Cover biohazardous wastes, if applicable;
 9. Cover environmental services in an area of the collaborating outpatient treatment center's premises shared with a colocator that affect patient care; and
 10. Cover how personnel members and nontreatment personnel will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual in an area of the collaborating outpatient treatment center's premises shared with a colocator.
- H.** An administrator of a collaborating outpatient treatment center shall ensure that:
1. Areas of the collaborating outpatient treatment center's premises shared with a colocator are:
 - a. Sufficient to accommodate the outpatient treatment center's and any colocators' scopes of services;
 - b. Cleaned and disinfected according to the outpatient treatment center's policies and procedures to prevent, minimize, and control illness and infection; and
 - c. Free from a condition or situation that may cause an individual to suffer physical injury;
 2. A written log is maintained that documents the date, time, and circumstances each time a colocator provides emergency health care services in another colocator's designated treatment area; and
 3. The documentation in the written log required in subsection (H)(2) is maintained for at least 12 months after the date the colocator provides emergency health care services in another colocator's designated treatment area.
- I.** If any colocator at a collaborating outpatient treatment center includes children's behavioral health services as part of the colocator's scope of services, an administrator of the collaborating outpatient treatment center shall ensure that the governing authority, employees, personnel members, nontreatment personnel, and volunteers of the collaborating outpatient treatment center comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.

Historical Note

New Section made by exempt rulemaking at 22 A.A.R. 1035, pursuant to Laws 2015, Ch. 158, § 3; effective May 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

ARTICLE 11. ADULT DAY HEALTH CARE FACILITIES**R9-10-1101. Definitions**

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

"Care plan" means a written program of action for a participant's care based upon an assessment of the participant's physical, nutritional, psychosocial, economic, and environmental strengths and needs and implemented according to established short- and long-term goals.

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Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1102. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as an adult day health care facility shall include on the application the number of participants for whom the applicant is requesting authorization to provide adult day health services.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1102 renumbered to Section R9-10-1103; new Section R9-10-1102 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1103. Administration**A.** A governing authority shall:

1. Consist of one or more individuals responsible for the organization, operation, and administration of an adult day health care facility;
2. Establish, in writing:
 - a. An adult day health care facility's scope of services, and
 - b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1104;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate in writing, an acting administrator, who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on an adult day health care facility's premises for more than 30 calendar days, or
 - b. Not present on an adult day health care facility's premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I), when there is a change in an administrator and identify the name and qualifications of the new administrator.

B. An administrator:

1. Is 21 years of age or older;
2. Is directly accountable to the governing authority of an adult day health care facility for the daily operation of the adult day health care facility and all services provided by or at the adult day health care facility;
3. Has the authority and responsibility to manage the adult day health care facility; and
4. Except as provided in subsection (A)(6), designates, in writing, an individual who is 21 years of age or older and present on the adult day health care facility's premises and accountable for the adult day health care facility when the administrator is not present on the adult day health care facility premises and participants are present on the adult day health care facility's premises.

C. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Cover certification in cardiopulmonary resuscitation and first aid training;
 - d. Include how a personnel member may submit a complaint relating to services provided to a participant;
 - e. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - f. Include a method to identify a participant to ensure that the participant receives the appropriate services;
 - g. Cover participant rights, including assisting a participant who does not speak English or who has a disability to become aware of participant rights;
 - h. Cover specific steps for:
 - i. A participant to file a complaint, and
 - ii. The adult day health care facility to respond to a participant complaint;
 - i. Cover medical records, including electronic medical records; and
 - j. Cover a quality management program, including incident reports and supporting documentation;
2. Policies and procedures for services provided by an adult day health care facility are established, documented, and implemented to protect the health and safety of a participant that:
 - a. Cover screening, enrollment, and discharge;
 - b. Cover the provision of the services in the adult day health care facility's scope of services;
 - c. Cover dispensing, administering, and disposing of medications, including provisions for inventory control and preventing diversion of controlled substances;
 - d. Cover how personnel members will respond to a participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual;
 - e. Cover food services;
 - f. Cover environmental services;
 - g. Cover infection control;
 - h. Cover contracted services;
 - i. Cover emergency treatment provided at the adult day health care facility; and
 - j. Designate which employees or personnel members are required to have current certification in cardiopulmonary resuscitation and first aid training;
3. Policies and procedures are:
 - a. Available to personnel members, employees, volunteers, and students, and
 - b. Reviewed at least once every three years and updated as needed; and
4. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and

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- b. When documentation or information is required by this Chapter to be submitted on behalf of an adult day health care facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the adult day health care facility.

D. An administrator shall:

- 1. Maintain, and make available to individuals upon request, a schedule of rates and charges;
- 2. Ensure that a monthly calendar of planned activities is:
 - a. Posted before the beginning of a month, and
 - b. Maintained on the premises for at least 90 calendar days after the end of the month;
- 3. Ensure that materials, supplies, and equipment are provided for the planned activities; and
- 4. Assist in the formation of a participants' council according to R9-10-1112.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1103 renumbered to Section R9-10-1104; new Section R9-10-1103 renumbered from Section R9-10-1102 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1104. 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 services provided to participants;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to participant 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 participant 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 participant care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to participant care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1104 renumbered to Section R9-10-1105; new Section R9-10-1104 renumbered from Section R9-10-1103 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1105. Contracted Services

An administrator shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1105 renumbered to Section R9-10-1106; new Section R9-10-1105 renumbered from Section R9-10-1104 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1106. Personnel

A. An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the participants receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
- 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
- 3. Sufficient personnel members are present on an adult day health care facility's premises when participants are present and have the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the adult day health care facility's scope of services,
 - b. Meet the needs of a participant, and
 - c. Ensure the health and safety of a participant;
- 4. A personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a partic-

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ipant for more than eight hours a week, provides evidence of freedom from infectious tuberculosis:

- a. On or before the date the individual begins providing services at or on behalf of the adult day health care facility, and
 - b. As specified in R9-10-113; and
5. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.
- B.** An administrator shall ensure that a personnel member:
1. Is 18 years of age or older, and
 2. Is not a participant of the adult day health care facility.
- C.** An administrator shall ensure that a personnel record for each personnel member, employee, volunteer, or student:
1. Includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 - c. Documentation of:
 - i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education as required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - v. Cardiopulmonary resuscitation training, if required for the individual according to this Article and policies and procedures;
 - vi. First aid training, if required for the individual according to this Article and policies and procedures; and
 - vii. Evidence of freedom from infectious tuberculosis, if required for the individual according to this Article or policies and procedures;
 2. Is maintained:
 - a. Throughout the individual's period of providing services in or for the adult day health care facility, and
 - b. For at least 24 months after the last date the individual provided service in or for the adult day health care facility; and
 3. For a personnel member who has not provided physical health services or behavioral health services at or for the adult day health care facility during the previous 12 months, is provided to the Department within 72 hours after the Department's request.
 4. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training;
- D.** An administrator shall ensure that:
1. At least two personnel members are present on the premises whenever two or more participants are in the adult day health care facility;
 2. At least one personnel member with cardiopulmonary resuscitation and first-aid certification is on the premises at all times;

3. A registered nurse manages the nursing services and provides direction for health-related services provided by the adult day health care facility; and
4. A nurse is on the premises daily to:
 - a. Administer medications and treatments, and
 - b. Monitor a participant's health status.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1106 renumbered to Section R9-10-1107; new Section R9-10-1106 renumbered from Section R9-10-1105 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1107. Enrollment

- A.** An administrator shall ensure that a participant provides evidence of freedom from infectious tuberculosis:
1. Before the participant's participation, and
 2. As specified in R9-10-113.
- B.** Before or at the time of enrollment, an administrator shall ensure that a participant or the participant's representative signs a written agreement with the adult day health care facility that includes:
1. The participant's name and date of birth,
 2. Enrollment requirements,
 3. A list of the customary services that the adult day health care facility provides,
 4. A list of services that are available at an additional cost,
 5. A list of fees and charges,
 6. Procedures for termination of the agreement,
 7. The requirements of the adult day health care facility,
 8. The names and telephone numbers of individuals designated by the participant to be notified in the event of an emergency, and
 9. A copy of the adult day health care facility's procedure on health care directives.
- C.** An administrator shall give a copy of the agreement in subsection (B) to the participant or the participant's representative and keep the original in the participant's medical record.
- D.** An administrator shall ensure that a participant has a signed written medical assessment that:
1. Was completed by the participant's medical practitioner within 60 calendar days before enrollment; and
 2. Includes:
 - a. Information that addresses the participant's:
 - i. Physical health;
 - ii. Cognitive awareness of self, location, and time; and
 - iii. Deficits in cognitive awareness;
 - b. Physical, mental, and emotional problems experienced by the participant;
 - c. A schedule of the participant's medications;
 - d. A list of treatments the participant is receiving;
 - e. The participant's special dietary needs; and
 - f. The participant's known allergies.
- E.** At the time of enrollment, an administrator shall ensure that the participant or participant's representative:
1. Documents whether the participant may sign in and out of the adult day health care facility; and
 2. Provides the following:

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- a. The name and telephone number of the:
 - i. Participant's representative;
 - ii. Family member to be contacted in an emergency;
 - iii. Participant's medical practitioner; and
 - iv. Adult who provides the participant with supervision and assistance in the preparation of meals, housework, and personal grooming, if applicable; and
 - b. If applicable, a copy of the participant's health care directive.
- F.** An administrator shall ensure that a comprehensive assessment of the participant:
- 1. Is completed by a registered nurse before the participant's tenth visit or within 30 calendar days after enrollment, whichever comes first;
 - 2. Documents the participant's:
 - a. Physical health,
 - b. Mental and emotional status, and
 - c. Social history; and
 - 3. Includes:
 - a. Medical practitioner orders,
 - b. Adult day health care services recommended for the participant's care plan, and
 - c. The signature of the registered nurse conducting the comprehensive assessment and date signed.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1107 renumbered to Section R9-10-1108; new Section R9-10-1107 renumbered from Section R9-10-1106 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1108. Care Plan

An administrator shall ensure that a care plan for a participant:

- 1. Is developed within seven calendar days after the completion of the participant's comprehensive assessment;
- 2. Has input from:
 - a. The participant or participant's representative,
 - b. The registered nurse who performed the comprehensive assessment, and
 - c. Personnel who have provided services to the participant;
- 3. Is based on the participant's comprehensive assessment;
- 4. Includes:
 - a. A summary of the participant's medical or health problems, including physical, mental, and emotional disabilities or impairments;
 - b. Adult day health services to be provided;
 - c. Goals and objectives of care that are time-limited and measurable;
 - d. Interventions required to achieve objectives, including recommendations for therapy and referrals to other service providers; and
 - e. Discharge instructions according to R9-10-1109(B); and
- 5. Is reviewed and updated at least once every six months and whenever there is a significant change in the participant's condition.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1108 renumbered to Section R9-10-1109; new Section R9-10-1108 renumbered from Section R9-10-1107 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1109. Discharge

- A.** An administrator may discharge a participant from an adult day health care facility by terminating the agreement in R9-10-1107(B):
- 1. After giving the participant or participant's representative five working days written notice; and
 - 2. For any of the following reasons:
 - a. Evidence of repeated failure to comply with the requirements of the adult day health care facility,
 - b. Documented proof of failure to pay,
 - c. Behavior that is dangerous to self or that interferes with the physical or psychological well-being of other participants, or
 - d. The participant requires services not in the adult day health care facility's scope of services.
- B.** An administrator shall ensure that discharge instructions for a participant are:
- 1. Developed that:
 - a. Identify any specific needs of the participant after discharge,
 - b. Are completed before discharge occurs,
 - c. Include a description of the level of care that may meet the participant's assessed and anticipated needs after discharge, and
 - d. Are documented in the participant's medical record within 48 hours after the discharge instructions are completed; and
 - 2. Provided to the participant or the participant's representative before the discharge occurs.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1109 renumbered to Section R9-10-1110; new Section R9-10-1109 renumbered from Section R9-10-1108 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1110. Participant Rights

- A.** An administrator shall ensure that:
- 1. The requirements in subsection (B) and the participant rights in subsection (C) are conspicuously posted on the premises;
 - 2. At the time of enrollment, a participant or the participant's representative receives a written copy of the requirements in subsection (B) and the participant rights in subsection (C); and
 - 3. Policies and procedures include:
 - a. How and when a participant or the participant's representative is informed of participant rights in subsection (C), and
 - b. Where participant rights are posted as required in subsection (A)(1).
- B.** An administrator shall ensure that:

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1. A participant is treated with dignity, respect, and consideration;
2. A participant is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by the adult day health care facility's personnel members, employees, volunteers, or students; and
3. A participant or the participant's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed alternatives to the treatment, associated risks, and possible complications;
 - d. Is informed of the following:
 - i. The policy on health care directives,
 - ii. The participant complaint process,
 - iii. Rates and charges for participating at the adult day health care facility, and
 - iv. The process for contacting the local office of Adult Protective Services;
 - e. Consents to photographs of the participant before the participant is photographed, except that a participant may be photographed when enrolled at an adult day health care facility for identification and administrative purposes; and
 - f. Except as otherwise permitted by law, provides written consent to the release of information in the participant's:
 - i. Medical record, or
 - ii. Financial records.
- C. A participant has the following rights:
 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that supports and respects the participant's individuality, choices, strengths, and abilities;
 3. To communicate, associate, and meet privately with individuals of the participant's choice;
 4. To have access to a telephone, to make and receive calls, and to send and receive correspondence without interception or interference by the adult day health care facility;
 5. To arrive and depart from the adult day health care facility, consistent with the participant's care plan and personal safety;
 6. To receive privacy in treatment and care for personal needs;
 7. To review, upon written request, the participant's own records;
 8. To receive a referral to another health care institution if the adult day health care facility is not authorized or not able to provide physical health services or behavioral health services needed by the participant;
 9. To participate or have the participant's representative participate in the development of a care plan or decisions concerning treatment;
 10. To participate or refuse to participate in research or experimental treatment; and
 11. To receive assistance from a family member, the participant's representative, or other individual in understanding, protecting, or exercising the participant's rights.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1110 renumbered to Section R9-10-1111; new Section R9-10-1110 renumbered from Section R9-10-1109 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1111. Medical Records

- A. An administrator shall ensure that:
 1. A medical record is established and maintained for a participant according to A.R.S. Title 12, Chapter 13, Article 7.1;
 2. An entry in a participant's medical record is:
 - a. Recorded only by an individual authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 3. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 4. A participant's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the participant's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the participant or the participant's representative; or
 - c. As permitted by law; and
 5. A participant's medical record is protected from loss, damage, or unauthorized use.
- B. If an adult day health care facility maintains participant's medical records electronically, an administrator shall ensure that:
 1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a participant's medical record is recorded by the computer's internal clock.
- C. An administrator shall ensure that a participant's medical record contains:
 1. Participant information that includes:
 - a. The participant's name;
 - b. The participant's address;
 - c. The participant's date of birth; and
 - d. Any known allergies, including medication allergies;
 2. The name of the participant's medical practitioner or other individuals involved in the care of the participant;
 3. An enrollment agreement and date of the participant's first visit;
 4. If applicable, documented general consent and informed consent by the participant or the participant's representative;
 5. If applicable, the name and contact information of the participant's representative and:

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- a. The document signed by the participant consenting for the participant's representative to act on the participant's behalf; or
- b. If the participant's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
- 6. Documentation of medical history;
- 7. A copy of the participant's health care directive, if applicable;
- 8. Orders;
- 9. The medical assessment required in R9-10-1107(D);
- 10. A care plan;
- 11. The comprehensive assessment required in R9-10-1107(F);
- 12. Progress notes;
- 13. If applicable, documentation of any actions taken to control the participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual;
- 14. Documentation of adult day health services provided to the participant;
- 15. The disposition of the participant upon discharge;
- 16. The discharge date, if applicable;
- 17. Documentation of a medication administered to the participant that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. The identification and signature of the individual administering, providing assistance in the self-administration of medication, or observing the participant's self-administration of the medication;
 - d. If medication for pain is administered on a PRN basis to a participant:
 - i. An identification of the participant's pain before administering the medication, and
 - ii. The effect of the medication administered; and
 - e. Any adverse reaction a participant has to the medication;
- 18. If applicable, documentation of:
 - a. A significant change in the participant's condition,
 - b. An injury or accident that occurred at the adult day health care facility and required medical services, and
 - c. Notification provided to the participant's medical practitioner or the participant's representative of the significant change in subsection (C)(18)(a) or the injury or accident in subsection (C)(18)(b);
- 19. Documentation of whether the participant may sign in or out of the adult day health care facility;
- 20. Documentation of freedom from infectious tuberculosis required in R9-10-1107(A); and
- 21. Names and telephone numbers of individuals to be notified in the event of an emergency.

Historical Note

Amended effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-

1111 renumbered to Section R9-10-1112; new Section R9-10-1111 renumbered from Section R9-10-1110 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1112. Participant's Council

- A. A participants' council:
 - 1. Is composed of participants, who are willing to serve on the council and take part in scheduled meetings;
 - 2. May develop guidelines that govern the council's activities;
 - 3. May meet quarterly;
 - 4. May record minutes of the meetings; and
 - 5. May provide written input on planned activities and policies of the adult day health care facility.
- B. A participants' council may invite personnel or the administrator to attend their meetings.
- C. An administrator shall act as a liaison between the participants' council and personnel members, employees, and volunteers.

Historical Note

Amended effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1112 renumbered to Section R9-10-1113; new Section R9-10-1112 renumbered from Section R9-10-1111 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1113. Adult Day Health Services

- A. An administrator shall ensure that a personnel member provides supervision for a participant, except during periods of the day when the participant signs out or is signed out according to policies and procedures.
- B. An administrator shall ensure that a personnel member provides assistance with activities of daily living and supervision of personal hygiene according to the participant's care plan and policies and procedures.
- C. An administrator shall ensure that a personnel member provides a participant with planned therapeutic individual and group activities:
 - 1. According to the:
 - a. Participant's care plan,
 - b. Policies and procedures, and
 - c. Monthly calendar of planned activities required in R9-10-1103(D)(2); and
 - 2. That include:
 - a. Physical activities,
 - b. Group discussion,
 - c. Techniques a participant may use to maintain or improve the participant's independence in performing activities of daily living,
 - d. Assessment of deficits in cognitive awareness and reinforcement of remaining cognitive awareness,
 - e. Activities of daily living,
 - f. Participants' council meetings, and
 - g. Leisure time.
- D. An administrator shall ensure that a nurse monitors the health status of a participant according to the participant's care plan and policies and procedures by:

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1. Observing the participant's mental and physical condition, including monthly monitoring of the participant's vital signs and nutritional status;
 2. Documenting changes in the participant's mental and physical condition in the participant's medical record; and
 3. Reporting any changes to the participant's representative or medical practitioner.
- E.** If an adult day health care facility administers medication or provides assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication administration or assistance in the self-administration of medication:
1. Include:
 - a. A process for providing information to a participant about medication prescribed for the participant including:
 - 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:
 - i. A medication error,
 - ii. An adverse response to a medication, or
 - iii. A medication overdose; and
 - c. Procedures for documenting medication services and assistance in the self-administration of medication; and
 2. Specify a process for review through the quality management program of:
 - a. A medication administration error, and
 - b. An adverse reaction to a medication.
- F.** An administrator shall ensure that:
1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a pharmacist, medical practitioner, or registered nurse; and
 - b. Ensure that medication is administered to a participant only as prescribed;
 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
 3. A medication administered to a participant:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the participant's medical record.
- G.** If an adult day health care facility provides assistance in the self-administration of medication, an administrator shall ensure that:
1. A participant's medication is stored by the adult day health care facility;
 2. The following assistance is provided to a participant:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the participant;
 - c. Observing the participant while the participant removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the participant's medical practitioner by confirming that:
 - i. The participant taking the medication is the individual stated on the medication container label,
 - ii. The participant is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
 - iii. The participant is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
 - e. Observing the participant while the participant takes the medication;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a pharmacist, medical practitioner, or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (G)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a participant:
 - a. Is in compliance with an order, and
 - b. Is documented in the participant's medical record.
- H.** An administrator shall ensure that:
1. A current drug reference guide is available for use by personnel members, and
 2. A current toxicology reference guide is available for use by personnel members.
- I.** When medication is stored at an adult day health care facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions on the medication container; and
 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication; and
 - b. Storing, inventorying, and dispensing controlled substances.
- J.** A medication error or a participant's refusal to take a medication is:
1. Reported to the participant's representative within 12 hours, and

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2. Documented in the participant's medical record within 24 hours.
 - K.** An adverse reaction is:
 1. Reported to the participant's representative and medical practitioner within 12 hours, and
 2. Documented in the participant's medical record within 24 hours.
 - L.** An administrator shall:
 1. Immediately notify a participant's representative and medical practitioner of an injury that may require medical services;
 2. Report an injury to Adult Protective Services according to A.R.S. § 46-454, when applicable;
 3. Prepare a written report on the day of occurrence or when any injury of unknown origin is detected that includes the:
 - a. Name of the participant;
 - b. Type of injury;
 - c. Names of witnesses, if applicable; and
 - d. Action taken;
 4. Investigate the injury within 24 hours and documenting any corrective action in the report; and
 5. Retain the report for at least 12 months after the date of the injury.
 - M.** For a participant whose care plan includes counseling on an individual or group basis, an administrator shall ensure that:
 1. If the counseling needed by the participant is within the adult day health care facility's scope of services, a personnel member provides the counseling to the participant according to policies and procedures; or
 2. If the counseling needed by the participant is not within the adult day health care facility's scope of services, a personnel member assists the participant or the participant's representative to obtain counseling for the participant according to policies and procedures.
- Historical Note**
- Amended effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1113 renumbered to Section R9-10-1114; new Section R9-10-1113 renumbered from Section R9-10-1112 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).
- R9-10-1114. Food Services**
- A.** An administrator shall:
 1. Designate a food service supervisor who is responsible for food service in an adult day health care facility; and
 2. If an adult day health care facility provides a therapeutic diet to participants, ensure that:
 - a. The therapeutic diet is prescribed in writing by:
 - i. The participant's medical practitioner, or
 - ii. A registered dietitian; and
 - b. A current therapeutic diet reference manual is available to the food service supervisor.
 - B.** A food service supervisor shall ensure that:
 1. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one calendar day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 2. Meals and snacks provided by the adult day health care facility are served according to posted menus;
 3. Meals and snacks for each day are planned using the applicable guidelines in the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
 4. A participant is provided a diet that meets the participant's nutritional needs as specified in the participant's comprehensive assessment, under R9-10-1107(F), or the participant's care plan;
 5. Water is available and accessible to participants at all times, unless otherwise stated by the participant's medical practitioner; and
 6. A participant requiring assistance to eat is provided with assistance that recognizes the participant's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils, such as a plate guard, rocking fork, or assistive hand device, if not provided by the participant.
- 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. Food is prepared:
 - a. Using methods that conserve nutritional value, flavor, and appearance; and
 - b. In a form to meet the needs of a participant, such as cut, chopped, ground, pureed, or thickened;
 4. 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 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and
 - vi. Leftovers are reheated to a temperature of at least 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.
- D.** An administrator shall ensure that:

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1. If an adult day health care facility is licensed to provide adult day health services to more than 15 participants, the adult day health care facility:
 - a. Has a license or permit as a food establishment under 9 A.A.C. 8, Article 1; and
 - b. Maintains a copy of the adult day health care facility's food establishment license or permit;
2. If the adult day health care facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the adult day health care facility, a copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the adult day health care facility; and
3. The adult day health care facility is able to store, refrigerate, and reheat food to meet the dietary needs of a participant.

Historical Note

Amended effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1114 renumbered to Section R9-10-1115; new Section R9-10-1114 renumbered from Section R9-10-1113 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1115. Emergency and Safety Standards

- A. An administrator shall ensure that:
 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and employees, and, if necessary, implemented that includes:
 - a. Procedures for protecting the health and safety of participants and other individuals on the premises;
 - b. Assigned responsibilities for each personnel member and employee;
 - c. Instructions for the evacuation of participants, including:
 - i. When, how, and where participants will be relocated; and
 - ii. A plan for notifying the emergency contact for each participant;
 - d. A plan to ensure each participant's medications will be available to administer to the participant during a disaster; and
 - e. A plan for providing water, food, and needed services to participants present in the adult day health care facility or the adult day health care facility's relocation site during a disaster;
 2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement; and

4. A disaster drill for assigned personnel is conducted on each shift at least once every three months and documented.

B. An administrator shall ensure that:

1. A participant receives orientation to the exits from the adult day health care facility and the route to be used when evacuating participants within two visits after the participant's enrollment, and
2. A participant's orientation is documented in the participant's medical record.

C. An administrator shall ensure that:

1. An evacuation drill for employees and participants is conducted at least once every six months;
2. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for all employees and participants to evacuate to a designated area;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
3. An evacuation path is conspicuously posted on each hallway of each floor of the adult day health care facility.

Historical Note

Adopted effective September 2, 1977 (Supp. 77-5). Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1115 renumbered to Section R9-10-1116; new Section R9-10-1115 renumbered from Section R9-10-1114 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1116. Environmental Standards**A. An administrator shall ensure that:**

1. The adult day health care facility's premises are:
 - a. Cleaned and disinfected according to policies and procedures to prevent, minimize, and control illness and infection; and
 - b. Free from a condition or situation that may cause a participant or an individual to suffer physical injury;
2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
3. Windows and doors opening to the outside are screened if they are kept open at any time for ventilation or other purposes;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
5. Equipment used at the adult day health care 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
6. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;

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7. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
 8. Heating and cooling systems maintain the adult day health care facility at a temperature between 70° F and 84° F;
 9. The supply of hot and cold water is sufficient to meet the personal hygiene needs of participants and the cleaning and sanitation requirements in this Article;
 10. Soiled linen and soiled clothing stored by the adult day health care facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
 11. Oxygen containers are secured in an upright position;
 12. Poisonous or toxic materials stored by the adult day health care facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to participants;
 13. Combustible or flammable liquids and hazardous materials stored by the adult day health care facility are stored in the original labeled containers or safety containers in a locked area inaccessible to participants; and
 14. Pets or animals are:
 - a. Controlled to prevent endangering the participants and to maintain sanitation;
 - b. Not allowed in treatment, food storage, food preparation, or dining areas;
 - c. Licensed consistent with local ordinances; and
 - d. For a dog or cat, vaccinated against rabies.
- B.** If a swimming pool is located on the premises, an administrator shall ensure that:
1. On a day that a participant uses the swimming pool, an employee:
 - a. Tests the swimming pool's water quality at least once for compliance with one of the following chemical disinfection standards:
 - i. A free chlorine residual between 1.0 and 3.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test;
 - ii. A free bromine residual between 2.0 and 4.0 ppm as measured by the N, N-Diethyl-p-phenylenediamine test; or
 - iii. An oxidation-reduction potential equal to or greater than 650 millivolts; and
 - b. Records the results of the water quality tests in a log that includes the date tested and test result;
 2. Documentation of the water quality test is maintained for at least 12 months after the date of the test;
 3. A swimming pool is not used by a participant if a water quality test shows that the swimming pool water does not comply with subsection (B)(1)(a);
 4. At least one personnel member with cardiopulmonary resuscitation training, required in R9-10-1106(D), is present in the pool area when a participant is in the pool area; and
 5. At least two personnel members are present in the pool area if two or more participants are in the pool area.

Historical Note

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-

1116 renumbered to Section R9-10-1117; new Section R9-10-1116 renumbered from Section R9-10-1115 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

R9-10-1117. Physical Plant Standards

- A.** An administrator shall ensure that an adult day health care facility complies with the physical plant health and safety codes and standards incorporated by reference in R9-10-104.01, in effect on the date the adult day health care facility submitted the application including the notarized attestation of architectural plans according to R9-10-104.
- B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
 1. The services stated in the adult day health care facility's scope of services, and
 2. An individual accepted as a participant by the adult day health care facility.
- C.** An administrator shall ensure that an adult day health care facility has at least 40 square feet of indoor activity space for each participant, excluding bathrooms, halls, storage areas, kitchens, wall thicknesses, and rooms designated for use by individuals who are not participants.
- D.** An administrator shall ensure that an outside activity space is provided and available that:
 1. Is on the premises,
 2. Has a hard-surfaced section for wheelchairs,
 3. Has an available shaded area, and
 4. Has a means of egress without entering the adult day health care facility.
- E.** An administrator shall ensure that:
 1. There is at least one working toilet that flushes and has a seat and one sink with running water for each ten participants;
 2. A bathroom for use by participants provides privacy when in use and contains in a location accessible to participants:
 - a. A mirror;
 - b. Toilet paper for each toilet;
 - c. Soap accessible from each sink;
 - d. Paper towels in a dispenser or an air hand dryer; and
 - e. Grab bars for the toilet and other assistive devices, if required, to provide for participant safety;
 3. A bathroom has a window that opens or another means of ventilation;
 4. If a bathing facility is provided:
 - a. The bathing facility provides privacy when in use,
 - b. Shower enclosures have nonporous surfaces,
 - c. Showers and tubs have grab bars for participant safety, and
 - d. Tub and shower floors have slip-resistant surfaces;
 5. Dining areas are furnished with dining tables and chairs and large enough to accommodate participants;
 6. There is a wall or other means of physical separation between dining facilities and food preparation areas;
 7. If the adult day health care facility serves food, areas are designated for food preparation, storage, and handling and are not used as a passageway by participants; and
 8. All flooring is slip-resistant.
- F.** If the adult day health care facility has a swimming pool on the premises, an administrator shall ensure that:
 1. The swimming pool is equipped with the following:

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- a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
 - i. A removable strainer,
 - ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
 - iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
- b. An operational vacuum cleaning system;
2. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (F)(2)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground; and
 - iii. Is locked when the swimming pool is not in use;
3. A life preserver or shepherd's crook is available and accessible in the pool area; and
4. If the swimming pool is used by participants, pool safety requirements are conspicuously posted in the pool area.

Historical Note

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3). New Section R9-10-1117 renumbered from Section R9-10-1116 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1118. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1119. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1120. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1121. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1122. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1123. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1124. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1125. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1126. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1127. Repealed**Historical Note**

Adopted effective September 2, 1977 (Supp. 77-5).
 Repealed effective July 22, 1994 (Supp. 94-3).

ARTICLE 12. HOME HEALTH AGENCIES**R9-10-1201. Definitions**

In addition to the definitions in A.R.S. §§ 36-401, 36-151 and R9-10-101, the following apply in this Article, unless otherwise specified:

1. "Branch office" means a location other than a home health agency's main administrative office that:
 - a. Operates under the license of the home health agency, and
 - b. Is under the control of the home health agency's administrator.
2. "Home health services director" means an individual who provides direction for the home health services provided by or through a home health agency.
3. "Medical social services" means activities that assist a patient to cope with concerns about the patient's illness or injury, and may include helping to find resources to address the patient's concerns.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 651 (February 28, 2025), effective April 6, 2025 (Supp. 25-1).

R9-10-1202. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a home health agency shall:

1. Include on the application:
 - a. The name and address of each proposed branch office, if applicable; and
 - b. The geographic region to be served by:

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- i. The proposed home health agency's administrative office, and
 - ii. Each proposed branch office; and
2. Submit to the Department a copy of a valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1 for:
 - a. The applicant, if the applicant is an individual; or
 - b. Each individual with a 10% or greater ownership of the business organization, if the applicant is a business organization.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1203. Administration**A. A governing authority shall:**

1. Consist of one or more individuals responsible for the organization, operation, and administration of the home health agency;
2. Establish, in writing:
 - a. A home health agency's scope of services, and
 - b. Qualifications for an administrator;
3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1204;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present in a home health agency's administrative office for more than 30 calendar days, or
 - b. Not present in a home health agency's administrative office for more than 30 calendar days;
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator;
8. Appoint, according to A.R.S. § 36-151(5)(b), an advisory group that consists of four or more members that include:
 - a. A physician;
 - b. A registered nurse who has at least one year of experience as a registered nurse providing home health services; and
 - c. Two or more individuals who represent a medical, nursing, or health-related profession; and
9. Ensure that the advisory group appointed according to subsection (A)(8):
 - a. Meets at least once every 12 months,
 - b. Documents meetings, and
 - c. Assists in establishing and evaluating policies and procedures for the home health agency.

B. An administrator:

1. Shall serve no more than five home health agencies;
2. Is directly accountable to the governing authority of a home health agency for all services provided by the home health agency;
3. Has the authority and responsibility to manage the home health agency;

4. Except as provided in subsection (A)(6), designates, in writing, an individual who is present at the home health agency's administrative office and accountable for services provided by the home health agency when the administrator is not present at the home health agency's administrative office; and
5. Ensures compliance with A.R.S. § 36-411.

C. An administrator shall:

1. Ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, and volunteers;
 - b. Cover orientation and in-service education for personnel members, employees, and volunteers;
 - c. Cover how a personnel member may submit a complaint relating to patient care;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Include a method to identify a patient to ensure the patient receives the appropriate services;
 - f. Cover patient rights, including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
 - g. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The home health agency to respond to a patient complaint;
 - h. Cover health care directives;
 - i. Cover medical records, including electronic medical records;
 - j. Cover a quality management program, including incident reports and supporting documentation;
 - k. Cover contracted services; and
 - l. Cover and designate which personnel members or employees are required to have current certification in cardiopulmonary resuscitation and first aid training;
2. Ensure that policies and procedures for services provided by a home health agency are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient admission, discharge planning, and discharge;
 - b. Cover the provision of home health services and, if applicable, specific types of supportive services and medical social services;
 - c. Include when general consent and informed consent are required;
 - d. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 - e. Cover medication procurement, if applicable, and administration; and
 - f. Cover infection control;
3. Ensure that policies and procedures are:
 - a. Available to personnel members, employees, and volunteers, and
 - b. Reviewed at least once every three years and updated as needed;
4. Ensure that records of advisory group meetings are maintained for at least 24 months after the date of the meeting;

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5. Designate, in writing, a home health services director who is:
 - a. A physician with at least 24 months of experience working for or with a home health agency; or
 - b. A registered nurse with at least three years of nursing experience, including at least 24 months of experience as a registered nurse providing home health services;
6. Ensure that:
 - a. Speech therapy or speech-language pathology services are provided by a speech-language pathologist according to A.R.S. § 36-1940.01 or speech-language pathologist assistant licensed according to A.R.S. § 36-1940.04;
 - b. Nutritional services are provided by a registered dietitian;
 - c. Occupational therapy services are provided by an occupational therapist or occupational therapy assistant;
 - d. Physical therapy services are provided by a physical therapist or a physical therapist assistant;
 - e. Respiratory care services are provided by a respiratory therapist, respiratory therapy technician licensed according to A.R.S. Title 32, Chapter 35, or a practical nurse or registered nurse licensed according to A.R.S. Title 32, Chapter 15;
 - f. Pharmacy services are provided by a pharmacist; and
 - g. Medical social services are provided:
 - i. By a personnel member qualified according to policies and procedures that coordinates medical social services; and
 - ii. For medical social services, related to the practice of social work in A.R.S. § 32-3251, by a personnel member licensed under A.R.S. Title 32, Chapter 33, Article 5;
7. Ensure that the services specified in subsection (C)(6) are provided to a patient only under an order by the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
8. Unless otherwise stated, ensure that:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a home health agency, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the home health agency.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3391 with an immediate effective date of November 6, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 651 (February 28, 2025), effective April 6, 2025 (Supp. 25-1).

R9-10-1204. Quality Management

An administrator shall ensure that:

1. A plan for a quality management program for the home health agency is established, documented, and implemented that includes:
 - a. A method to identify, document, and evaluate incidents;
 - b. A method to collect data to evaluate the provision of services, including oversight of personnel members;
 - c. A method to evaluate the data collected to identify a concern about the provision of services;
 - d. A method to make changes or take action as a result of the identification of a concern about the provision of services;
 - e. A method to determine whether actions taken improved the provision of services; and
 - f. The frequency of submitting the documented report required in subsection (2) to the governing authority;
2. A documented report is submitted to the governing authority that includes:
 - a. Each identified concern about the delivery of services related to patient care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1205. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1206. Personnel

A. An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired

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- the specific skills and knowledge for the personnel member to provide the expected services listed in the established job description, and
- iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services, and
 - b. According to policies and procedures;
 3. Sufficient personnel members are available with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the home health agency's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient; and
 4. A personnel member, an employee, a volunteer, or a student who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
 - a. On or before the date the individual begins providing services at or on behalf of the home health agency, and
 - b. As specified in R9-10-113.
- B.** An administrator shall ensure that a personnel record for each personnel member, employee, or volunteer:
1. Includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service, and if applicable, ending date; and
 - c. Documentation of:
 - i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education as required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - v. The individual's compliance with the requirements in A.R.S. § 36-411;
 - vi. Cardiopulmonary resuscitation training, if required for the individual according to this Article and policies and procedures;
 - vii. First aid training, if required for the individual according to this Article and policies and procedures; and
 - viii. Evidence of freedom from infectious tuberculosis, if required according to subsection (A)(4);
 2. Is maintained:
 - a. Throughout the individual's period of providing services in or for the home health agency; and
 - b. For at least 24 months after the last date the individual provided services in or for the home health agency; and

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

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3391 with an immediate effective date of November 6, 2019 (Supp. 19-4). Amended by final expedited rulemaking, at 25 A.A.R. 3391 with an immediate effective date of November 6, 2019 (Supp. 19-4).

R9-10-1207. Care Plan

- A.** An administrator shall ensure that a care plan is developed for each patient:
1. Based on an assessment of the patient as required in R9-10-1210(D)(1) or (F)(2)(e)(i);
 2. With participation from:
 - a. The patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
 - b. A registered nurse;
 3. That includes:
 - a. The patient's diagnosis;
 - b. Surgery dates relevant to home health services, if applicable;
 - c. The patient's cognitive awareness of self, location, and time;
 - d. Functional abilities and limitations;
 - e. Goals for functional rehabilitation, if applicable;
 - f. The type, duration, and frequency of each service to be provided;
 - g. Treatments the patient is receiving from a source other than the home health agency;
 - h. Medications and herbal supplements reported by the patient or the patient's representative as being used by the patient, and the dose, route of administration, and schedule for administration of each medication or herbal supplement;
 - i. Any known drug allergies;
 - j. Nutritional requirements and preferences;
 - k. Specific measures to improve the patient's safety and protect the patient against injury; and
 - l. A discharge plan for the patient including, if applicable, a plan for assessing the accomplishment of treatment or therapy goals for the patient; and
 4. That is established and implemented within five days of start of care.
- B.** An administrator shall ensure that:
1. Home health services are provided to a patient by the home health agency according to the patient's care plan;
 2. The patient's care plan is reviewed and updated:
 - a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of the services being provided;
 - b. If the patient's physician, registered nurse practitioner, or podiatrist, as applicable, orders a change in the care plan; and
 - c. At least every 60 calendar days;
 3. The patient's care plan is reviewed and documented by a registered nurse, an occupational therapist, an occupational therapist assistant, a physical therapist, or a physi-

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- cal therapist assistant, with the patient or the patient's representative at least every 30 calendar days;
4. The patient's physician, physician assistant, registered nurse practitioner, or podiatrist, as applicable, authenticates the care plan with a signature within 30 calendar days after the care plan is initially developed and whenever the care plan is updated; and
 5. A home health agency documents and responds to a referral from a health care provider within 48 hours of receiving the referral.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 651 (February 28, 2025), effective April 6, 2025 (Supp. 25-1).

R9-10-1208. Patient Rights**A.** An administrator shall ensure that:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted at the home health agency's administrative office;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
 - b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by a home health agency's personnel members, employees, or volunteers; and
3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed alternatives to a psychotropic medication and the associated risks and possible complications of a psychotropic medication;
 - d. Is informed of the following:
 - i. The home health agency's policy on health care directives;
 - ii. The patient complaint process;

- iii. Home health services provided by or through the home health agency; and
- iv. The rates and charges for services before the services are initiated and before a change in rates, charges, or services;
- e. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a home health agency for identification and administrative purposes; and
- f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.

C. A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the home health agency is not authorized or not able to provide physical health services needed by the patient;
6. To participate or have the patient's representative participate in the development of a care plan or decisions concerning treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1209. Medical Records**A.** An administrator shall ensure that:

1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
 - a. Recorded only by an individual authorized by policies and procedures to make the entry;
 - b. Dated, timed, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a physician, registered nurse practitioner, or podiatrist according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the physician, registered nurse practitioner, or podiatrist issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signa-

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- ture the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to personnel members, physicians, registered nurse practitioners, or podiatrists authorized by policies and procedures to access the patient's medical record;
 6. Information in a patient's medical record is disclosed to an individual not authorized under subsection (A)(5) only with the written consent of a patient or the patient's representative or as permitted by law; and
 7. A patient's medical record is protected from loss, damage, or unauthorized use.
- B.** If a home health agency maintains patients' medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
 - a. The patient's name;
 - b. The patient's address and telephone number;
 - c. The patient's date of birth; and
 - d. Any known allergies, including medication allergies;
 2. The date the patient began receiving services from the home health agency and, if applicable, the date the patient stopped receiving services from the home health agency;
 3. The name and telephone of the patient's physician or registered nurse practitioner;
 4. The name and telephone number of patient's podiatrist, if applicable;
 5. Documentation of general consent and, if applicable, informed consent;
 6. Documentation of medical history and current diagnoses;
 7. A copy of the patient's health care directive, if applicable;
 8. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Is a legal guardian, a copy of the court order establishing guardianship; or
 - ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
 9. Orders;
 10. Assessments;
 11. Care plan;
 12. Progress notes;
 13. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 14. Documentation of meetings with the patient to assess the home health services and supportive services provided to the patient;
 15. The disposition of the patient upon discharge;
 16. The discharge plan;
 17. Discharge instructions and discharge summary, if applicable;
 18. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Diagnostic reports, and
 - d. Consultation reports;
 19. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and
 - f. Any adverse reaction a patient has to the medication;
 20. Documentation of tasks assigned to a home health aide or other personnel member;
 21. Documentation of coordination of patient care;
 22. Copies of patient summary reports sent to the patient's physician, registered nurse practitioner, or podiatrist, as applicable; and
 23. Documentation of contacts with the patient's physician, registered nurse practitioner, or podiatrist, as applicable, by a personnel member or the patient.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 651 (February 28, 2025), effective April 6, 2025 (Supp. 25-1).

R9-10-1210. Home Health Services

- A.** An administrator shall ensure that an individual admitted to the home health agency has an order from a physician, registered nurse practitioner, physician assistant, or podiatrist for home health services.
- B.** An administrator shall ensure that the home health services director provides direction for home health services provided by or through the home health agency.
- C.** A home health services director shall ensure that nursing services are provided by a registered nurse or practical nurse, according to policies and procedures.
- D.** A home health services director shall ensure that a registered nurse:
1. Unless a patient's physician, physician assistant, or registered nurse practitioner orders only speech therapy, occupational therapy, or physical therapy for the patient, within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts and document an initial assessment of the patient to determine:
 - a. The needs of the patient;
 - b. Resources available to address the patient's needs;

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- c. The patient's home and family environment;
 - d. Goals for patient care;
 - e. Medications used by the patient, including non-compliance, drug interactions, side effects, and contraindications; and
 - f. Medical supplies or equipment needed by the patient;
2. Reviews a patient's health care directives at the time of the initial assessment;
 3. Implements a patient's care plan, developed as specified in R9-10-1207;
 4. Coordinates patient care with other individuals providing home health services or other services to the patient;
 5. Immediately informs the patient's physician or registered nurse practitioner of a change in a patient's condition that requires medical services; and
 6. At least every 60 calendar days until a patient is discharged:
 - a. Reassesses the patient based on the patient's care plan, needs, and medical condition; and
 - b. Summarizes the patient's condition and needs for the patient's physician, registered nurse practitioner, or podiatrist, as applicable.
- E.** A home health services director shall ensure that:
1. A patient's condition and the services provided to the patient are documented in the patient's medical record after each patient contact; and
 2. Verbal orders from a patient's physician, registered nurse practitioner, or podiatrist, as applicable, are:
 - a. Except as specified in subsection (F)(2)(d), received by a registered nurse and documented by the registered nurse in the patient's medical record; and
 - b. Authenticated by the patient's physician, registered nurse practitioner, or podiatrist, as applicable, with a signature, within 30 calendar days.
- F.** A home health services director shall ensure that:
1. A registered nurse:
 - a. Except as specified in subsection (F)(2)(b)(i) and (ii):
 - i. Assigns tasks in writing to a home health aide or licensed health aide who is providing home health services to a patient; and
 - ii. Verifies the competency of the home health aide or licensed health aide in performing assigned tasks;
 - b. Except as specified in subsection (F)(2)(b)(iii), provides direction for the home health aide or licensed health aide services provided to a patient; and
 - c. Except as specified in subsection (F)(2)(e)(ii), meets with a patient who is receiving home health aide or licensed health aide services to assess the home health services provided by the home health aide or licensed health aide:
 - i. At least every two weeks when the patient is also receiving nursing services or therapy services; and
 - ii. At least every 60 calendar days when the patient is only receiving home health aide or licensed health aide services;
 2. When a patient's physician or registered nurse practitioner orders speech therapy, occupational therapy, or physical therapy for the patient, an individual specified in R9-10-1203(C)(6)(a), (c), or (d), as applicable:
 - a. Provides the applicable therapy service to the patient according to the patient's care plan;
 - b. If a home health aide or licensed health aide is assigned to assist the patient in performing activities related to the therapy service:
 - i. Assigns tasks in writing to the home health aide or licensed health aide who is assisting the patient;
 - ii. Verifies the competency of the home health aide or licensed health aide in performing assigned tasks; and
 - iii. Provides direction to the home health aide or licensed health aide in performing the assigned tasks related to the therapy service;
 - c. Coordinates the provision of the therapy service to the patient with the registered nurse providing direction for other home health services for the patient;
 - d. Documents in the patient's medical record any orders by the patient's physician or registered nurse practitioner received concerning the therapy service; and
 - e. If the only home health services ordered for the patient are speech therapy, occupational therapy, or physical therapy:
 - i. Within 48 hours after the patient begins receiving home health services provided by or through the home health agency, conducts an initial assessment of the patient as specified in subsections (D)(1)(a) through (f); and
 - ii. Meets with a patient who is receiving home health services from a home health aide or licensed health aide every two weeks to assess the home health services provided by the home health aide; and
 3. A home health aide:
 - a. Is only assigned to provide services the home health aide can competently perform; and
 - b. Only performs tasks assigned to the home health aide in writing by a registered nurse or as specified in subsection (F)(2)(b)(i).
 4. A licensed health aide:
 - a. Is only licensed to provide services the licensed health aide can competently perform, and
 - b. Only performs tasks assigned to the licensed health aide in writing by a registered nurse and as specified under A.R.S. § 32-1601(14).

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 651 (February 28, 2025), effective April 6, 2025 (Supp. 25-1).

R9-10-1211. Supportive Services

- A.** A governing authority may include supportive services, including personal care services, in the scope of services for a home health agency.
- B.** An administrator:
1. May allow:
 - a. Supportive services to be provided to a patient without an order from a physician, registered nurse practitioner, or podiatrist; and

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- b. A personnel member who is not a home health aide to perform personal care services; and
- 2. Shall ensure that:
 - a. Supportive services are provided to a patient according to policies and procedures;
 - b. A registered nurse:
 - i. Assesses a patient's need for supportive services,
 - ii. Assigns specific tasks in writing to a home health aide providing supportive services other than personal care services,
 - iii. Assigns specific tasks in writing to a personnel member providing personal care services,
 - iv. Provides direction for supportive services, and
 - v. Includes supportive services in the reassessment of a patient required in R9-10-1210(D)(6); and
 - c. Supportive services are documented in a patient's medical record.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1212. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1213. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1214. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1215. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1216. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1217. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1218. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1219. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1220. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1221. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1222. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1223. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1224. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1225. Reserved**R9-10-1226. Repealed****Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1227. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1228. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

R9-10-1229. Reserved

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R9-10-1230. Repealed**Historical Note**

Adopted effective February 4, 1981 (Supp. 81-1). Section repealed by final rulemaking at 8 A.A.R. 3721, effective August 9, 2002 (Supp. 02-3).

ARTICLE 13. BEHAVIORAL HEALTH SPECIALIZED TRANSITIONAL FACILITY**R9-10-1301. Definitions**

Definitions in A.R.S. § 36-401 and R9-10-101 apply in this Article unless otherwise specified.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Reference in paragraph (24) corrected (Supp. 94-2). Section R9-10-1301 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-1302. Administration

A. The governing authority for a behavioral health specialized transitional facility:

1. Is the superintendent of the state hospital; and
2. Shall:
 - a. Establish, in writing:
 - i. A behavioral health specialized transitional facility's scope of services; and
 - ii. Qualifications for an administrator;
 - b. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(a)(ii);
 - c. Adopt a quality management program according to R9-10-1303;
 - d. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
 - e. Designate an acting administrator, in writing, who has the qualifications established in subsection (A)(2)(a)(ii), if the administrator is:
 - i. Expected not to be present on the behavioral health specialized transitional facility's premises for more than 30 calendar days; or
 - ii. Not present on the behavioral health specialized transitional facility's premises for more than 30 calendar days; and
 - f. Except as provided in subsection (A)(2)(e), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

B. An administrator:

1. Is directly accountable to the superintendent of the state hospital for the daily operation of the behavioral health specialized transitional facility and for all services pro-

vided by or at the behavioral health specialized transitional facility;

2. Has the authority and responsibility to manage the behavioral health specialized transitional facility; and
3. Except as provided in subsection (A)(2)(e), designates, in writing, an individual who is present on the behavioral health specialized transitional facility's premises and accountable for the behavioral health specialized transitional facility when the administrator is not present on the behavioral health specialized transitional facility's premises.

C. An administrator shall ensure that:

1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Cover patient admission, assessment, treatment plan, transfer, discharge planning, and recordkeeping;
 - d. Cover discharge, including the amount of medication provided to a patient at discharge, based on an assessment of the patient's medical condition;
 - e. 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;
 - f. Cover the requirements in A.R.S. §§ 36-3708, 36-3709, and 36-3714;
 - g. Establish the process for warning an identified or identifiable individual, as described in A.R.S. § 36-517.02 (B) through (C), if a patient communicates to a personnel member a threat of imminent serious physical harm or death to the identified or identifiable individual and the patient has the apparent intent and ability to carry out the threat;
 - h. Cover when informed consent is required and how informed consent is obtained;
 - i. Cover the criteria and process for conducting research using patients or patients' medical records;
 - j. Include the establishment of, disbursing from, and recordkeeping for a patient personal funds account;
 - k. Include a method of patient identification to ensure a patient receives the services ordered for the patient;
 - l. Cover contracted services;
 - m. Cover health care directives;
 - n. Cover medical records, including electronic medical records;
 - o. Cover medication procurement, storage, inventory monitoring and control, and disposal;
 - p. Cover infection control;
 - q. Cover and designate which personnel members or employees are required to have current certification in cardiopulmonary resuscitation and first aid training;
 - r. Cover environmental services that affect patient care;
 - s. Cover training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect and reporting suspected or alleged

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- abuse, neglect, exploitation, or other criminal activity;
- t. Cover quality management, including incident reports and supporting documentation;
- u. Cover emergency treatment and disaster plan;
- v. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
- w. Include security of the facility, patients and their possessions, personnel members, and visitors at the behavioral health specialized transitional facility;
- x. Include preventing unauthorized patient absences;
- y. Cover transportation of patients, including the criteria for using a locking mechanism to restrict a patient's movement during transportation;
- z. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The behavioral health specialized transitional facility to respond to a patient's complaint;
- aa. Cover visitation, telephone usage, sending or receiving mail, computer usage, and other recreational activities;
- bb. Include equipment inspection and maintenance; and
- cc. Cover religious visitation by a clergy member in compliance with A.R.S. § 36-407.02;
- 2. Policies and procedures are available to each personnel member;
- 3. Laboratory services are provided by a laboratory that holds a certificate of accreditation or certificate of compliance issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
- 4. Food services are provided as specified in R9-10-1314;
- 5. The following individuals have access to a patient:
 - a. The patient's representative,
 - b. An individual assigned by a court of law to provide services to the patient, and
 - c. An attorney hired by the patient or patient's family;
- 6. Labor performed by a patient for the behavioral health specialized transitional facility is consistent with A.R.S. § 36-510 and applicable state and federal law; and
- 7. The following information is posted in an area easily viewed by a patient or an individual entering or leaving the behavioral health specialized transitional facility:
 - a. Patient rights,
 - b. Telephone number for the Department and the Office of Human Rights,
 - c. Location of inspection reports,
 - d. Complaint procedures, and
 - e. Visitation hours and procedures.
- D. An administrator shall:
 - 1. Provide written notification to the Department of a patient's:
 - a. Death, if the patient's death is required to be reported according to A.R.S. § 11-593, within one working day after the patient's death;
 - b. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical service provider; and
 - c. Absence, within one working day after an unauthorized patient absence from the behavioral health specialized transitional facility is discovered;
 - 2. Maintain the documentation required in subsection (D)(1) for at least 12 months after the date of the notification; and
 - 3. Ensure that sufficient personnel are present at the behavioral health specialized transitional facility at all times to maintain safe and secure conditions.
- E. If an administrator has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while the patient is receiving services from an employee or personnel member of the behavioral health specialized transitional facility, the administrator shall:
 - 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the patient according to A.R.S. § 46-454;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation of the patient;
 - b. Any action taken according to subsection (E)(1); and
 - c. The report in subsection (E)(2);
 - 4. Maintain the documentation required in subsection (E)(3) for at least 12 months after the date of the report;
 - 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (E)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the patient related to the abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 - 6. Maintain a copy of the documented information required in subsection (E)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- F. An administrator shall:
 - 1. Unless otherwise stated, ensure that:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a behavioral health specialized transitional facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the behavioral health specialized transitional facility;
 - 2. Appoint a medical director, to direct the medical and nursing services provided by or at the behavioral health specialized transitional facility, who:
 - a. Is a medical staff member, and
 - b. Has at least two years of experience providing services in an organized psychiatric services unit of a hospital or in a behavioral health facility; and
 - 3. Appoint a clinical director, to provide direction for the behavioral health services provided by or at the behavioral health specialized transitional facility, who:

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- a. Is a psychiatrist or a psychologist;
 - b. Has at least two years of experience providing services in an organized psychiatric services unit of a hospital or in a behavioral health facility; and
 - c. May, if qualified, also serve as the medical director.
- G. A medical director:**
- 1. Is responsible for the medical services, nursing services, and physical health-related services provided to patients consistent with the patients behavioral treatment plan; and
 - 2. Shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Restraint and seclusion, according to R9-10-225;
 - b. The process for patient assessments, including the identification of and criteria for the on-going monitoring of a patient's physical health conditions;
 - c. Dispensing and administration of medications, including the process and criteria for determining whether a patient is capable of and eligible to self-administer medication;
 - d. The process by which emergency medical treatment will be provided to a patient; and
 - e. The requirements for completion of medication records and recording of adverse events.
- H. A clinical director:**
- 1. Is responsible for the behavioral health services provided to patients;
 - 2. Shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that cover:
 - a. Assessing the competency and proficiency of a behavioral health personnel member for each type of service the personnel member provides and each type of patient to which the personnel member is assigned;
 - b. Providing:
 - i. Supervision to behavioral health paraprofessionals, according to R9-10-115(2); and
 - ii. Clinical oversight to behavioral health technicians, according to R9-10-115(3);
 - c. The qualifications for personnel members who provide clinical oversight;
 - d. The process for patient assessments, including the identification of and criteria for the on-going monitoring of a patient's behavioral health issues;
 - e. The process for developing and implementing a patient's treatment plan;
 - f. The frequency of and process for reviewing and modifying a patient's treatment plan, based on the ongoing monitoring of the patient's response to treatment; and
 - g. The process for determining whether a patient is eligible for discharge or conditional release to a less restrictive alternative;
 - 3. Shall ensure that patient services are provided by personnel that are competent and proficient in providing the services; and
 - 4. Shall ensure that clinical oversight of personnel members is provided according to the policies and procedures.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective

February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1302 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1303. 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 services provided to patients;
 - 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 change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1303 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the

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Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1304. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted without change effective November 25, 1992 (Supp. 92-4). Section R9-10-1304 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1305. Personnel Requirements and Records

A. An administrator shall ensure that a personnel member:

1. Is at least 18 years old; and
2. Either:
 - a. Holds a valid fingerprint clearance card issued under A.R.S. Title 41, Chapter 12, Article 3.1; or
 - b. Submits to the administrator a copy of a fingerprint clearance card application showing that the personnel member submitted the application to the fingerprint division of the Department of Public Safety under A.R.S. § 41-1758.02 within seven working days after becoming a personnel member.

B. An administrator shall ensure that each personnel member submits to the administrator a copy of the individual's valid fingerprint clearance card:

1. Except as provided in subsection (A)(2)(b), before the personnel member's starting date of employment; and
2. Each time the fingerprint clearance card is issued or renewed.

C. If a personnel member holds a fingerprint clearance card that was issued before the individual became a personnel member, an administrator shall:

1. Contact the Department of Public Safety within seven working days after the individual becomes a personnel member to determine whether the fingerprint clearance card is valid; and
2. Make a record of this determination, including the name of the personnel member, the date of the contact with the Department of Public Safety, and whether the fingerprint clearance card is valid.

D. An administrator shall ensure:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures; and
3. Personnel members are present on a behavioral health specialized transitional facility's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the behavioral health specialized transitional facility's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient.
- E. An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.
- F. An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a patient for more than eight hours a week, provides evidence of freedom from infectious tuberculosis:
 1. On or before the date the individual begins providing service at or on behalf of the behavioral health specialized transition facility, and
 2. As specified in R9-10-113.
- G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
 1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;

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- c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - f. Cardiopulmonary resuscitation training, if required for the individual according to this Article or policies and procedures;
 - g. First aid training, if required for the individual according to this Article or policies and procedures;
 - h. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F); and
 - i. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training.
- H.** An administrator shall ensure that personnel records are maintained:
- 1. Throughout an individual's period of providing services in or for the behavioral health specialized transitional facility; and
 - 2. For at least 24 months after the last date the individual provided services in or for the behavioral health specialized transitional facility.
- I.** An administrator shall ensure that:
- 1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented.
 - 2. A personnel member completes orientation before providing behavioral health services or physical health services;
 - 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 - 4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented and implemented;
 - 5. A personnel member's in-service education 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; and
 - 6. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1305 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the

Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1306. Admission Requirements

- A.** An administrator shall ensure that, before a patient is admitted to the behavioral health specialized transitional facility, a court of competent jurisdiction has ordered the patient to be:
- 1. Detained under A.R.S. § 36-3705(B) or § 36-3713(B); or
 - 2. Committed under A.R.S. § 36-3707.
- B.** An administrator shall ensure that, at the time a patient is admitted to the behavioral health specialized transitional facility:
- 1. The administrator receives a copy of the court order for the patient to be detained at or committed to the behavioral health specialized transitional facility,
 - 2. The patient's possessions are taken to the bedroom to which the patient has been assigned, and
 - 3. The patient is provided with a written list and verbal explanation of the patient's rights and responsibilities.
- C.** Within seven calendar days after a patient is admitted to the behavioral health specialized transitional facility, a medical director shall ensure that:
- 1. A medical history is taken from the patient and a physical examination performed on the patient;
 - 2. Except as specified in subsection (C)(3), a patient provides evidence of freedom from infectious tuberculosis as required in R9-10-113;
 - 3. A patient is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
 - a. Fewer than 12 months have passed since the patient was screened for tuberculosis, and
 - b. The documentation of freedom from infectious tuberculosis required in subsection (C)(2) accompanies the patient at the time of the patient's admission to the behavioral health specialized transitional facility; and
 - 4. An assessment for the patient is completed:
 - a. According to the behavioral health specialized transitional facility's policies and procedures;
 - b. That includes the patient's:
 - i. Legal history, including criminal justice record;
 - ii. Behavioral health treatment history;
 - iii. Medical conditions and history; and
 - iv. Symptoms reported by the patient and referrals needed by the patient, if any; and
 - c. That includes:
 - i. Recommendations for further assessment or examination of the patient's needs,
 - ii. The physical health services or ancillary services that will be provided to the patient until the patient's treatment plan is completed; and
 - iii. The signature of the personnel member conducting the assessment and the date signed.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days

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(Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1306 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

Amended by final expedited rulemaking at 28 A.A.R. 1113 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1307. Discharge or Conditional Release to a Less Restrictive Alternative

- A.** An administrator shall ensure that annual written notice is given to a patient of the patient's right to petition for:
 1. Conditional release to a less restrictive alternative under A.R.S. § 36-3709, or
 2. Discharge under A.R.S. § 36-3714.
- B.** An administrator shall ensure that a patient who is detained at or committed to the behavioral health specialized transitional facility is transported to a hearing to determine the patient's continued detention at or commitment to the behavioral health specialized transitional facility.
- C.** An administrator shall ensure that a patient is not discharged or conditionally released to a less restrictive alternative before the behavioral health specialized transitional facility receives documentation from a court of competent jurisdiction of the patient's:
 1. Conditional release to a less restrictive alternative, or
 2. Discharge including the disposition of the patient upon discharge.
- D.** A clinical director shall ensure that before a patient is discharged or conditionally released to a less restrictive alternative:
 1. The clinical director or the clinical director's designee, as specified in the behavioral health specialized transitional facility's discharge policies and procedures, receives the name of the health care provider or behavioral health professional to whom a copy of the patient's discharge summary will be sent; and
 2. The patient receives:
 - a. Written follow-up instructions including as applicable to the patient:
 - i. On-going behavioral health issues and physical health conditions;
 - ii. A list of the patient's medications and, for each medication, directions for taking the medication, possible side-effects, and possible results of not taking the medication; and
 - iii. Counseling goals; and

- b. A supply of medications determined according to the policies and procedures specified in R9-10-1302(C)(1)(d).

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1307 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

R9-10-1308. Transportation

An administrator of a behavioral health specialized transitional facility that uses a vehicle owned or leased by the behavioral health specialized transitional facility to provide transportation to a patient shall ensure that:

1. The vehicle:
 - a. Is safe and in good repair,
 - b. Contains a locked first aid kit,
 - c. Contains a working heating and air conditioning system, and
 - d. Contains drinking water sufficient to meet the needs of each patient present in the vehicle;
2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
3. A driver of the vehicle:
 - a. Is 21 years of age or older,
 - b. Has a valid driver license,
 - c. Operates the vehicle in a manner that does not endanger a patient in the vehicle,
 - d. Does not leave a patient in the vehicle unattended, and
 - e. Ensures the safe and hazard-free loading and unloading of patients; and
4. Transportation safety is maintained as follows:
 - a. Each individual in the vehicle is sitting in a seat and wearing a working seat belt while the vehicle is in motion, and
 - b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a patient's body.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to

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A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1308 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1309. Patient Rights

An administrator shall ensure that:

1. A patient:
 - a. Has privacy in treatment and personal care needs;
 - b. Has the opportunity for and privacy in correspondence, communications, and visitation unless:
 - i. Restricted by court order; or
 - ii. Contraindicated on the basis of clinical judgment, as documented in the patient's medical record;
 - c. Is given the opportunity to seek, speak to, and be assisted by legal counsel:
 - i. Whom the court assigns to the patient, or
 - ii. Whom the patient obtains at the patient's own expense; and
 - d. Is not subjected to:
 - i. Abuse;
 - ii. Neglect;
 - iii. Exploitation;
 - iv. Coercion;
 - v. Manipulation;
 - vi. Seclusion, if not necessary to prevent imminent harm to self or others;
 - vii. Restraint, if not necessary to prevent imminent harm to self or others;
 - viii. Sexual abuse according to A.R.S. § 13-1404; or
 - ix. Sexual assault according to A.R.S. § 13-1406; and
2. A patient or the patient's representative:
 - a. Is provided with the opportunity to participate in the development of the patient's treatment plan and in treatment decisions before the treatment is initiated, except in a medical emergency;
 - b. Is provided with information about proposed treatments, alternatives to treatments, associated risks, and possible complications;
 - c. Is allowed to control the patient's finances and have access to the patient's personal funds account according to the behavioral health specialized transitional facility's policies and procedures specified in R9-10-1302(C)(1)(j);
 - d. Has an opportunity to review the medical record for the patient according to the behavioral health specialized transitional facility's policies and procedures; and
 - e. Receives information about the behavioral health specialized transitional facility's policies and procedures for:
 - i. Health care directives;
 - ii. Filing complaints, including the telephone number of an individual at the behavioral health specialized transitional facility to contact

about a complaint and the Department's telephone number; and

- iii. Petitioning a court for a patient's discharge or conditional release to a less restrictive alternative.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1309 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

R9-10-1310. Behavioral Health Services

A. A clinical director shall ensure that:

1. A treatment plan is developed and implemented for the patient:
 - a. According to the behavioral health specialized transitional facility's policies and procedures;
 - b. Based on the assessment conducted under R9-10-1306(C)(4) and on-going changes to the assessment of the patient's behavioral health issues, mental disorders, and physical health conditions, as applicable; and
 - c. Including:
 - i. The physical health services, behavioral health services, and ancillary services to be provided to the patient until completion of the treatment plan;
 - ii. The type, frequency, and duration of counseling or other treatment ordered for the patient;
 - iii. The name of each individual who ordered medication, counseling, or other treatment for the patient;
 - iv. The signature of the patient or the patient's representative and dated signed, or documentation of the refusal to sign;
 - v. The date when the patient's treatment plan will be reviewed;
 - vi. If a discharge date has been determined, the treatment needed after discharge; and
 - vii. The signature of the personnel member who developed the treatment plan and the date signed; and
2. A patient's treatment plan is reviewed and updated:
 - a. According to the review date specified in the treatment plan,
 - b. When a treatment goal is accomplished or changes,

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- 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.** A clinical director shall ensure that treatment is:
 - 1. Offered to a patient according to the patient's treatment plan;
 - 2. Except for a patient obtaining treatment under A.R.S. § 36-512, only provided after obtaining informed consent to the treatment from the patient; and
 - 3. Documented in the patient's medical record as specified in R9-10-1312.
- C.** The clinical director shall ensure that restraint and seclusion are used, performed, and documented according to the behavioral health specialized transitional facility's policies and procedures.
- D.** A clinical director shall ensure that:
 - 1. A patient receives the annual examination required by A.R.S. § 36-3708, and
 - 2. A report of the patient's annual examination is prepared according to the behavioral health specialized transitional facility's policies and procedures.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1310 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

R9-10-1311. Physical Health Services

- A.** A medical director shall ensure that:
 - 1. A patient's physical health is assessed during the physical examination specified in R9-10-1306(C)(1), and
 - 2. Any physical health conditions identified through the assessment are addressed in the patient's treatment plan.
- B.** A medical director shall ensure that on-going assessment or treatment of a patient's physical health condition is:
 - 1. Offered to a patient according to the patient's treatment plan;
 - 2. Except for a patient obtaining treatment under A.R.S. § 36-512, only provided after obtaining informed consent to the assessment or treatment from the patient; and
 - 3. Documented in the patient's medical record as specified in R9-10-1312.
- C.** An administrator shall ensure that, if a patient requires assessment or treatment not available at the behavioral health specialized transitional facility, the patient is provided with

transportation to the location where assessment or treatment may be provided to the patient.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1311 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1312. Medical Records

- A.** An administrator shall ensure that:
 - 1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
 - 2. An entry in a patient's medical record is:
 - a. Recorded only by an individual authorized by 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 patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to facility policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or the electronic signature;
 - 5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
 - c. As permitted by law;
 - 6. A patient's medical record is available to the patient or patient's representative upon request at a time agreed upon by the patient or patient's representative and the administrator; and
 - 7. A patient's medical record is protected from loss, damage, or unauthorized use.
- B.** If a behavioral health specialized transitional facility maintains patient's medical records electronically, an administrator shall ensure that:
 - 1. Safeguards exist to prevent unauthorized access, and

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2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C. An administrator shall ensure that a patient's medical record contains:
 1. A copy of the court order requiring the patient to be detained at or committed to the behavioral health specialized transitional facility;
 2. The date the patient was detained at or committed to the behavioral health specialized transitional facility;
 3. Patient information that includes:
 - a. The patient's name;
 - b. The patient's address;
 - c. The patient's date of birth; and
 - d. Any known allergies, including medication allergies;
 4. Documentation of the patient's freedom from infectious tuberculosis as required in R9-10-1306(C)(2);
 5. Documentation of general consent and, if applicable, informed consent for treatment by the patient or the patient's representative, except in an emergency;
 6. If applicable, the name and contact information of the patient's representative and:
 - a. The document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Is a legal guardian, a copy of the court order establishing guardianship; or
 - ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
 7. Documentation of medical history and physical examination of the patient;
 8. A copy of patient's health care directives, if applicable;
 9. Orders;
 10. The patient's assessment including updates;
 11. The patient's treatment plan including updates;
 12. Progress notes;
 13. Documentation of transportation provided to the patient;
 14. Documentation of behavioral health services and physical health services provided to the patient;
 15. Documentation of patient's annual examination and report required by A.R.S. § 36-3708;
 16. Documentation of the annual written notice of the patient of the patient's right to petition for:
 - a. Conditional release to a less restrictive alternative as required by A.R.S. § 36-3709, or
 - b. Discharged as required by A.R.S. § 36-3714;
 17. A copy of any petition for discharge or conditional release to a less restrictive alternative filed by the patient and provided to the behavioral health specialized transitional facility and the outcome of the petition;
 18. Documentation of the patient's, if applicable:
 - a. Conditional release to a less restrictive alternative; or
 - b. Discharge, including the disposition of the patient upon discharge;
 19. If a patient has been discharged, a discharge summary that includes:
 - a. A summary of the treatment provided to the patient;
 - b. The patient's progress in meeting treatment goals, including treatment goals that were and were not achieved;
 - c. The name, dosage, and frequency of each medication for the patient ordered at the time of the patient's discharge from the behavioral health specialized transitional facility;
 - d. A description of the disposition of the patient's possessions, funds, or medications; and
 - e. The date the patient was discharged from the behavioral health specialized transitional facility;
 20. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Diagnostic reports,
 - d. Documentation of restraint or seclusion,
 - e. Patient follow-up instructions, and
 - f. Consultation reports; and
 21. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication;
 - f. Any adverse reaction a patient has to the medication; and
 - g. If applicable, a patient's refusal to take medication ordered for the patient.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1312 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 24 A.A.R. 2764, effective September 11, 2018 (Supp. 18-3).

R9-10-1313. Medication Services

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- A.** An administrator shall ensure that policies and procedures for medication services:
1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient, including:
 - 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:
 - i. A medication error,
 - ii. An adverse response to a medication, or
 - iii. A medication overdose;
 - c. Procedures for documenting medication services and assistance in the self-administration of medication; and
 - d. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 2. 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.** A medical director shall ensure that:
1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication; and
 - c. Ensure that medication is administered to a patient only as prescribed;
 2. A patient's refusal to take prescribed medication is documented in the patient's medical record;
 3. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
 4. A medication administered to a patient:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the patient's medical record; and
 5. If pain medication is administered to a patient on a PRN basis, documentation in the patient's medical record includes:
 - a. An identification of the patient's pain before administering the medication, and
 - b. The effect of the pain medication administered.
- C.** If a behavioral health specialized transitional facility provides assistance in the self-administration of medication, a medical director shall ensure that:
1. A patient's medication is stored by the behavioral health specialized transitional facility;
 2. The following assistance is provided to a patient:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the patient;
 - c. Observing the patient while the patient removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
 - i. The patient taking the medication is the individual stated on the medication container label,
 - ii. The dosage of the medication is the same as stated on the medication container label, and
 - iii. The medication is being taken by the patient at the time stated on the medication container label; and
 - e. Observing the patient while the patient takes the medication;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. Process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a medical practitioner or nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a patient:
 - a. Is in compliance with an order, and
 - b. Is documented in the patient's medical record.
- D.** 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; and
 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.
- E.** When medication is stored at a behavioral health specialized transitional facility, an administrator shall ensure that:
1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication;
 2. Medication is stored according to the instructions on the medication container; and
 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication;

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- d. Storing, inventorying, and dispensing controlled substances; and
 - e. Documenting the maintenance of a medication requiring refrigeration.
- F.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the behavioral health specialized transitional facility's medical director.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1313 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1314. Food Services**A.** An administrator shall ensure that:

1. The behavioral health specialized transitional facility has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
2. A copy of the behavioral health specialized transitional facility's food establishment license is maintained;
3. If a behavioral health specialized transitional facility contracts with a food establishment, as defined in 9 A.A.C. 8, Article 1, to prepare and deliver food to the behavioral health specialized transitional facility:
 - a. A copy of the food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the behavioral health specialized transitional facility; and
 - b. The behavioral health specialized transitional facility is able to store, refrigerate, and reheat food to meet the dietary needs of a patient;
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. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one day before the first meal on the food menu will be served,

- d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
2. Meals and snacks provided by the behavioral health specialized transitional facility are served according to posted menus;
 3. Meals for each day are planned using the applicable dietary guidelines according to the U.S. Department of Health and Human Services and the U.S. Department of Agriculture;
 4. A patient is provided:
 - a. A diet that meets the patient's nutritional needs as specified in the patient's assessment plan;
 - b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (B)(4)(d);
 - c. The option to have a daily evening snack identified in subsection (B)(4)(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 group 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;
 5. 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
 6. Water is available and accessible to a patient at all times, unless otherwise specified in the 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. 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;
 4. Potentially hazardous food is maintained as follows:
 - a. Foods requiring refrigeration are maintained at 41° F or below; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and ground meats are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. Roast beef and beef steak are cooked to an internal temperature of at least 155° F; and

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- vi. Leftovers are reheated to a temperature of at least 165° F;
- 5. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed 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.

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1314 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). New Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1315. Emergency and Safety Standards

- A.** A medical director shall ensure that policies and procedures for providing medical emergency treatment to a patient are established, documented, and implemented and include:
 - 1. The medications, supplies, and equipment required on the premises for the medical emergency treatment provided by the behavioral health specialized transitional facility;
 - 2. A system to ensure all medications, supplies, and equipment are available, have not been tampered with, and, if applicable, have not expired;
 - 3. A requirement that a cart or container is available for medical emergency treatment that contains all of the medication, supplies, and equipment specified in the behavioral health specialized transitional facility's policies and procedures;
 - 4. A method to verify and document that the contents of the cart or container in subsection (A)(3) are available for medical emergency treatment; and
 - 5. A method for ensuring a patient may be transported to a hospital or other health care institution to receive treatment for a medical emergency that the behavioral health specialized transitional facility is not able or not authorized to provide.
- B.** An administrator shall ensure that medical emergency treatment is provided to a patient admitted to the behavioral health specialized transitional facility according to the behavioral health specialized transitional facility's policies and procedures.
- C.** An administrator shall ensure that the behavioral health specialized transitional facility has:

- 1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and a sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order; or
- 2. An alternative method to ensure a patient's safety, documented and approved by the local jurisdiction.
- D.** An administrator shall ensure that:
 - 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. Procedures for protecting the health and safety of patients and other individuals at the behavioral health specialized transitional facility;
 - b. When, how, and where patients will be relocated;
 - c. How each patient's medical record will be available to personnel providing services to the patient during a disaster;
 - d. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
 - e. A plan for obtaining food and water for individuals present in the behavioral health specialized transitional facility or the behavioral health specialized transitional facility's relocation site during a disaster;
 - 2. The disaster plan required in subsection (D)(1) is reviewed at least once every 12 months;
 - 3. A disaster drill is performed on each shift at least once every 12 months;
 - 4. Documentation of a disaster plan review required in subsection (D)(2) and a disaster drill required in subsection (D)(3) is created, is maintained for at least 12 months after the date of the disaster plan review or disaster drill, and includes:
 - a. The date and time of the disaster plan review or disaster drill;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review or disaster drill;
 - c. A critique of the disaster plan review or disaster drill; and
 - d. If applicable, recommendations for improvement;
 - 5. An evacuation drill for employees and patients:
 - a. Is conducted on each shift at least once every three months;
 - b. Includes all individuals on the premises except for:
 - i. A patient whose medical record contains documentation that evacuation from the behavioral health inpatient facility would cause harm to the patient, and
 - ii. Sufficient personnel members to ensure the health and safety of patients not evacuated according to subsection (B)(5)(b)(i);
 - 6. Documentation of an evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for all employees and patients to evacuate the behavioral health specialized transitional facility;

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- c. If applicable, an identification of patients needing assistance for evacuation;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
7. An evacuation path is conspicuously posted on each hallway of each floor of the behavioral health specialized transitional facility.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1316. Environmental Standards

- A.** An administrator shall ensure that:
- 1. The premises and equipment are:
 - a. Cleaned and, if applicable, disinfected according to policies and procedures designed to prevent, minimize, and control illness or infection; and
 - b. Free from a condition or situation that may cause a patient or other individual to suffer physical injury;
 - 2. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
 - 3. Biohazardous medical wastes are identified, stored, and disposed of according to 18 A.A.C. 13, Article 14;
 - 4. Equipment used at the behavioral health specialized transitional 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 - 5. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 - 6. Garbage and refuse are:
 - a. Stored in covered containers, and
 - b. Removed from the premises at least once a week;
 - 7. Heating and cooling systems maintain the behavioral health specialized transitional facility at a temperature between 70° F and 84° F;
 - 8. Common areas:
 - a. Are lighted to assure the safety of patients, and
 - b. Have lighting sufficient to allow personnel members to monitor patient activity;
 - 9. Hot water temperatures are maintained between 95° F and 120° F in the areas of a behavioral health specialized transitional facility used by patients;
 - 10. 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;
 - 11. Soiled linen and soiled clothing stored by the behavioral health specialized transitional facility are maintained separate from clean linen and clothing and stored in closed

containers away from food storage, kitchen, and dining areas; and

- 12. Pets and animals, except for service animals, are prohibited on the premises.
- B.** An administrator shall ensure that smoking or tobacco products are not permitted within or on the premises of the facility.
- C.** An administrator shall ensure that:
- 1. Poisonous or toxic materials stored by the behavioral health specialized transitional facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
 - 2. Combustible or flammable liquids and hazardous materials stored by a behavioral health specialized transitional facility are stored in the original labeled containers or safety containers in an area inaccessible to patients; and
 - 3. Poisonous, toxic, combustible, or flammable medical supplies in use for a patient are stored in a locked area according to the behavioral health specialized transitional facility's policies and procedures.
- D.** An administrator shall ensure that:
- 1. A patient's bedroom is provided with:
 - a. An individual storage space, such as a dresser or chest;
 - b. A bed that:
 - i. Consists of at least a mattress and frame, and
 - ii. Is at least 36 inches wide and 72 inches long; and
 - c. A pillow and linens that include:
 - i. A mattress pad;
 - ii. A top sheet and a bottom sheet are large enough to tuck under the mattress;
 - iii. A pillow case;
 - iv. A waterproof mattress cover, if needed; and
 - v. A blanket or bedspread sufficient to ensure the patient's warmth;
 - 2. Clean linens and bath towels are provided to a patient as needed and at least once every seven calendar days; and
 - 3. A patient's clothing may be cleaned according to policies and procedures.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

R9-10-1317. Physical Plant Standards

- A.** An administrator shall ensure that a behavioral health specialized transitional facility complies with the applicable physical plant health and safety codes and standards for secure residential facilities, incorporated by reference in R9-10-104.01, in effect on the date the behavioral health specialized transitional facility submitted the application including the notarized attestation of architectural plans according to R9-10-104.
- B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
- 1. The services stated in the behavioral health specialized transitional facility's scope of services, and
 - 2. An individual accepted as a patient by the behavioral health specialized transitional facility.
- C.** An administrator shall ensure that a behavioral health specialized transitional facility has:

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1. An area in which a patient may meet with a visitor,
2. Areas where patients may receive individual treatment,
3. Areas where patients may receive group counseling or other group treatment,
4. An area for community dining; and
5. Sufficient space in one or more common areas for individual and group activities.

D. An administrator shall ensure that the behavioral health specialized transitional facility has:

1. A bathroom adjacent to a common area for use by patients and visitors that:
 - a. Provides privacy to the user; and
 - b. Contains:
 - i. A working sink with running water,
 - ii. A working toilet that flushes and has a seat,
 - iii. Toilet tissue dispenser,
 - iv. Dispensed soap for hand washing,
 - v. Single use paper towels or a mechanical air hand dryer,
 - vi. Lighting, and
 - vii. A means of ventilation;
2. An indoor common area that is not used as a sleeping area and that has:
 - a. A working telephone that allows a patient to make a private telephone call;
 - b. A distortion-free mirror;
 - c. A current calendar and an accurate clock;
 - d. A variety of books, current magazines and newspapers, and arts and crafts supplies appropriate to the age, educational, cultural, and recreational needs of patients; and
 - e. A working television and access to a radio;
3. A dining room or dining area that:
 - a. Is lighted and ventilated,
 - b. Contains tables and seats, and
 - c. Is not used as a sleeping area;
4. An outdoor area that:
 - a. Is accessible to patients,
 - b. Has sufficient space to accommodate the social and recreational needs of patients, and
 - c. Has shaded and unshaded areas;
5. For every ten patients, at least one working toilet that flushes and has a seat and dispensed toilet tissue;
6. For every 12 patients, at least one sink with running water, dispensed soap for hand washing, and single use paper towels or a mechanical air hand dryer;
7. For every 12 patients, at least one working bathtub or shower with a slip resistant surface; and
8. For each patient, a private bedroom that:
 - a. Contains at least 60 square feet of floor space, not including the closet;
 - b. Has walls from floor to ceiling;
 - c. Has a door that opens into a hallway or common area;
 - d. Is constructed and furnished to provide unimpeded access to the door;
 - e. Is not used as a passageway to another bedroom or a bathroom, unless the bathroom is for the exclusive use of the patient occupying the bedroom; and
 - f. Has sufficient lighting for a patient to read.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws

2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

ARTICLE 14. SUBSTANCE ABUSE TRANSITIONAL FACILITIES

R9-10-1401. Definitions

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

“Emergency medical care technician” has the same meaning as in A.R.S. § 36-2201.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1402. Administration

A. A governing authority shall:

1. Consist of one or more individuals accountable for the organization, operation, and administration of a substance abuse transitional facility;
2. Establish, in writing:
 - a. A substance abuse transitional facility’s scope of services, and
 - b. Qualifications for an administrator;
3. Designate, in writing, an administrator who meets the qualifications established in subsection (A)(2)(b);
4. Adopt a quality management program according to R9-10-1403;
5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on a substance abuse transitional facility’s premises for more than 30 calendar days, or
 - b. Not present on a substance abuse transitional facility’s premises for more than 30 calendar days; and
7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.

B. An administrator:

1. Is directly accountable to the governing authority for the daily operation of the substance abuse transitional facility and all services provided by or at the substance abuse transitional facility;
2. Has the authority and responsibility to manage the substance abuse transitional facility; and
3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on a substance abuse transitional facility’s premises and accountable for the substance abuse transitional facility when the administrator is not present on the substance abuse transitional facility’s premises.

C. An administrator shall ensure that:

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1. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a participant;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training, including:
 - i. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation;
 - 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 that the individual has received cardiopulmonary resuscitation training;
 - f. Include a method to identify a participant to ensure the participant receives physical health services and behavioral health services as ordered;
 - g. Cover first aid training;
 - h. Cover participant rights, including assisting a participant who does not speak English or who has a physical or other disability to become aware of participant rights;
 - i. Cover specific steps for:
 - i. A participant to file a complaint, and
 - ii. The substance abuse transitional facility to respond to a participant's complaint;
 - j. Cover medical records, including electronic medical records;
 - k. Cover quality management, including incident reports and supporting documentation;
 - l. Cover contracted services; and
 - m. Cover when an individual may visit a participant in the substance abuse transitional facility;
 2. Policies and procedures for services are established, documented, and implemented to protect the health and safety of a participant that:
 - a. Cover participant screening, admission, assessment, transfer, discharge planning, and discharge;
 - b. Include when general consent and informed consent are required;
 - c. Cover the provision of behavioral health services and physical health services;
 - d. Cover medication administration, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
 - e. Cover infection control;
 - f. Cover environmental services that affect participant care;
 - g. Cover the process for receiving a fee from and refunding a fee to a participant or the participant's representative;
 - h. Cover the security of a participant's possessions that are allowed on the premises;
 - i. Cover smoking tobacco products on the premises;
 - j. Cover how the facility will respond to a participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual; and
 - k. Cover how often periodic monitoring occurs based on a participant's condition;
 3. Policies and procedures are reviewed at least once every three years and updated as needed;
 4. Policies and procedures are available to employees; and
 5. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a substance abuse transitional facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the substance abuse transitional facility.
- D.** An administrator shall provide written notification to the Department of a participant's:
1. Death, if the participant's death is required to be reported according to A.R.S. § 11-593, within one working day after the participant's death; and
 2. Self-injury, within two working days after the participant inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- E.** If abuse, neglect, or exploitation of a participant is alleged or suspected to have occurred before the participant was admitted or while the participant is not on the premises and not receiving services from a substance abuse transitional facility's employee or personnel member, an administrator shall immediately report the alleged or suspected abuse, neglect, or exploitation of the participant according to A.R.S. § 46-454.
- F.** If an administrator has a reasonable basis, according to A.R.S. § 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a participant is receiving services from a substance abuse transitional facility's employee or personnel member, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Report the suspected abuse, neglect, or exploitation of the participant according to A.R.S. § 46-454;
 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;

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- b. A description of any injury to the participant and any change to the participant's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- G.** An administrator shall establish, document, and implement a process for responding to a participant's need for immediate and unscheduled behavioral health services or physical health services.
- H.** An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, an employee, a participant, or a participant's representative:
- 1. The participant rights listed in R9-10-1409,
 - 2. The facility's current license,
 - 3. The location at which inspection reports are available for review or can be made available for review, and
 - 4. The days and times when a participant may accept visitors and make telephone calls.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1402 repealed; new Section R9-10-1402 renumbered from Section R9-10-1403 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1403. 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 services provided to participants;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to participant 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 participant 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 participant care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to participant care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1403 renumbered to R9-10-1402; new Section R9-10-1403 renumbered from R9-10-1404 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1404. Contracted Services

An administrator shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1404 renumbered to R9-10-1403; new Section R9-10-1404 renumbered from R9-10-1405 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1405. Personnel

A. An administrator shall ensure that:

- 1. A personnel member is:
 - a. At least 21 years old, or
 - b. If providing behavioral health services, at least 18 years old;
- 2. An employee is at least 18 years old;
- 3. A student is at least 18 years old; and
- 4. A volunteer is at least 21 years old.

B. An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of participants receiving behavioral health services or physical health services from the personnel member according to the established job description;
 - b. Include:
 - i. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description;
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behavioral health services or physical health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected behav-

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- ioral health services or physical health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides behavioral health services or physical health services, and
 - b. According to policies and procedures;
 3. An emergency medical care technician complies with the requirements in 9 A.A.C. 25 for certification and medical direction;
 4. A substance abuse transitional facility has sufficient personnel members with the qualifications, education, experience, skills, and knowledge necessary to:
 - a. Provide the behavioral health services and physical health services in the substance abuse transitional facility's scope of services,
 - b. Meet the needs of a participant, and
 - c. Ensure the health and safety of a participant;
 5. A written plan is developed and implemented to provide orientation specific to the duties of a personnel member;
 6. A personnel member's orientation is documented, to include:
 - a. The personnel member's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 7. In addition to the training required in subsections (B)(1) and (B)(5), a written plan is developed and implemented to provide a personnel member with in-service education specific to the duties of the personnel member;
 8. A personnel member's skills and knowledge are verified and documented:
 - a. Before providing services related to participant care, and
 - b. At least once every 12 months after the date the personnel member begins providing services related to participant care; and
 9. An individual's in-service education and, if applicable, training in how to respond to a participant's sudden, intense, or out-of-control behavior 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.
- C.** An administrator shall ensure that an individual who is licensed under A.R.S. Title 32, Chapter 33 as a baccalaureate social worker, master social worker, associate marriage and family therapist, associate counselor, or associate substance abuse counselor receives direct supervision as defined in A.A.C. R4-6-101.
- D.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have direct interaction with a participant for more than eight hours in a week, provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the substance abuse transitional facility, and
 2. As specified in R9-10-113.
- E.** An administrator shall comply with the requirements for behavioral health technicians and behavioral health paraprofessionals in R9-10-115.
- F.** An administrator shall ensure that a personnel record is maintained for a personnel member, employee, volunteer, or student that contains:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. The individual's completion of the training required in subsection (B)(8), if applicable;
 - f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - g. Cardiopulmonary resuscitation training, if required for the individual according to subsection (H) or policies and procedures;
 - h. First aid training, if required for the individual according to subsection (H) or policies and procedures;
 - i. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (D); and
 - j. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training.
- G.** An administrator shall ensure that personnel records are:
1. Maintained:
 - a. Throughout an individual's period of providing services at or for a substance abuse transitional facility, and
 - b. For at least 24 months after the last date the individual provided services at or for a substance abuse transitional facility; and
 2. For a personnel member who has not provided physical health services or behavioral health services at or for the substance abuse transitional facility during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- H.** An administrator shall ensure at least one personnel member who is present at the substance abuse transitional facility during hours of facility operation has first-aid and cardiopulmonary resuscitation training certification 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 a substance abuse transitional facility at all times when a participant 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 substance abuse transitional facility if needed;
 3. A substance abuse transitional facility has sufficient personnel members to provide general participant supervision and treatment and sufficient personnel members or employees to provide ancillary services to meet the scheduled and unscheduled needs of each participant;
 4. There is a daily staffing schedule that:

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- a. Indicates the date, scheduled work hours, and name of each individual assigned to work, including on-call individuals;
- b. Includes documentation of the employees who work each day and the hours worked by each employee; and
- c. Is maintained for at least 12 months after the last date on the documentation;
5. A behavioral health professional is present on the substance abuse transitional facility's premises or on-call;
6. A registered nurse is present on the substance abuse transitional facility's premises or on-call; and
7. A fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1405 renumbered to R9-10-1404; new Section R9-10-1405 renumbered from R9-10-1406 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1406. Admission; Assessment

An administrator shall ensure that:

1. A participant is admitted based upon the participant's presenting behavioral health issue and treatment needs and the substance abuse transitional facility's ability and authority to provide behavioral health services or physical health services consistent with the participant's needs;
2. General consent is obtained from a participant or the participant's representative before or at the time of admission;
3. The general consent obtained in subsection (2) is documented in the participant's medical record;
4. An assessment of a participant is completed or updated by an emergency medical care technician or a registered nurse;
5. If an assessment is completed or updated by an emergency medical care technician, a registered nurse reviews the assessment within 24 hours after the completion of the assessment to ensure that the assessment identifies the behavioral health services and physical health services needed by the participant;
6. If an assessment that complies with the requirements in this Section is received from a behavioral health provider other than the substance abuse transitional facility or the substance abuse transitional facility has a medical record for the participant that contains an assessment that was completed within 12 months before the date of the participant's current admission:
 - a. The participant's assessment information is reviewed and updated if additional information that affects the participant's assessment is identified, and
 - b. The review and update of the participant's assessment information is documented in the participant's medical record within 48 hours after the review is completed;
7. An assessment:
 - a. Documents a participant's:
 - i. Presenting issue;
 - ii. Substance abuse history;
 - iii. Co-morbidity;
 - iv. Medical condition and history;
 - v. Behavioral health treatment history;
 - vi. Symptoms reported by the participant; and
 - vii. Referrals needed by the participant, if any;
 - b. Includes:
 - i. Recommendations for further assessment or examination of the participant's needs,
 - ii. The behavioral health services and physical health services that will be provided to the participant, and
 - iii. The signature and date signed of the personnel member conducting the assessment; and
 - c. Is documented in participant's medical record;
8. A participant is referred to a medical practitioner if a determination is made that the participant requires immediate physical health services or the participant's behavioral health issue may be related to the participant's medical condition;
9. If a participant requires behavioral health services that the substance abuse transitional facility is not authorized or not able to provide, a personnel member arranges for the participant to be provided transportation to transfer to another health care institution where the behavioral health services can be provided;
10. A request for participation in a participant's assessment is made to the participant or the participant's representative;
11. An opportunity for participation in the participant's assessment is provided to the participant or the participant's representative;
12. Documentation of the request in subsection (10) and the opportunity in subsection (11) is in the participant's medical record; and
13. A participant's assessment information is:
 - a. Documented in the medical record within 48 hours after completing the assessment, and
 - b. Reviewed and updated when additional information that affects the participant's assessment is identified.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1406 renumbered to R9-10-1405; new Section R9-10-1406 renumbered from R9-10-1407 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1407. Discharge

A. An administrator shall ensure that:

1. If a participant is not being transferred to another health care institution, before discharging the participant from a substance abuse transitional facility, a personnel member:
 - a. Identifies the specific needs of the participant after discharge necessary to assist the participant to address the participant's substance abuse issues;
 - b. Identifies any resources, including family members, community social services, peer support services,

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- and Regional Behavioral Health Agency staff, that may be available to assist the participant; and
- c. Documents the information in subsection (A)(1)(a) and the resources in subsection (A)(1)(b) in the participant's medical record; and
- 2. When an individual is discharged, a personnel member:
 - a. Provides the participant with discharge information that includes:
 - i. The identified specific needs of the participant after discharge, and
 - ii. Resources that may be available for the participant; and
 - b. Contacts any resources identified as required in subsection (A)(1)(b).
- B. An administrator shall ensure that there is a documented discharge order by a medical practitioner before a participant is discharged unless the participant leaves the facility against a medical practitioner's advice.
- C. An administrator shall ensure that, at the time of discharge, a participant receives a referral for behavioral health services that the participant may need after discharge, if applicable.
- D. An administrator shall ensure that a discharge summary:
 - 1. Is entered into the participant's medical record within 10 working days after a participant's discharge; and
 - 2. Includes the following information completed by an individual authorized by policies and procedures:
 - a. The participant's presenting issue and other behavioral health and physical health issues identified in the participant's assessment;
 - b. A summary of the behavioral health services and physical health services provided to the participant;
 - c. The name, dosage, and frequency of each medication for the participant ordered at the time of the participant's discharge by a medical practitioner at the facility; and
 - d. A description of the disposition of the participant's possessions, funds, or medications brought to the facility by the participant.
- E. An administrator shall ensure that a participant who is dependent upon a prescribed medication is offered a written referral to detoxification services or opioid treatment before the participant is discharged.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).
 Section R9-10-1407 renumbered to R9-10-1406; new Section R9-10-1407 renumbered from R9-10-1408 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1408. Transfer

Except for a transfer of a participant due to an emergency, an administrator shall ensure that:

- 1. A personnel member coordinates the transfer and the services provided to the participant;
- 2. According to policies and procedures:
 - a. An evaluation of the participant is conducted before the transfer;
 - b. Information in the participant's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and

- c. A personnel member explains risks and benefits of the transfer to the participant or the participant's representative; and
- 3. Documentation in the participant's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the participant during a transfer.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).
 Section R9-10-1408 renumbered to R9-10-1407; new Section R9-10-1408 renumbered from R9-10-1409 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1409. Participant Rights

- A. An administrator shall ensure that:
 - 1. The requirements in subsection (B) and the participant rights in subsection (C) are conspicuously posted on the premises;
 - 2. At the time of admission, a participant or the participant's representative receives a written copy of the requirements in subsection (B) and the participant rights in subsection (C); and
 - 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a participant that include:
 - a. How and when a participant or the participant's representative is informed of participant rights in subsection (C), and
 - b. Where participant rights are posted as required in subsection (A)(1).
- B. An administrator shall ensure that:
 - 1. A participant is treated with dignity, respect, and consideration;
 - 2. A participant is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity;
 - k. Misappropriation of personal and private property by the substance abuse transitional facility's personnel members, employees, volunteers, or students; or
 - l. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the participant's treatment needs, except as established in a fee agreement signed by the participant or the participant's representative; and
 - 3. A participant or the participant's representative:
 - a. Except in an emergency, either consents to or refuses treatment;

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- b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication, associated risks, and possible complications;
 - d. Is informed of the participant complaint process; and
 - e. Except as otherwise permitted by law, provides written consent to the release of information in the participant's:
 - i. Medical record, or
 - ii. Financial records.
 - C. A participant has the following rights:
 - 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 - 2. To receive treatment that:
 - a. Supports and respects the participant's individuality, choices, strengths, and abilities;
 - b. Supports the participant's personal liberty and only restricts the participant's personal liberty according to a court order, by the participant's or the participant's representative's general consent, or as permitted in this Chapter; and
 - c. Is provided in the least restrictive environment that meets the participant's treatment needs;
 - 3. To receive privacy in treatment and care for personal needs, including the right not to be fingerprinted, photographed, or recorded without consent, except:
 - a. A participant may be photographed when admitted to a substance abuse transitional facility for identification and administrative purposes;
 - b. For a participant receiving treatment according to A.R.S. Title 36, Chapter 37; or
 - c. For video recordings used for security purposes that are maintained only on a temporary basis;
 - 4. To review, upon written request, the participant's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 - 5. To receive a referral to another health care institution if the substance abuse transitional facility is not authorized or not able to provide behavioral health services or physical health services needed by the participant;
 - 6. To participate or have the participant's representative participate in the development of or decisions concerning treatment;
 - 7. To receive assistance from a family member, the participant's representative, or other individual in understanding, protecting, or exercising the participant's rights;
 - 8. To be provided locked storage space for the participant's belongings while the participant receives services; and
 - 9. To be informed of the requirements necessary for the participant's discharge.
- Historical Note**
- Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1409 renumbered to R9-10-1408; new Section R9-10-1409 renumbered from R9-10-1410 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).
- R9-10-1410. Medical Records**
- A. An administrator shall ensure that:
- 1. A medical record is established and maintained for each participant according to A.R.S. Title 12, Chapter 13, Article 7.1;
 - 2. An entry in a participant's medical record is:
 - a. Recorded only by a personnel member authorized by 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 participant's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 5. A participant's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the participant's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the participant or the participant's representative; or
 - c. As permitted by law; and
 - 6. A participant's medical record is protected from loss, damage, or unauthorized use.
- B.** If a substance abuse transitional agency maintains participants' medical records electronically, an administrator shall ensure that:
- 1. Safeguards exist to prevent unauthorized access, and
 - 2. The date and time of an entry in a medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a participant's medical record contains:
- 1. Participant information that includes:
 - a. The participant's name;
 - b. The participant's address;
 - c. The participant's date of birth; and
 - d. Any known allergies, including medication allergies;
 - 2. A participant's presenting behavioral health issue;
 - 3. Documentation of general consent and, if applicable, informed consent for treatment by the participant or the participant's representative, except in an emergency;
 - 4. If applicable, the name and contact information of the participant's representative and:
 - a. The document signed by the participant consenting for the participant's representative to act on the participant's behalf; or
 - b. If the participant's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;

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5. Documentation of medical history and results of a physical examination;
6. The date of admission and, if applicable, date of discharge;
7. Orders;
8. Assessment;
9. Progress notes;
10. Documentation of substance abuse transitional agency services provided to the participant;
11. If applicable, documentation of any actions taken to control the participant's sudden, intense, or out-of-control behavior to prevent harm to the participant or another individual;
12. The disposition of the participant upon discharge;
13. The discharge plan;
14. A discharge summary, if applicable; and
15. Documentation of a medication administered to a participant that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain:
 - i. An evaluation of the participant's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication:
 - i. An evaluation of the participant's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The signature of the individual administering the medication; and
 - f. Any adverse reaction a participant has to the medication.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1410 renumbered to R9-10-1409; new Section R9-10-1410 renumbered from R9-10-1411 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1411. Behavioral Health Services

- A. An administrator shall ensure that counseling is:
 1. Offered as described in the substance abuse transitional facility's scope of services,
 2. Provided according to the frequency and number of hours identified in the participant's assessment, and
 3. Provided by a behavioral health professional.
- B. An administrator shall ensure that:
 1. A behavioral health professional 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. Each counseling session is documented in a participant's medical record to include:
 - a. The date of the counseling session;
 - b. The amount of time spent in the counseling session;
 - c. Whether the counseling was individual counseling, family counseling, or group counseling;

- d. The treatment goals addressed in the counseling session; and
- e. The signature of the personnel member who provided the counseling and the date signed.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1411 renumbered to R9-10-1410; new Section R9-10-1411 renumbered from R9-10-1412 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1412. Medication Services

- A. If a facility provides medication administration or assistance in the self-administration of medication, an administrator shall ensure that policies and procedures for medication services:
 1. Include:
 - a. A process for providing information to a participant about medication prescribed for the participant including:
 - 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:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures to ensure that a participant's medication regimen is reviewed by a medical practitioner to ensure the medication regimen meets the participant's needs;
 - d. Procedures for documenting medication administration and assistance in the self-administration of medication;
 - e. Procedures for assisting a participant in obtaining medication; and
 - f. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 2. 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. If a substance abuse transitional facility provides medication administration, an administrator shall ensure that:
 1. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a participant only as prescribed;
 - d. Cover the documentation of a participant's refusal to take prescribed medication in the participant's medical record;

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2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
3. A medication administered to a participant:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the participant's medical record.
- C. If a substance abuse transitional facility provides assistance in the self-administration of medication, an administrator shall ensure that:
 1. A participant's medication is stored by the substance abuse transitional facility;
 2. The following assistance is provided to a participant:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the participant;
 - c. Observing the participant while the participant removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the participant's medical practitioner by confirming that:
 - i. The participant taking the medication is the individual stated on the medication container label,
 - ii. The participant is taking the dosage of the medication stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label, and
 - iii. The participant is taking the medication at the time stated on the medication container label or according to an order from a medical practitioner dated later than the date on the medication container label; or
 - e. Observing the participant while the participant takes the medication;
 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse;
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 6. Assistance in the self-administration of medication provided to a participant:
 - a. Is in compliance with an order, and
 - b. Is documented in the participant's medical record.
- D. An administrator shall ensure that:
 1. A current drug reference guide is available for use by personnel members, and
 2. A current toxicology reference guide is available for use by personnel members.
- E. When medication is stored at the substance abuse transitional facility, an administrator shall ensure that:
 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 2. Medication is stored according to the instructions of the medication container; and
 3. Policies and procedures are established, documented, and implemented for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of participants who received recalled medication;
 - d. Storing, inventorying, and dispensing controlled substances;
 - e. If applicable, donated medicine according to A.R.S. § 32-1909; and
 - f. Documenting the maintenance of a medication requiring refrigeration.
- F. An administrator shall ensure that a personnel member immediately reports a medication error or a participant's adverse reaction to a medication to the medical practitioner who ordered the medication and the registered nurse required in R9-10-1405(I)(6).

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1412 renumbered to R9-10-1411; new Section R9-10-1412 renumbered from R9-10-1413 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1413. Food Services

- A. An administrator shall ensure that:
 1. If a substance abuse transitional facility has a licensed capacity of more than 10 participants:
 - a. Food services are provided in compliance with 9 A.A.C. 8, Article 1; and
 - b. A copy of the substance abuse transitional facility's food establishment license or permit required according to subsection (A)(1) is maintained;
 2. If a substance abuse transitional facility contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the facility:
 - a. A copy of the contracted food establishment's license or permit is maintained by the substance abuse transitional facility; and
 - b. The substance abuse transitional facility is able to store, refrigerate, and reheat food to meet the dietary needs of a participant;
 3. A registered dietitian is employed full-time, part-time, or as a consultant; and

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4. 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 participants.
- 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 participant such as cut, chopped, ground, pureed, or thickened;
 2. A food menu is:
 - a. Prepared at least one week in advance,
 - b. Conspicuously posted, and
 - c. Maintained for at least 60 calendar days after the last day included in the food menu;
 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;
 4. Meals and snacks provided by the substance abuse transitional facility are served according to posted menus;
 5. Meals and snacks for each day are planned using the applicable guidelines in the most recent dietary guidelines according to the U.S. Department of Health and Human Services and U.S. Department of Agriculture;
 6. A participant is provided:
 - a. A diet that meets the participant's nutritional needs as specified in the participant's assessment;
 - b. Three meals a day with not more than 14 hours between the evening meal and breakfast, except as provided in subsection (B)(6)(d);
 - c. The option to have a daily evening snack identified in subsection (B)(6)(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. The participant agrees; and
 - ii. The participant 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;
 7. A participant requiring assistance to eat is provided with assistance that recognizes the participant's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils; and
 8. Water is available and accessible to participants at all times, unless otherwise stated in a participant's assessment.
- 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; and
 - b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 145° F for 15 seconds, except that:
 - i. Ground beef and any food containing ground beef are cooked to heat all parts of the food to at least 155° F;
 - ii. Poultry, poultry stuffing, stuffed meats, and stuffing that contains meat are cooked to heat all parts of the food to at least 165° F;
 - iii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
 - iv. Raw shell eggs for immediate consumption are cooked to at least 145° F for 15 seconds and any food containing raw shell eggs is cooked to heat all parts of the food to at least 155° F;
 - v. If the facility serves a population that is not a highly susceptible population, rare roast beef may be served cooked to an internal temperature of at least 145° F for at least three minutes and a whole muscle intact beef steak may be served cooked on both top and bottom to a surface temperature of at least 145° F; and
 - vi. Leftovers are reheated to a temperature of at least 165° F;
 4. A refrigerator contains a thermometer, accurate to plus or minus 3° F, placed at the warmest part of the refrigerator;
 5. Frozen foods are stored at a temperature of 0° F or below; and
 6. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1413 renumbered to R9-10-1412; new Section R9-10-1413 renumbered from R9-10-1414 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1414. Emergency and Safety Standards

- A.** An administrator shall ensure that:
 1. An evacuation drill for employees and participants on the premises is conducted at least once every six months on each shift;
 2. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the drill;
 - b. The amount of time taken for all employees and participants to evacuate the substance abuse transitional facility;
 - c. Any problems encountered in conducting the drill; and
 - d. Recommendations for improvement, if applicable;
 3. An evacuation path is conspicuously posted on each hallway of each floor of the facility;
 4. A disaster plan is developed, documented, maintained in a location accessible to personnel members, and, if necessary, implemented that includes:
 - a. When, how, and where participants will be relocated;
 - b. How a participant's medical record will be available to individuals providing services to the participant during a disaster;
 - c. A plan to ensure a participant's medication will be available to administer to the participant during a disaster; and
 - d. A plan for obtaining food and water for individuals present in the substance abuse transitional facility or

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the substance abuse transitional facility's relocation site during a disaster;

5. The disaster plan required in subsection (A)(4) is reviewed at least once every 12 months;
 6. Documentation of a disaster plan review required in subsection (A)(5) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each employee or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement; and
 7. A disaster drill for employees is conducted on each shift at least once every three months and documented.
- B.** An administrator shall ensure that:
1. A fire inspection is conducted by a local fire department or the State Fire Marshal before licensing and according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Any repairs or corrections stated on the fire inspection report are made, and
 3. Documentation of a current fire inspection is maintained.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1414 renumbered to R9-10-1413; new Section R9-10-1414 renumbered from R9-10-1415 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1415. Environmental Standards

- A.** An administrator shall ensure that:
1. The premises and equipment are sufficient to accommodate the activities, treatment, and ancillary services stated in the substance abuse transitional facility's scope of services;
 2. The premises and equipment are:
 - a. Maintained in a condition that allows the premises and equipment to be used for the original purpose of the premises and equipment,
 - b. Clean, and
 - c. Free from a condition or situation that may cause a participant or other individual to suffer physical injury or illness;
 3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
 4. Biohazardous waste and hazardous waste are identified, stored, used, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 5. Equipment used at the substance abuse transitional 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;

6. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
7. Garbage and refuse are:
 - a. Stored in plastic bags in covered containers, and
 - b. Removed from the premises at least once a week;
8. Heating and cooling systems maintain the facility at a temperature between 70° F and 84° F at all times;
9. A space heater is not used;
10. Common areas:
 - a. Are lighted to assure the safety of participants, and
 - b. Have lighting sufficient to allow personnel members to monitor participant activity;
11. Hot water temperatures are maintained between 95° F and 120° F in the areas of the substance abuse transitional facility used by participants;
12. The supply of hot and cold water is sufficient to meet the personal hygiene needs of participants and the cleaning and sanitation requirements in this Article;
13. Soiled linen and soiled clothing stored by the substance abuse transitional facility are maintained separate from clean linen and clothing and stored in closed containers away from food storage, kitchen, and dining areas;
14. Oxygen containers are secured in an upright position;
15. Poisonous or toxic materials stored by the substance abuse transitional facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to participants;
16. Combustible or flammable liquids and hazardous materials stored by the substance abuse transitional facility are stored in the original labeled containers or safety containers in a locked area inaccessible to participants;
17. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 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 tobacco products is not permitted within a substance abuse transitional facility; and
2. Smoking tobacco products may be permitted on the premises outside a substance abuse transitional 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.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1415 renumbered to R9-10-1414; new Section R9-10-1415 renumbered from R9-10-1416 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

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R9-10-1416. Physical Plant Standards

A. An administrator shall ensure that a substance abuse transitional facility has:

1. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and a sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order; or
2. An alternative method to ensure participant safety that is documented and approved by the local jurisdiction.

B. An administrator shall ensure that:

1. If a participant 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 participant; and
2. A substance abuse transitional facility has:
 - a. A room that provides privacy for a participant to receive treatment or visitors; and
 - b. A common area and a dining area that:
 - i. Are not converted, partitioned, or otherwise used as a sleeping area; and
 - ii. Contain furniture and materials to accommodate the recreational and socialization needs of the participants and other individuals in the facility.

C. An administrator shall ensure that:

1. For every six participants, there is at least one working toilet that flushes and one sink with running water;
2. For every eight participants, there is at least one working bathtub or shower;
3. A participant bathroom provides privacy when in use and contains:
 - a. A shatter-proof mirror;
 - b. Toilet tissue for each toilet;
 - c. Soap accessible from each sink;
 - d. Paper towels in a dispenser or a mechanical air hand dryer for a bathroom that is used by more than one participant;
 - e. A window that opens or another means of ventilation; and
 - f. Nonporous surfaces for shower enclosures, clean usable shower curtains, and slip-resistant surfaces in tubs and showers;
4. Each participant is provided a bedroom for sleeping; and
5. A participant bedroom complies with the following:
 - a. Is not used as a common area;
 - b. Except as provided in subsection (D):
 - i. Contains a door that opens into a hallway, common area, or outdoors; and
 - ii. In addition to the door in subsection (C)(5)(b)(i), contains another means of egress;
 - c. Is constructed and furnished to provide unimpeded access to the door;
 - d. Has window or door covers that provide participant privacy;
 - e. Except as provided in subsection (D), 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;
 - f. Has floor to ceiling walls;
 - g. Is a:
 - i. Private bedroom that contains at least 60 square feet of floor space, not including the closet; or
 - ii. Shared bedroom that, except as provided in subsection (D):
 - (1) Is shared by no more than eight participants;
 - (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 or bunk beds;

D. Except as provided in subsection (D), contains for each participant 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 personnel effects and clothing such as a dresser or chest; and
- i. Has sufficient lighting for participant occupying the bedroom to read.

D. An administrator of a substance abuse transitional facility that uses a building that was licensed as a rural substance abuse transitional center before October 1, 2013 shall ensure that:

1. A bedroom has a door that allows egress from the bedroom,
2. A shared bedroom contains enough space to allow each participant occupying the bedroom to freely move about the bedroom,
3. A bed is of a sufficient size to accommodate a participant using the bed and provide space for all parts of the participant's body on the bed's mattress, and
4. A participant is provided storage space on a substance abuse transitional facility's premises that is accessible to the participant.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1416 renumbered to R9-10-1415; new Section R9-10-1416 renumbered from R9-10-1417 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

R9-10-1417. Renumbered**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1417 renumbered to R9-10-1416 by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

ARTICLE 15. ABORTION CLINICS**R9-10-1501. Definitions**

In addition to the definitions in A.R.S. §§ 36-401, 36-449.01, 36-449.03, 36-2151, 36-2158, and 36-2301.01 and R9-10-101, the following definitions apply in this Article, unless otherwise specified:

1. "Admitting privileges" means permission extended by a hospital to a physician to allow admission of an individual as an inpatient, as defined in R9-10-201:
 - a. By the patient's own physician, or
 - b. Through a written agreement between the patient's physician and another physician that states that the

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- other physician has permission to personally admit the patient to a hospital in this state and agrees to do so.
2. "Course" means training or education, including hands-on practice under the supervision of a physician.
 3. "Employee" means an individual who receives compensation from a licensee, but does not provide medical services, nursing services, or health-related services.
 4. "First trimester" means 1 through 14 weeks as measured from the first day of the last menstrual period or 1 through 12 weeks as measured from the date of fertilization.
 5. "Incident" means an abortion-related patient death or serious injury to a patient or fetus delivered alive.
 6. "Local" means under the jurisdiction of a city or county in Arizona.
 7. "Medical director" means a physician who is responsible for the direction of the medical services, nursing services, and health-related services provided to patients at an abortion clinic.
 8. "Medical evaluation" means obtaining a patient's medical history, performing a physical examination of a patient's body, and conducting laboratory tests as provided in R9-10-1509.
 9. "Monitor" means to observe and document, continuously or intermittently, the values of certain physiologic variables on a patient such as pulse, blood pressure, oxygen saturation, respiration, and blood loss.
 10. "Neonatal resuscitation" means procedures to assist in maintaining the life of a fetus delivered alive, as described in A.R.S. § 36-2301(D)(3).
 11. "Patient" means a female receiving medical services, nursing services, or health-related services related to an abortion.
 12. "Patient care staff member" means a physician, registered nurse practitioner, nurse, physician assistant, or surgical assistant who provides medical services, nursing services, or health-related services to a patient.
 13. "Patient transfer" means relocating a patient requiring medical services from an abortion clinic to another health care institution.
 14. "Personally identifiable patient information" means:
 - a. The name, address, telephone number, e-mail address, Social Security number, and birth date of:
 - i. The patient,
 - ii. The patient's representative,
 - iii. The patient's emergency contact,
 - iv. The patient's children,
 - v. The patient's spouse,
 - vi. The patient's sexual partner, and
 - vii. Any other individual identified in the patient's medical record other than patient care staff;
 - b. The patient's place of employment;
 - c. The patient's referring physician;
 - d. The patient's insurance carrier or account;
 - e. Any "individually identifiable health information" as proscribed in 45 CFR 164-514; and
 - f. Any other information in the patient's medical record that could reasonably lead to the identification of the patient.
 15. "Personnel" means patient care staff members, employees, and volunteers.
 16. "Serious injury" means a life-threatening physical condition related to an abortion procedure.
 17. "Surgical assistant" means an individual who is not licensed as a physician, physician assistant, registered nurse practitioner, or nurse who performs duties as directed by a physician, physician assistant, registered nurse practitioner, or nurse.
 18. "Volunteer" means an individual who, without compensation, performs duties as directed by a patient care staff member at an abortion clinic.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1502. Application Requirements and Documentation Submission

- A. An applicant shall submit an application for licensure that meets the requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1.
- B. A licensee shall submit to the Department the documentation required according to A.R.S. § 36-449.02(B) with the applicable fees required in R9-10-106(C).

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

Exhibit A. Repealed**Historical Note**

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed

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effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

R9-10-1503. Administration

- A.** A licensee is responsible for the organization and management of an abortion clinic.
- B.** A licensee shall:
 1. Adopt policies and procedures for the administration and operation of an abortion clinic;
 2. Designate a medical director who:
 - a. Is licensed according to A.R.S. Title 32, Chapter 13, 17, or 29; and
 - b. May be the same individual as the licensee;
 3. Ensure the following documents are conspicuously posted on the premises:
 - a. Current abortion clinic license issued by the Department,
 - b. Current telephone number and address of the unit in the Department responsible for licensing the abortion clinic,
 - c. Evacuation map, and
 - d. Signs that comply with A.R.S. § 36-2153(H); and
 4. Except as specified in R9-10-1512(D)(4), ensure that documentation required by this Article is provided to the Department within two hours after a Department request.
- C.** A medical director shall ensure written policies and procedures are established, documented, and implemented to protect the health and safety of a patient including:
 1. Personnel qualifications, duties, and responsibilities;
 2. Individuals qualified to provide counseling in the abortion clinic and the amount and type of training required for an individual to provide counseling;
 3. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age:
 - a. Individuals qualified in neonatal resuscitation and the amount and type of training required for an individual to provide neonatal resuscitation, and
 - b. Designation of an individual to arrange the transfer to a hospital of a fetus delivered alive;
 4. Verification of the competency of the physician performing an abortion according to R9-10-1506;
 5. The storage, administration, accessibility, disposal, and documentation of a medication or controlled substance;
 6. Accessibility and security of medical records;
 7. Abortion procedures including:
 - a. Recovery and follow-up care;
 - b. The minimum length of time a patient remains in the recovery room or area based on:
 - i. The type of abortion performed,
 - ii. The estimated gestational age of the fetus,
 - iii. The type and amount of medication administered, and
 - iv. The physiologic signs including vital signs and blood loss; and
 - c. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, the requirements in A.R.S. § 36-2301(D);
 8. Infection control including methods of sterilizing equipment and supplies;
 9. Medical emergencies; and
 10. Patient discharge and patient transfer.
- D.** For an abortion clinic that is not in substantial compliance or that is in substantial compliance but refuses to carry out a plan

of correction acceptable to the Department, the Department may take enforcement action as specified in R9-10-111.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 2078, effective July 24, 2014 (Supp. 14-3). Amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1504. Quality Management

A medical director 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 services provided to patients;
 - 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 licensee;
2. A documented report is submitted to the licensee 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 for at least 12 months after the date the report is submitted to the licensee.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the

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Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1504 renumbered to R9-10-1505; new Section R9-10-1504 made by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1505. Incident Reporting

- A.** A licensee shall ensure that the Department is notified of an incident as follows:
1. For the death of a patient, verbal notification the next working day;
 2. For a fetus delivered alive, verbal notification the next working day; and
 3. For a serious injury of a patient or viable fetus, written notification within 10 calendar days after the date of the serious injury.
- B.** A medical director shall conduct an investigation of an incident and document an incident report that includes:
1. The date and time of the incident;
 2. The name of the patient;
 3. A description of the incident, including, if applicable, information required in A.R.S. § 36-2161(A)(15);
 4. Names of individuals who observed the incident;
 5. Action taken by patient care staff members and employees during the incident and immediately following the incident; and
 6. Action taken by the patient care staff members and employees to prevent the incident from occurring in the future.
- C.** A medical director shall ensure that the incident report is:
1. Submitted to the Department and, if the incident involved a licensed individual, the applicable professional licensing board within 10 calendar days after the date of the notification in subsection (A); and
 2. Maintained on the premises for at least two years after the date of the incident.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1505 renumbered to R9-10-1506; new Section R9-10-1505 renumbered from R9-10-1504 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4). Amended by final expedited rulemak-

ing at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

R9-10-1506. Personnel Qualifications and Records

A licensee shall ensure that:

1. A physician who performs an abortion demonstrates to the medical director that the physician is competent to perform an abortion by:
 - a. The submission of documentation of education and experience, and
 - b. Observation by or interaction with the medical director;
2. Surgical assistants and volunteers who provide counseling and patient advocacy receive training in these specific responsibilities and any other responsibilities assigned and that documentation of the training received is maintained in the individual's personnel file;
3. An individual who performs an ultrasound provides documentation that the individual is:
 - a. A physician;
 - b. A physician assistant, registered nurse practitioner, or nurse who completed a course in performing ultrasounds under the supervision of a physician; or
 - c. An individual who:
 - i. Completed a course in performing ultrasounds under the supervision of a physician, and
 - ii. Is not otherwise precluded by law from performing an ultrasound;
4. An individual has completed a course for the type of ultrasound the individual performs;
5. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, an individual who is available to perform neonatal resuscitation provides documentation that the individual:
 - a. Is a:
 - i. Physician,
 - ii. Physician assistant,
 - iii. Registered nurse practitioner, or
 - iv. Nurse; and
 - b. Has completed a course in performing neonatal resuscitation that is consistent with training provided by the American Academy of Pediatrics Neonatal Resuscitation Program and includes:
 - i. Instruction in the use of resuscitation devices for positive-pressure ventilation, tracheal intubation, medications that may be necessary for neonatal resuscitation and their administration, and resuscitation of pre-term newborns; and
 - ii. Assessment of the individual's skill in applying the information provided through the instruction in subsection (5)(b)(i);
6. A personnel file for each patient care staff member and each volunteer is maintained either electronically or in writing and includes:
 - a. The individual's name and position title;
 - b. The first and, if applicable, the last date of employment or volunteer service;
 - c. Verification of qualifications, training, or licensure, as applicable;
 - d. Documentation of cardiopulmonary resuscitation certification, as applicable;
 - e. Documentation of verification of competency, as required in subsection (1), and signed and dated by the medical director;

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- f. Documentation of training for surgical assistants and volunteers;
 - g. Documentation of completion of a course as required in subsection (3), for an individual performing ultrasounds; and
 - h. Documentation of competency to perform neonatal resuscitation, as required in subsection (5), if applicable; and
7. Personnel files are maintained on the premises for at least two years after the ending date of employment or volunteer service.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1506 renumbered to R9-10-1507; new Section R9-10-1506 renumbered from R9-10-1505 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1507. Staffing Requirements

- A.** A licensee shall ensure that there is a sufficient number of patient care staff members and employees to:
- 1. Meet the requirements of this Article,
 - 2. Ensure the health and safety of a patient, and
 - 3. Meet the needs of a patient based on the patient's medical evaluation.
- B.** A licensee shall ensure that:
- 1. A patient care staff member other than a surgical assistant, who is current in cardiopulmonary resuscitation certification, is on the premises until all patients are discharged;
 - 2. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B), remains on the premises of the abortion clinic until all patients who received a medication abortion are stable and ready to leave;
 - 3. A physician, with admitting privileges at a health care institution that is classified by the director as a hospital according to A.R.S. § 36-405(B) and that is within 30 miles of the abortion clinic by road, as defined in A.R.S. § 17-451, remains on the abortion clinic's premises until all patients who received a surgical abortion are stable and discharged from the recovery room;
 - 4. A patient care staff member is on the premises to comply with R9-10-1509(H); and
 - 5. If the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, a patient care staff mem-

ber qualified according to policies and procedures to perform neonatal resuscitation is available for the abortion procedure.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1507 renumbered to R9-10-1508; new Section R9-10-1507 renumbered from R9-10-1506 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1508. Patient Rights

A licensee shall ensure that a patient is afforded the following rights, and is informed of these rights:

- 1. To refuse treatment, or withdraw consent for treatment;
- 2. To have medical records kept confidential; and
- 3. To be informed of:
 - a. Billing procedures and financial liability before abortion services are provided;
 - b. Proposed medical or surgical procedures, associated risks, possible complications, and alternatives;
 - c. Counseling services that are provided on the premises;
 - d. The right to review the ultrasound results with a physician, a physician assistant, a registered nurse practitioner, or a registered nurse before the abortion procedure; and
 - e. The right to receive a print of the ultrasound image.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended

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by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1508 renumbered to R9-10-1509; new Section R9-10-1508 renumbered from R9-10-1507 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1509. Abortion Procedures

- A.** A medical director shall ensure that a medical evaluation of a patient is conducted before the patient's abortion is performed that includes:
1. A medical history including:
 - a. Allergies to medications, antiseptic solutions, or latex;
 - b. Obstetrical and gynecological history;
 - c. Past surgeries;
 - d. Medication the patient is currently taking; and
 - e. Other medical conditions;
 2. A physical examination, performed by a physician that includes a bimanual examination to estimate uterine size and palpation of adnexa;
 3. The following laboratory tests:
 - a. A urine or blood test to determine pregnancy;
 - b. Rh typing, unless the patient provides written documentation of blood type acceptable to the physician;
 - c. Anemia screening; and
 - d. Other laboratory tests recommended by the physician or medical director on the basis of the physical examination; and
 4. An ultrasound imaging study of the fetus, performed as required in A.R.S. §§ 36-2156 and 36-2301.02(A).
- B.** If the medical evaluation indicates a patient is Rh negative, a medical director shall ensure that:
1. The patient receives information from a physician on this condition;
 2. The patient is offered RhO(d) immune globulin within 72 hours after the abortion procedure;
 3. If a patient refuses RhO(d) immune globulin, the patient signs and dates a form acknowledging the patient's condition and refusing the RhO(d) immune globulin;
 4. The form in subsection (B)(3) is maintained in the patient's medical record; and
 5. If a patient refuses RhO(d) immune globulin or if a patient refuses to sign and date an acknowledgment and refusal form, the physician documents the patient's refusal in the patient's medical record.
- C.** A physician shall estimate the gestational age of the fetus, based on one of the following criteria, and record the estimated gestational age in the patient's medical record:
1. Ultrasound measurements of the biparietal diameter, length of femur, abdominal circumference, visible pregnancy sac, or crown-rump length or a combination of these; or
 2. The date of the last menstrual period or the date of fertilization and a bimanual examination of the patient.
- D.** A medical director shall ensure that:
1. The ultrasound of a patient required in subsection (A)(4) is performed by an individual who meets the requirements in R9-10-1506(3);
 2. An ultrasound estimate of gestational age of a fetus is performed using methods and tables or charts in a publication distributed nationally that contains peer-reviewed medical information, such as medical information derived from a publication describing research in obstetrics and gynecology or in diagnostic imaging;
 3. An original patient ultrasound image is:
 - a. Interpreted by a physician, and
 - b. Maintained in the patient's medical record in either electronic or paper form; and
 4. If requested by the patient, the ultrasound image is reviewed with the patient by a physician, physician assistant, registered nurse practitioner, or registered nurse.
- E.** A medical director shall ensure that before an abortion is performed on a patient:
1. Written consent, that meets the requirements in A.R.S. § 36-2152 or 36-2153, as applicable, and A.R.S. § 36-2158 is signed and dated by the patient or the patient's representative;
 2. Information is provided to the patient on the abortion procedure, including alternatives, risks, and potential complications;
 3. Information specified in A.R.S. § 36-2161(A)(12) is requested from the patient; and
 4. If applicable, information required in A.R.S. § 36-2161(C) is provided to the patient.
- F.** A medical director shall ensure that an abortion is performed according to the abortion clinic's policies and procedures and this Article.
- G.** A medical director shall ensure that:
1. A patient care staff member monitors a patient's vital signs throughout an abortion procedure to ensure the patient's health and safety;
 2. Intravenous access is established and maintained on a patient undergoing an abortion after the first trimester unless the physician determines that establishing intravenous access is not appropriate for the particular patient and documents that fact in the patient's medical record;
 3. If an abortion procedure is performed at or after 20 weeks gestational age, a patient care staff member qualified in neonatal resuscitation, other than the physician performing the abortion procedure, is in the room in which the abortion procedure takes place before the delivery of the fetus; and
 4. If a fetus is delivered alive:
 - a. Resuscitative measures, including the following, are used to support life:
 - i. Warming and drying of the fetus,
 - ii. Clearing secretions from and positioning the airway of the fetus,
 - iii. Administering oxygen as needed to the fetus, and
 - iv. Assessing and monitoring the cardiopulmonary status of the fetus;
 - b. A determination is made of whether the fetus is a viable fetus;
 - c. A viable fetus is provided treatment to support life;
 - d. A viable fetus is transferred as required in R9-10-1510; and
 - e. Resuscitative measures and the transfer, as applicable, are documented.
- H.** To ensure a patient's health and safety, a medical director shall ensure that following the abortion procedure:
1. A patient's vital signs and bleeding are monitored by:
 - a. A physician;
 - b. A physician assistant;
 - c. A registered nurse practitioner;
 - d. A nurse; or
 - e. If a physician is able to provide direct supervision, as defined in A.R.S. § 32-1401 or A.R.S. § 32-1800, as applicable, to a medical assistant, as defined in

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A.R.S. § 32-1401 or A.R.S. § 32-1800, a medical assistant under the direct supervision of the physician; and

2. A patient remains in the recovery room or recovery area until a physician, physician assistant, registered nurse practitioner, or nurse examines the patient and determines that the patient's medical condition is stable and the patient is ready to leave the recovery room or recovery area.

I. A medical director shall ensure that follow-up care:

1. For a surgical abortion is offered to a patient that includes:
 - a. With a patient's consent, a telephone call made to the patient to assess the patient's recovery:
 - i. By a patient care staff member other than a surgical assistant; and
 - ii. Within 24 hours after the patient's discharge following a surgical abortion; and
 - b. A follow-up visit scheduled, if requested, no more than 21 calendar days after the abortion that includes:
 - i. A physical examination,
 - ii. A review of all laboratory tests as required in subsection (A)(3), and
 - iii. A urine pregnancy test;
2. For a medication abortion includes a follow-up visit, scheduled between seven and 21 calendar days after the initial dose of a substance used to induce an abortion, that includes:
 - a. A urine pregnancy test, and
 - b. An assessment of the degree of bleeding; and
3. Is documented in the patient's medical record, including:
 - a. A patient's acceptance or refusal of a follow-up visit following a surgical abortion;
 - b. If applicable, the results of the follow-up visit; and
 - c. If applicable, whether the patient consented to a telephone call and, if so, whether the patient care staff member making the telephone call to the patient:
 - i. Spoke with the patient about the patient's recovery, or
 - ii. Was unable to speak with the patient.

J. If a continuing pregnancy is suspected as a result of the follow-up visit in subsection (I)(1)(b) or (I)(2), a physician who performs abortions shall be consulted.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1509 renumbered to R9-10-1510; new Section R9-10-1509 renumbered from R9-10-1508 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4). Amended by final expedited rulemaking at 25 A.A.R. 1893, effective July 2, 2019 (Supp. 19-3).

R9-10-1510. Patient Transfer and Discharge

A. A medical director shall ensure that:

1. For a patient:
 - a. A patient is transferred to a hospital for an emergency involving the patient;
 - b. A patient transfer is documented in the patient's medical record; and
 - c. Documentation of a medical evaluation, treatment provided, and laboratory and diagnostic information is transferred with a patient; and
2. For a viable fetus:
 - a. A viable fetus requiring emergency care is transferred to a hospital,
 - b. The transfer of a viable fetus is documented in the viable fetus's medical record, and
 - c. Documentation of an assessment of cardiopulmonary function and treatment provided to a viable fetus is transferred with the viable fetus.

B. A medical director shall ensure that before a patient is discharged:

1. A physician signs the patient's discharge order; and
2. A patient receives follow-up instructions at discharge that include:
 - a. Signs of possible complications,
 - b. When to access medical services in response to complications,
 - c. A telephone number of an individual or entity to contact for medical emergencies,
 - d. Information and precautions for resuming vaginal intercourse after the abortion, and
 - e. Information specific to the patient's abortion or condition.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1510 renumbered to R9-10-1511; new Section R9-10-1510 renumbered from R9-10-1509 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1511. Medications and Controlled Substances

A medical director shall ensure that:

1. The abortion clinic complies with the requirements for medications and controlled substances in A.R.S. Title 32, Chapter 18, and A.R.S. Title 36, Chapter 27;
2. A medication is administered in compliance with an order from a physician, physician assistant, registered nurse practitioner, or as otherwise provided by law;
3. A medication is administered to a patient or to a viable fetus by a physician or as otherwise provided by law;

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4. Medications and controlled substances are maintained in a locked area on the premises;
 5. Only personnel designated by policies and procedures have access to the locked area containing medications and controlled substances;
 6. Expired, mislabeled, or unusable medications and controlled substances are disposed of according to policies and procedures;
 7. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is immediately reported to the medical director and licensee, and recorded in the patient's medical record;
 8. Medication information for a patient is maintained in the patient's medical record and contains:
 - a. The patient's name, age, and weight;
 - b. The medications the patient is currently taking;
 - c. Allergies or sensitivities to medications, antiseptic solutions, or latex; and
 - d. If medication is administered to the patient:
 - i. The date and time of administration;
 - ii. The name, strength, dosage form, amount of medication, and route of administration; and
 - iii. The identification and signature of the individual administering the medication; and
 9. If administered to a fetus delivered alive, the following are documented in the fetus's medical record:
 - a. The date and time of oxygen administration;
 - b. The amount and flow rate of the oxygen;
 - c. The identification and signature of the individual administering the oxygen; and
 - d. For a viable fetus:
 - i. The date and time of medication administration;
 - ii. The name, strength, dosage form, amount of medication, and route of administration; and
 - iii. The identification and signature of the individual administering the medication.
- A. A licensee shall ensure that a medical record is established and maintained for a patient that contains:
 1. Patient identification including:
 - a. The patient's name, address, and date of birth;
 - b. The designated patient's representative, if applicable; and
 - c. The name and telephone number of an individual to contact in an emergency;
 2. The patient's medical history required in R9-10-1509(A)(1);
 3. The patient's physical examination required in R9-10-1509(A)(2);
 4. The laboratory test results required in R9-10-1509(A)(3);
 5. The ultrasound results, including the original print, required in R9-10-1509(A)(4);
 6. The physician's estimated gestational age of the fetus required in R9-10-1509(C);
 7. Each consent form signed by the patient or the patient's representative;
 8. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 9. A record of medical services, nursing services, and health-related services provided to the patient;
 10. The patient's medication information;
 11. Documentation related to follow-up care specified in R9-10-1509(I); and
 12. If the abortion procedure was performed at or after 20 weeks gestational age and the fetus was not delivered alive, documentation from the physician and other patient care staff member present certifying that the fetus was not delivered alive.
 - B. A licensee shall ensure that a medical record is established and maintained for a fetus delivered alive that contains:
 1. An identification of the fetus, including:
 - a. The name of the patient from whom the fetus was delivered alive, and
 - b. The date the fetus was delivered alive;
 2. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 3. A record of medical services, nursing services, and health-related services provided to the fetus delivered alive;
 4. If applicable, information about medication administered to the fetus delivered alive; and
 5. If the abortion procedure was performed at or after 20 weeks gestational age:
 - a. Documentation of the requirements in R9-10-1509(G)(4); and
 - b. If the fetus had a lethal fetal condition, the results of the confirmation of the lethal fetal condition.
 - C. A licensee shall ensure that:
 1. A medical record is accessible only to the Department or personnel authorized by policies and procedures;
 2. Medical record information is confidential and released only with the written informed consent of a patient or the patient's representative or as otherwise permitted by law;
 3. A medical record is protected from loss, damage, or unauthorized use and is maintained and accessible for at least seven years after the date of an adult patient's discharge or if the patient is a child, either for at least three years after the child's 18th birthday or for at least seven years after the patient's discharge, whichever date occurs last;

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 2078, effective July 24, 2014 (Supp. 14-3). Section R9-10-1511 renumbered to R9-10-1512; new Section R9-10-1511 renumbered from R9-10-1510 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1512. Medical Records

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4. A medical record is maintained at the abortion clinic for at least six months after the date of the patient's discharge; and
 5. Vital records and vital statistics are retained according to A.R.S. § 36-343.
- D.** If the Department requests patient medical records for review, the licensee:
1. Is not required to produce any patient medical records created or prepared by a referring physician's office;
 2. May provide patient medical records to the Department either in paper or in an electronic format that is acceptable to the Department;
 3. Shall provide the Department with the following patient medical records related to medical services associated with an abortion, including any follow-up visits to the abortion clinic in connection with the abortion:
 - a. The patient's medical history required in R9-10-1509(A)(1);
 - b. The patient's physical examination required in R9-10-1509(A)(2);
 - c. The laboratory test results required in R9-10-1509(A)(3);
 - d. The physician's estimate of gestational age of the fetus required in R9-10-1509(C);
 - e. The ultrasound results required in R9-10-1509(D)(2);
 - f. Each consent form signed by the patient or the patient's representative;
 - g. Orders issued by a physician, physician assistant, or registered nurse practitioner;
 - h. A record of medical services, nursing services, and health-related services provided to the patient; and
 - i. The patient's medication information;
 4. If the Department's request is in connection with a licensing or compliance inspection:
 - a. Is not required to produce any patient medical records associated with an abortion that occurred before the licensing inspection or a previous compliance inspection of the abortion clinic; and
 - b. Shall:
 - i. Redact only personally identifiable patient information from the patient medical records before the licensee discloses the patient medical records to the Department;
 - ii. Upon request by the Department, code the requested patient medical records by a means that allows the Department to track all patient medical records related to a specific patient without the personally identifiable patient information; and
 - iii. Unless the Department and the licensee agree otherwise, provide redacted copies of patient medical records to the Department:
 - (1) For one to ten patients, within two working days after the request, and
 - (2) For every additional five patients, within an additional two working days; and
 5. If the Department's request is in connection with a complaint investigation, shall:
 - a. Not redact patient information from the patient medical records before the licensee discloses the patient medical records to the Department; and
 - b. Ensure the patient medical records include:
 - i. The patient's name, address, and date of birth;
 - ii. The patient's representative, if applicable; and
 - iii. The name and telephone number of an individual to contact in an emergency.
- E.** A medical director shall ensure that only personnel authorized by policies and procedures, records or signs an entry in a medical record and:
1. An entry in a medical record is dated and legible;
 2. An entry is authenticated by:
 - a. A signature; or
 - b. An individual's initials if the individual's signature already appears in the medical record;
 3. An entry is not changed after it has been recorded, but additional information related to an entry may be recorded in the medical record;
 4. When a verbal or telephone order is entered in the medical record, the entry is authenticated within 21 calendar days by the individual who issued the order;
 5. If a rubber-stamp signature or an electronic signature is used:
 - a. An individual's rubber stamp or electronic signature is not used by another individual;
 - b. The individual who uses a rubber stamp or electronic signature signs a statement that the individual is responsible for the use of the rubber stamp or the electronic signature; and
 - c. The signed statement is included in the individual's personnel record; and
 6. If an abortion clinic maintains medical records electronically, the medical director shall ensure the date and time of an entry is recorded by the computer's internal clock.
- F.** As required by A.R.S. § 36-449.03(J), the Department shall not release any personally identifiable patient or physician information.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1512 renumbered to R9-10-1513; new Section R9-10-1512 renumbered from R9-10-1511 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1513. Environmental and Safety Standards

A licensee shall ensure that:

1. The premises:
 - a. Provide lighting and ventilation to ensure the health and safety of a patient,
 - b. Are maintained in a clean condition,
 - c. Are free from a condition or situation that may cause a patient to suffer physical injury,
 - d. Are maintained free from insects and vermin, and
 - e. Are smoke-free;

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2. A warning notice is placed at the entrance to a room or area where oxygen is in use;
3. Soiled linen and clothing are kept:
 - a. In a covered container, and
 - b. Separate from clean linen and clothing;
4. Personnel wash hands after each direct patient contact and after handling soiled linen, soiled clothing, or biohazardous medical waste;
5. A written emergency plan is established, documented, and implemented that includes procedures for protecting the health and safety of patients and other individuals in a fire, natural disaster, loss of electrical power, or threat or incidence of violence;
6. An evacuation drill is conducted at least once every six months that includes all personnel on the premises on the day of the evacuation drill; and
7. Documentation of the evacuation drill is maintained on the premises for at least one year after the date of the evacuation drill and includes:
 - a. The date and time of the evacuation drill, and
 - b. The names of personnel participating in the evacuation drill.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1513 renumbered to R9-10-1514; new Section R9-10-1513 renumbered from R9-10-1512 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1514. Equipment Standards

A licensee shall ensure that:

1. Equipment and supplies are maintained in a:
 - a. Clean condition, and
 - b. Quantity sufficient to meet the needs of patients present in the abortion clinic;
2. Equipment to monitor vital signs is in each room in which an abortion is performed;
3. A surgical or gynecologic examination table is used for an abortion;
4. The following equipment and supplies are available in the abortion clinic:
 - a. Equipment to measure blood pressure;
 - b. A stethoscope;
 - c. A scale for weighing a patient;
 - d. Supplies for obtaining specimens and cultures and for laboratory tests; and
 - e. Equipment and supplies for use in a medical emergency including:
 - i. Ventilatory assistance equipment,
 - ii. Oxygen source,
 - iii. Suction apparatus, and

- iv. Intravenous fluid equipment and supplies; and
- f. Ultrasound equipment;
5. In addition to the requirements in subsection (4), the following equipment is available for an abortion procedure performed after the first trimester:
 - a. Drugs to support cardiopulmonary function of a patient, and
 - b. Equipment to monitor the cardiopulmonary status of a patient;
6. In addition to the requirements in subsections (4) and (5), if the abortion clinic performs an abortion procedure at or after 20 weeks gestational age, the following equipment is available for the abortion procedure:
 - a. Equipment to provide warmth and drying of a fetus delivered alive,
 - b. Equipment necessary to clear secretions from and position the airway of a fetus delivered alive,
 - c. Equipment necessary to administer oxygen to a fetus delivered alive,
 - d. Equipment to assess and monitor the cardiopulmonary status of a fetus delivered alive, and
 - e. Drugs to support cardiopulmonary function in a viable fetus;
7. Equipment and supplies are clean and, if applicable, sterile before each use;
8. Equipment required in this Section is maintained in working order, tested and calibrated at least once every 12 months or according to the manufacturer's recommendations, and used according to the manufacturer's recommendations; and
9. Documentation of each equipment test, calibration, and repair is maintained on the premises for at least 12 months after the date of the testing, calibration, or repair and provided to the Department for review within two hours after the Department requests the documentation.

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4). New Section adopted effective April 1, 2000, under an exemption from the provisions of the Arizona Administrative Procedure Act pursuant to Laws 1999, Chapter 311; filed with the Office of the Secretary of State December 23, 1999 at 6 A.A.R. 351 (Supp. 99-4). Amended by exempt rulemaking at 6 A.A.R. 3755, effective January 1, 2001 (Supp. 00-3). Amended by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section R9-10-1514 renumbered to R9-10-1515; new Section R9-10-1514 renumbered from R9-10-1513 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4).

R9-10-1515. Physical Plant Standards

- A. A licensee shall ensure that an abortion clinic complies with all local building codes, ordinances, fire codes, and zoning requirements. If there are no local building codes, ordinances, fire codes, or zoning requirements, the abortion clinic shall comply with the applicable codes and standards incorporated by reference in R9-10-104.01 that were in effect on the date the abortion clinic submitted the application including the

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notarized attestation of architectural plans according to R9-10-104.

B. A licensee shall ensure that an abortion clinic provides areas or rooms:

1. That provide privacy for:
 - a. A patient's interview, medical evaluation, and counseling;
 - b. A patient to dress; and
 - c. Performing an abortion procedure;
2. For personnel to dress;
3. With a sink and a flushable toilet in working order;
4. For cleaning and sterilizing equipment and supplies;
5. For storing medical records;
6. For storing equipment and supplies;
7. For hand washing before the abortion procedure; and
8. For a patient recovering after an abortion.

C. A licensee shall ensure that an abortion clinic has an emergency exit to accommodate a stretcher or gurney.

Historical Note

New Section R9-10-1515 made by exempt rulemaking at 20 A.A.R. 448, effective April 1, 2014 (Supp. 14-1). Section repealed; new Section renumbered from R9-10-1514 and amended by final rulemaking at 24 A.A.R. 3043, effective October 2, 2018 (Supp. 18-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

ARTICLE 16. BEHAVIORAL HEALTH RESPITE HOMES

R9-10-1601. Definitions

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

1. "Acceptance" means, after a referral from a collaborating health care institution, an individual receives services from a provider in a behavioral health respite home.
2. "Provider" means an individual who lives in a behavioral health respite home and ensures that a recipient receives the behavioral health services and ancillary services in the recipient's treatment plan.
3. "Recipient" means an individual referred by a collaborating health care institution to and accepted by a behavioral health respite home.
4. "Release" means a documented termination of services by a provider to a recipient that is authorized by a collaborating health care institution.
5. "Sibling" means one of two or more individuals having one or both parents in common.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1602. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, an applicant shall include, in a format provided by the Department, the following information for the behavioral health respite home's collaborating health care institution:

1. Name,
2. Address,
3. Class or subclass,
4. License number, and

5. Name and contact information for an individual assigned by the collaborating health care institution to monitor the behavioral health respite home.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1602 renumbered to R9-10-1603; new Section R9-10-1602 made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1603. Administration

A. A governing authority of a behavioral health respite home:

1. Consists of no more than two providers, who live in the behavioral health respite home;
2. Has the authority and responsibility to manage the behavioral health respite home;
3. Has a documented agreement with a collaborating health care institution that establishes the responsibilities of the behavioral health respite home and the collaborating health care institution, consistent with the requirements in this Chapter;
4. Shall establish, in writing, the behavioral health respite home's scope of services, which are approved by the collaborating health care institution; and
5. Shall ensure that:
 - a. Except as provided in R9-10-1612(A), no more than three recipients are accepted by the behavioral health respite home;
 - b. A provider is on the premises whenever a recipient is present in the behavioral health respite home;
 - c. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - d. When documentation or information is required by this Chapter to be submitted on behalf of the behavioral health respite home, the documentation or information is provided to the unit in the Department that is responsible for licensing the behavioral health respite home.

B. A provider:

1. Is at least 21 years of age;
2. Holds current certification in cardiopulmonary resuscitation and first aid training applicable to the ages of recipients;
3. Has the skills and knowledge established by the collaborating health care institution as specified in R9-10-118;
4. Has documentation of completion of training in assistance in the self-administration of medication as specified in R9-10-118; and
5. Has documentation of evidence of freedom from infectious tuberculosis:
 - a. On or before the date the provider begins providing services at or on behalf of the behavioral health respite home, and
 - b. As specified in R9-10-113.

C. A provider shall ensure that policies and procedures are:

1. Established, documented, and implemented to protect the health and safety of a recipient that cover:
 - a. Recordkeeping;
 - b. Recipient acceptance and release;
 - c. The release of a recipient under 18 years of age to an individual other than the recipient's parent or guardian;

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- d. Recipient rights;
 - e. The provision of respite care services, including coordinating the provision of behavioral health services;
 - f. Recipients' medical records, including electronic medical records;
 - g. Assistance in the self-administration of medication;
 - h. Infection control; and
 - i. How a provider will respond to a recipient's sudden, intense, or out-of-control behavior to prevent harm to the recipient or another individual;
2. Approved, in writing, by the behavioral health respite home's collaborating health care institution before implementation and when the policies and procedures are reviewed or updated; and
 3. Reviewed by the provider and the behavioral health respite home's collaborating health care institution at least once every three years and updated as needed.
- D.** A provider shall provide written notification to the Department and the collaborating health care institution of a recipient's:
1. Death, if the recipient's death is required to be reported according to A.R.S. § 11-593, within one working day after the recipient's death; and
 2. Self-injury, within two working days after the recipient inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- E.** If abuse, neglect, or exploitation of a recipient is alleged or suspected to have occurred before the recipient was accepted or while the recipient is not at a behavioral health respite home and not receiving services from the behavioral health respite home, a provider shall report the alleged or suspected abuse, neglect, or exploitation of the recipient as follows:
1. For a recipient 18 years of age or older, according to A.R.S. § 46-454; or
 2. For a recipient under 18 years of age, according to A.R.S. § 13-3620.
- F.** If a provider has a reasonable basis, according to A.R.S. § 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a recipient is receiving behavioral health respite home services, the provider shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Report the suspected abuse, neglect, or exploitation of the recipient as follows:
 - a. To the behavioral health respite home's collaborating health care institution; and
 - b. For a:
 - i. Recipient 18 years of age or older, according to A.R.S. § 46-454; and
 - ii. Recipient under 18 years of age, according to A.R.S. § 13-3620;
 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the recipient related to the suspected abuse or neglect and any change to the recipient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The action taken by the provider to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- G.** A provider shall ensure that a recipient under 18 years of age is only released to an individual who, according to policies and procedures:
1. Is designated by the recipient's parent or guardian to release the recipient, and
 2. Presents documentation at the time of the recipient's release that verifies the individual's identity.
- H.** A provider shall maintain a record for each provider that includes:
1. The provider's:
 - a. Name,
 - b. Date of birth, and
 - c. Contact telephone number; and
 2. Documentation of:
 - a. Verification of skills and knowledge, completed by the behavioral health respite home's collaborating health care institution;
 - b. Certification in cardiopulmonary resuscitation and first aid training;
 - c. Completion of training in assistance in the self-administration of medication, provided by the behavioral health respite home's collaborating health care institution; and
 - d. Evidence of freedom from infectious tuberculosis.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1603 renumbered to R9-10-1604; new Section R9-10-1603 renumbered from R9-10-1602 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1604. Recipient Rights

- A.** A provider shall ensure that:
1. A recipient is treated with dignity, respect, and consideration;
 2. A recipient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by:
 - i. A behavioral health respite home's provider, or

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- ii. An individual other than a recipient residing in the behavioral health respite home; and
- 3. A recipient or the recipient's representative:
 - a. Is informed of the recipient complaint process;
 - b. Consents to photographs of the recipient before the recipient is photographed, except that a recipient may be photographed when accepted by a behavioral health respite home for identification and administrative purposes; and
 - c. Except as otherwise permitted by law, provides written consent to the release of information in the recipient's medical record.

B. A recipient has the following rights:

- 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- 2. To receive services that support and respect the recipient's individuality, choices, strengths, and abilities;
- 3. To receive privacy in care for personal needs;
- 4. To review, upon written request, the recipient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- 5. To receive a referral to another health care institution if the provider is not authorized or not able to provide physical health services or behavioral health services needed by the recipient; and
- 6. To receive assistance from a family member, recipient's representative, or other individual in understanding, protecting, or exercising the recipient's rights.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1604 renumbered to R9-10-1605; new Section R9-10-1604 renumbered from R9-10-1603 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1605. Providing Services

- A.** A provider shall ensure that behavioral health services and ancillary services are provided to a recipient according to the recipient's treatment plan obtained from the behavioral health respite home's collaborating health care institution.
- B.** A provider shall submit to the behavioral health respite home's collaborating health care institution and, if applicable, the recipient's case manager:
 - 1. Documentation of any significant change in a recipient's behavior or physical, cognitive, or functional condition and the action taken by a provider to address the recipient's changing needs; and
 - 2. Notification of a recipient's unexpected self-release.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1605 renumbered to R9-10-1606; new Section R9-10-1605 renumbered from R9-10-1604 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1606. Assistance in the Self-Administration of Medication

- A.** If a provider provides assistance in the self-administration of medication, the provider shall ensure that:

- 1. If a recipient is receiving assistance in the self-administration of medication, the recipient's medication is stored by the provider;
- 2. The following assistance is provided to a recipient:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container or medication organizer for the recipient;
 - c. Observing the recipient while the recipient removes the medication from the medication container or medication organizer;
 - d. Verifying that the medication is taken as ordered by the recipient's medical practitioner by confirming that:
 - i. The recipient taking the medication is the individual stated on the medication container label,
 - ii. The recipient is taking the dosage of the medication as stated on the medication container label, and
 - iii. The recipient is taking the medication at the time stated on the medication container label; or
 - e. Observing the recipient while the recipient takes the medication; and
- 3. Assistance in the self-administration of medication provided to a recipient is documented in the recipient's medical record.

B. When medication is stored by a provider, the provider shall ensure that:

- 1. A locked cabinet, closet, or self-contained unit is used for medication storage;
- 2. Medication is stored according to the instructions on the medication container; and
- 3. Medication, including expired medication, that is no longer being used is discarded.

C. A provider shall immediately report a medication error or a recipient's adverse reaction to a medication to the:

- 1. Medical practitioner who ordered the medication, or
- 2. Contact individual at the behavioral health respite home's collaborating health care institution.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1606 renumbered to R9-10-1607; new Section R9-10-1606 renumbered from R9-10-1605 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1607. Medical Records**A. A provider shall ensure that:**

- 1. A medical record is established and maintained for each recipient according to A.R.S. Title 12, Chapter 13, Article 7.1;
- 2. An entry in a recipient's medical record is:
 - a. Only recorded by the provider or an individual designated by the provider to record an entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
- 3. A recipient's medical record is available to an individual:
 - a. Authorized by policies and procedures to access the recipient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the recipient or the recipient's representative; or
 - c. As permitted by law; and

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4. A recipient's medical record is protected from loss, damage, or unauthorized use.
- B. If a provider maintains recipients' medical records electronically, the provider shall ensure that safeguards exist to prevent unauthorized access.
- C. A provider shall ensure that a recipient's medical record contains:
 1. Recipient information that includes:
 - a. The recipient's name,
 - b. The recipient's date of birth,
 - c. Any known allergies, and
 - d. Medication information for the recipient;
 2. The names, addresses, and telephone numbers of:
 - a. The recipient's medical practitioner;
 - b. The recipient's case manager, if applicable;
 - c. The behavioral health professional assigned to the recipient by the behavioral health respite home's collaborating health care institution; and
 - d. An individual to be contacted in the event of an emergency;
 3. The date and time of the recipient's acceptance by the behavioral health respite home and, if applicable, the date and time of the recipient's release from the behavioral health respite home;
 4. If applicable, the name and contact information of the recipient's representative and:
 - a. If the recipient is 18 years of age or older or an emancipated minor, the document signed by the recipient consenting for the recipient's representative to act on the recipient's behalf; or
 - b. If the recipient's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 5. A copy of the recipient's treatment plan and any updates to the recipient's treatment plan obtained from the behavioral health respite home's collaborating health care institution;
 6. For a recipient receiving assistance in the self-administration of medication, documentation that includes for each medication:
 - a. The date and time of assistance;
 - b. The name, strength, dosage, and route of administration;
 - c. The provider's signature or first and last initials; and
 - d. Any adverse reaction the recipient has to the medication;
 7. Documentation of the recipient's refusal of a medication, if applicable;
 8. Documentation of any significant change in the recipient's behavior or physical, cognitive, or functional condition and the action taken by a provider to address the recipient's changing needs;
 9. If applicable, documentation of any actions taken to control the recipient's sudden, intense, or out-of-control behavior to prevent harm to the recipient or another individual;
 10. If applicable, documentation of a notification to the behavioral health respite home's collaborating health care

institution of an unexpected self-release of the recipient; and

11. A written notice of release from the behavioral health respite home, if applicable.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1607 renumbered to R9-10-1608; new Section R9-10-1607 renumbered from R9-10-1606 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1608. Food Services

A provider shall ensure that:

1. Food is obtained, handled, and stored to prevent contamination, spoilage, or a threat to the health of a recipient;
2. Three nutritionally balanced meals are served each day;
3. Nutritious snacks are available between meals;
4. Food served meets any special dietary needs of a recipient as prescribed by the recipient's physician or registered dietitian; and
5. Chemicals and detergents are not stored with food.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1608 renumbered to R9-10-1609; new Section R9-10-1608 renumbered from R9-10-1607 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1609. Emergency and Safety Standards

A provider shall ensure that:

1. A first aid kit is available at a behavioral health respite home sufficient to meet the needs of recipients;
2. If a firearm or ammunition for a firearm is stored at a behavioral health respite home:
 - a. The firearm is stored separate from the ammunition for the firearm; and
 - b. The firearm and the ammunition for the firearm are:
 - i. Stored in a locked closet, cabinet, or container; and
 - ii. Inaccessible to a recipient;
3. A smoke detector is installed in:
 - a. A bedroom used by a recipient,
 - b. A hallway in a behavioral health respite home, and
 - c. A behavioral health respite home's kitchen;
4. A smoke detector required in subsection (3):
 - a. Is maintained in operable condition; and
 - b. Is battery operated or, if hard-wired into the electrical system of a behavioral health respite home, has a back-up battery;
5. A behavioral health respite home has a portable fire extinguisher that is labeled 1A-10-BC by the Underwriters Laboratory and available in the behavioral health respite home's kitchen;
6. A portable fire extinguisher required in subsection (5) is:
 - a. If a disposable fire extinguisher, replaced when the fire extinguisher's indicator reaches the red zone; or
 - b. Serviced at least once every 12 months and has a tag attached to the fire extinguisher that includes the date of service;
7. A written evacuation plan is maintained and available for use by the provider and any recipient in a behavioral health respite home;

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8. An evacuation drill is conducted at least once every six months; and
9. A record of an evacuation drill required in subsection (8) is maintained for at least 12 months after the date of the evacuation drill.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1609 renumbered to R9-10-1610; new Section R9-10-1609 renumbered from R9-10-1608 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1610. Environmental Standards

- A.** A provider shall ensure that a behavioral health respite home:
1. Is in a building that:
 - a. Is arranged, designed, and used for the living, sleeping, and housekeeping activities for one family on a permanent basis; and
 - b. Is free of any plumbing, electrical, ventilation, mechanical, chemical, or structural hazard that may jeopardize the health or safety of a recipient;
 2. Has a living room accessible at all times to a recipient;
 3. Has a dining area furnished for group meals that is accessible to the provider, recipients, and any other individuals present in the behavioral health respite home;
 4. For each six individuals residing in the behavioral health respite home, including recipients, has at least one bathroom equipped with:
 - a. A working toilet that flushes and has a seat; and
 - b. A sink with running water accessible for use by a recipient;
 5. Has equipment and supplies to maintain a recipient's personal hygiene accessible to the recipient;
 6. Is clean and free from accumulations of dirt, garbage, and rubbish; and
 7. Implements a pest control program that complies with A.A.C. R3-8-201(C)(4) to minimize the presence of insects and vermin at the behavioral health respite home.
- B.** A provider shall ensure that any pets or other animals allowed on the premises are:
1. Controlled to prevent endangering a recipient and to maintain sanitation;
 2. Licensed consistent with local ordinances; and
 3. For a dog or cat, vaccinated against rabies.
- C.** If a swimming pool is located on the premises, a provider shall ensure that:
1. The swimming pool is equipped with the following:
 - a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
 - i. A removable strainer,
 - ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
 - iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
 - b. An operational cleaning system;
 2. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;

- c. Has no horizontal openings, except as described in subsection (C)(2)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and

3. A life preserver or shepherd's crook is available and accessible in the pool area.

- D.** A provider shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (C)(2) is covered and locked when not in use.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1610 renumbered to R9-10-1611; new Section R9-10-1610 renumbered from R9-10-1609 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

R9-10-1611. Adult Behavioral Health Respite Services

A provider shall ensure that:

1. A bedroom for use by a recipient:
 - a. Is separated from a hall, corridors, or other habitable room by floor to ceiling walls containing no interior openings except doors and is not used as a passageway to another bedroom or habitable room;
 - b. Provides sufficient space for an individual in the bedroom to have unobstructed access to the bedroom door;
 - c. Contains for each recipient using the bedroom:
 - i. A separate, adult-sized, single bed or larger bed with a clean mattress in good repair;
 - ii. Clean bedding appropriate for the season; and
 - iii. Storage space for personal effects and clothing such as shelves, a dresser, or chest of drawers; and
 - d. If used for:
 - i. Single occupancy, contains at least 60 square feet of floor space; or
 - ii. Double occupancy, contains at least 100 square feet of floor space;
2. A mirror is available to a recipient for grooming;
3. A recipient does not share a bedroom with an individual who is not a recipient;
4. No more than two recipients share a bedroom;
5. If two recipients share a bedroom, each recipient agrees, in writing, to share the bedroom; and
6. A recipient's bedroom is not used to store anything that may be a hazard to the recipient or another individual.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Section R9-10-1611 renumbered to R9-10-1612; new Section R9-10-1611 renumbered from R9-10-1610 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

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R9-10-1612. Children's Behavioral Health Respite Services

- A.** A provider may provide children's behavioral health respite services for up to four recipients if at least two of the recipients are siblings.
- B.** For a behavioral health respite home that provides children's behavioral health respite services, a provider shall:
1. Have a valid fingerprint clearance card according to A.R.S. § 36-425.03; and
 2. Ensure that:
 - a. If an adult other than a provider is present in the behavioral health respite home, the provider supervises the adult when and where a recipient is present;
 - b. A recipient does not share a bedroom with:
 - i. An individual that, based on the other individual's developmental levels, social skills, verbal skills, and personal history, may present a threat to the recipient;
 - ii. Except as provided in subsection (C), an adult; or
 - iii. Except as provided in subsection (B)(2)(c), an individual that is not the same gender;
 - c. A recipient may share a bedroom with an individual that is not the same gender if the individual is the recipient's sibling;
 - d. A bedroom used by a recipient:
 - i. If the bedroom is a private bedroom, contains at least 60 square feet of floor space, not including the closet; or
 - ii. If the bedroom is a shared bedroom:
 - (1) Contains at least 100 square feet of floor space, not including a closet, for two individuals occupying the bedroom or contains at least 140 square feet of floor space, not including a closet, for three individuals occupying the bedroom;
 - (2) If there are four siblings occupying the bedroom, contains at least 140 square feet of floor space, not including a closet;
 - (3) Provides space between beds or bunk beds; and
 - (4) Provides sufficient space for an individual in the bedroom to have unobstructed access to the bedroom door;
 - iii. For a recipient under three years of age, may contain a crib;
 - iv. Except for a recipient under three years of age who has a crib, contains a bed for the recipient that is at least 36 inches wide and at least 72 inches long, and consists of at least a frame and mattress and clean linens; and
 - v. Contains individual storage space for personal effects and clothing such as shelves, a dresser, or chest of drawers;
 - e. Clean linens for a bed include a mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, waterproof mattress covers as needed, and blankets to ensure warmth and comfort of a recipient;
 - f. A recipient older than three years of age does not sleep in a crib;
 - g. Clean and non-hazardous toys, educational materials, and physical activity equipment are available and accessible to recipients in a quantity sufficient to

meet each recipient's needs and are appropriate to each recipient's age and developmental level; and

- h. The following are stored in a labeled container separate from food storage areas and inaccessible to a recipient:
 - i. Materials and chemicals labeled as a toxic substance, and
 - ii. Substances that have a child warning label and may be a hazard to a recipient.

- C.** If a recipient is younger than 2 years of age and sleeps in a crib, the recipient may sleep in a crib placed in a provider's bedroom.

Historical Note

New Section R9-10-1612 renumbered from R9-10-1611 and amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

ARTICLE 17. UNCLASSIFIED HEALTH CARE INSTITUTIONS**R9-10-1701. Definitions**

Definitions in A.R.S. § 36-401 and R9-10-101 apply in this Article unless otherwise specified.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-1702. Administration

- A.** A governing authority for a health care institution not otherwise classified or subclassified in A.R.S. Title 36, Chapter 4 or 9 A.A.C. 10 shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of the health care institution;
 2. Establish, in writing:
 - a. A health care institution's scope of services, and
 - b. Qualifications for an administrator;
 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
 4. Adopt a quality management program according to R9-10-1703;
 5. Review and evaluate the effectiveness of the quality management program in R9-10-1703 at least once every 12 months;
 6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on a health care institution's premises for more than 30 calendar days, or
 - b. Not present on a health care institution's premises for more than 30 calendar days; and
 7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425 when there is a change in an administrator and identify the name and qualifications of the new administrator.
- B.** An administrator:
1. Is directly accountable to the governing authority of a health care institution for the daily operation of the health care institution and all services provided by or at the health care institution;
 2. Has the authority and responsibility to manage the health care institution; and

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3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the health care institution's premises and accountable for the health care institution when the administrator is not present on the health care institution's premises.
- C. An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers and students;
 - c. Include how a personnel member may submit a complaint relating to services provided to a patient;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training, including:
 - i. The method and content of cardiopulmonary resuscitation training;
 - ii. The qualifications for an individual providing cardiopulmonary resuscitation training;
 - iii. The time-frame for renewal of cardiopulmonary resuscitation training; and
 - iv. The documentation that verifies that the individual has received cardiopulmonary resuscitation training;
 - f. Include a method to identify a patient to ensure the patient receives services as ordered;
 - g. Cover first aid training;
 - h. Cover patient rights, including assisting a patient who does not speak English or who has a physical or other disability to become aware of patient rights;
 - i. Cover specific steps for:
 - i. A patient to file a complaint, and
 - ii. The health care institution to respond to and resolve a patient complaint;
 - j. Cover medical records, including electronic medical records;
 - k. Cover a quality management program, including incident report and supporting documentation;
 - l. Cover contracted services;
 - m. Cover health care directives;
 - n. Cover when an individual may visit a patient in a health care institution; and
 - o. Cover fall prevention and fall recovery that complies with requirements in A.R.S. § 36-420.01;
 2. Policies and procedures for health care institution services are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient screening, admission, assessment, treatment plan, transport, transfer, and discharge, if applicable;
 - b. Cover patient outings, if applicable;
 - c. Include when general consent and informed consent are required;
 - d. Cover the provision of services listed in the health care institution's scope of services;
 - e. Cover administering medication, assistance in the self-administration of medication, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances, if applicable;
 - f. Cover infection control;
 - g. Cover telehealth, if applicable;
 - h. Cover environmental services that affect patient care;
 - i. Cover smoking and the use of tobacco products on the health care institution's premises;
 - j. Cover how the health care institution will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 - k. Cover how incidents are reported and investigated; and
 - l. Designate which employees or personnel members are required to have current certification in cardiopulmonary resuscitation and first aid training;
 3. Policies and procedures are reviewed at least once every three years and updated as needed;
 4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
 5. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after the Department's request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a health care institution, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the health care institution.
- D. If applicable, an administrator shall designate a clinical director who:
1. Provides direction for behavioral health services provided at the health care institution, and
 2. Is a behavioral health professional.
- E. An administrator shall provide written notification to the Department of a patient's:
1. Death, if the patient's death is required to be reported according to A.R.S. § 11-593, within one working day after the patient's death; and
 2. Self-injury, within two working days after the patient inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- F. If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from a health care institution's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:
1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
 2. For a patient under 18 years of age, according to A.R.S. § 13-3620.
- G. If an administrator has a reasonable basis, according to A.R.S. § 13-3620 or § 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while the patient is receiving unclassified healthcare services, the administrator shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Report the suspected abuse, neglect, or exploitation of the patient:

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- a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
- b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (G)(1); and
 - c. The report in subsection (G)(2);
4. Maintain the documentation in subsection (G)(3) for at least 12 months after the date of the report in subsection (G)(2);
5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in (G)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The action taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
6. Maintain a copy of the documented information required in subsection (G)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

H. An administrator shall ensure that the following information or documents are conspicuously posted on the premises and are available upon request to a personnel member, an employee, a patient, or a patient's representative:

1. The health care institution's current license,
2. The evacuation plan listed in R9-10-1711, and
3. The location at which inspection reports required in R9-10-1711(B) are available for review or can be made available for review.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Amended by final rulemaking at 16 A.A.R. 688, effective November 1, 2010 (Supp. 10-2). Section amended by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Subsection reference for inspection reports corrected at R9-10-1702(H)(3), file number R20-03 at the request of the Department (Supp. 19-3). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1703. 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 services provided to patients;

- 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 for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1704. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article,
2. Documentation of current contracted services that includes a description of the contracted services provided is maintained.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1705. Personnel

A. An administrator shall ensure that:

1. A personnel member is:
 - a. At least 21 years old, or
 - b. If providing behavioral health services, at least 18 years old;
2. An employee is at least 18 years old;
3. A student is at least 18 years old; and
4. A volunteer is at least 21 years old.

B. An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of behavioral health services or physical health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of participants receiving behavioral health services or physical health services from

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- the personnel member according to the established job description;
- b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures;
 3. Sufficient personnel members are present on a health care institution's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the health care institution's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient.
- C.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, employee, volunteer, and student is developed, documented, and implemented;
 2. A personnel member completes orientation before providing behavioral health services or physical health services;
 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 4. A plan to provide in-service education specific to the duties of a personnel member is developed;
 5. A personnel member's in-service education 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; and
 6. A work schedule of each personnel member is developed and maintained at the health care institution for at least 12 months after the date of the work schedule.
- D.** An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
- a. On or before the date the individual begins providing services at or on behalf of the unclassified healthcare institution, and
 - b. As specified in R9-10-113.
- E.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. If the health care institution provides services to children, the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03;
 - f. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-1702(C)(2)(I);
 - g. First aid training, if required for the individual according to this Article or policies and procedures; and
 - h. Evidence of freedom from infectious tuberculosis, if the individual is required to provide evidence of freedom according to subsection (D).
- F.** An administrator shall ensure that personnel records are:
1. Maintained:
 - a. Throughout an individual's period of providing services in or for the health care institution, and
 - b. For at least 24 months after the last date the individual provided services in or for the health care institution; and
 2. For a personnel member who has not provided physical health services or behavioral health services at or for the health care institution during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- G.** An administrator shall ensure that at least one personnel member who is present at the health care institution during the hours of the health care institution operation has first-aid training and cardiopulmonary resuscitation certification specific to the populations served by the health care institution.
- H.** An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1706. Transport; Transfer

- A.** Except as provided in subsection (B), an administrator shall ensure that:
1. A personnel member coordinates the transport and the services provided to the patient;
 2. According to policies and procedures:

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- a. An evaluation of the patient is conducted before and after the transport;
 - b. Information in the patient's medical record is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transport to the patient or the patient's representative; and
 3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the personnel member accompanying the patient during a transport.
- B.** Subsection (A) does not apply to:
 1. Transportation to a location other than a licensed health care institution;
 2. Transportation provided for a patient by the patient or the patient's representative;
 3. Transportation provided by an outside entity that was arranged for a patient by the patient or the patient's representative; or
 4. A transport to another licensed health care institution in an emergency.
- C.** Except for a transfer of a patient due to an emergency, an administrator shall ensure that:
 1. A personnel member coordinates the transfer and the services provided to the patient;
 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information in the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains the risks and benefits of the transfer to the patient or the patient's representative; and
 3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.
3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
 - b. Where patient rights are posted as required in subsection (A)(1).
- B.** An administrator shall ensure that:
 1. A patient is treated with dignity, respect, and consideration;
 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by the unclassified health care institution's personnel members, employees, volunteers, or students; and
 3. A patient or the patient's representative:
 - a. Is informed of the patient complaint process;
 - b. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a health care institution for identification and administrative purposes; and
 - c. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record; or
 - ii. Financial records.
- C.** A patient has the following rights:
 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive services that support and respect the patient's individuality, choices, strengths, and abilities;
 3. To receive privacy in care for personal needs;
 4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 5. To receive a referral to another health care institution if the provider is not authorized or not able to provide physical health services or behavioral health services needed by the patient; and
 6. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1707. Patient Rights

- A.** An administrator shall ensure that:
 1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
 2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1708. Medical Records

- A.** An administrator shall ensure that:

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1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
 2. An entry in a patient's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the entry illegible;
 3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
 - c. As permitted by law;
 6. Policies and procedures include the maximum time-frame to retrieve a patient's medical record at the request of a medical practitioner, behavioral health professional, or authorized personnel member; and
 7. A patient's medical record is protected from loss, damage, or unauthorized use.
- B.** If a health care institution maintains a patient's medical records electronically, an administrator shall ensure that:
1. Safeguards exist to prevent unauthorized access, and
 2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.
- C.** An administrator shall ensure that a patient's medical record contains:
1. Patient information that includes:
 - a. The patient's name;
 - b. The patient's address;
 - c. The patient's date of birth; and
 - d. Any known allergies, including medication allergies;
 2. The name of the admitting medical practitioner or behavioral health professional;
 3. The date of admission and, if applicable, the date of discharge;
 4. An admitting diagnosis;
 5. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Is a legal guardian, a copy of the court order establishing guardianship; or
 - ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
 6. If applicable, documented general consent and informed consent by the patient or the patient's representative;
 7. Documentation of medical history and results of a physical examination;
 8. A copy of the patient's health care directive, if applicable;
 9. Orders;
 10. Assessment;
 11. Treatment plans;
 12. Interval note;
 13. Progress notes;
 14. Documentation of health care institution services provided to the patient;
 15. Disposition of the patient after discharge;
 16. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 17. Discharge plan;
 18. A discharge summary, if applicable;
 19. If applicable:
 - a. Laboratory reports,
 - b. Radiologic reports,
 - c. Diagnostic reports, and
 - d. Consultation reports; and
 20. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain, when initially administered or PRN:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication, when initially administered or PRN:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The identification, signature, and professional designation of the individual administering or observing the self-administration of the medication; and
 - f. Any adverse reaction a patient has to the medication.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1709. Medication Services

- A.** An administrator shall ensure that:
1. Policies and procedures for medication services include:
 - a. A process for providing information to a patient about medication prescribed for the patient including the prescribed medications:
 - i. Anticipated results,
 - ii. Potential adverse reactions,
 - iii. Potential side effects, and

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- 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;
 - c. Procedures for responding to and reporting an unexpected reaction to a medication;
 - d. Procedures to ensure that a patient's medication regimen and method of administration is reviewed by a medical practitioner and to ensure the medication regimen meets the patient's needs;
 - e. Procedures for:
 - i. Documenting, as applicable, medication administration and assistance in the self-administration of medication; and
 - ii. Monitoring a patient who self-administers medication;
 - f. Procedures for assisting a patient in obtaining medication; and
 - g. If applicable, procedures for providing medication administration or assistance in the self-administration of medication off the premises; and
 - 2. A process is specified for review through the quality management program of:
 - a. A medication administration error; and
 - b. An adverse reaction to a medication.
- B.** If a health care institution provides medication administration, an administrator shall ensure that:
- 1. Medication is stored by the health care institution;
 - 2. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication; and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication in the patient's medical record;
 - 3. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law; and
 - 4. A medication administered to a patient:
 - a. Is administered in compliance with an order; and
 - b. Is documented in the patient's medical record.
- C.** If a health care institution provides assistance in the self-administration of medication, an administrator shall ensure that:
- 1. A patient's medication is stored by the health care institution;
 - 2. The following assistance is provided to a patient:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the patient;
 - c. Observing the patient while the patient removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the patient's medical practitioner by confirming that:
 - i. The patient taking the medication is the individual stated on the medication container label;
 - ii. The patient is taking the dosage of the medication as stated on the medication container label; and
 - iii. The patient is taking the medication at the time stated on the medication container label; or
 - e. Observing the patient while the patient takes the medication;
- 3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by a medical practitioner or registered nurse;
 - 4. Training for a personnel member, other than a medical practitioner or registered nurse, in assistance in the self-administration of medication:
 - a. Is provided by a medical practitioner or registered nurse or an individual trained by a medical practitioner or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication;
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention; and
 - iii. Process for notifying the appropriate entities when an emergency medical intervention is needed;
 - 5. A personnel member, other than a medical practitioner or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
 - 6. Assistance in the self-administration of medication provided to a patient:
 - a. Is in compliance with an order; and
 - b. Is documented in the patient's medical record.
- D.** 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; and
 - 3. If pharmaceutical services are provided on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - i. Develop a drug formulary;
 - ii. Update the drug formulary at least once every 12 months;
 - iii. Develop medication usage and medication substitution policies and procedures; and
 - iv. Specify which medications and medication classifications are required to be automatically stopped after a specific time period unless the ordering medical practitioner specifically orders otherwise;
 - b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. 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
 - d. A copy of the pharmacy license is provided to the Department upon request.
- E.** When medication is stored at a health care institution, an administrator shall ensure that:
- 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and

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3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication;
 - d. Storing, inventorying, and dispensing controlled substances;
 - e. If applicable, donated medicine according to A.R.S. § 32-1909.
- F. An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the health care institution's clinical director.
5. A health care institution has a portable fire extinguisher that is labeled 1A-10-BC by the Underwriters Laboratory and is available to a personnel member;
6. A portable fire extinguisher required in subsection (A)(5) is:
 - a. If a disposable fire extinguisher, replaced when the fire extinguisher's indicator reaches the red zone; or
 - b. Serviced at least once every 12 months and has a tag attached to the fire extinguisher that includes the date of service;
7. A written evacuation plan is maintained and available for use by personnel members and any patient in a health care institution;
8. An evacuation drill is conducted at least once every six months; and
9. A record of an evacuation drill required in subsection (A)(8) is maintained for at least 12 months after the date of the evacuation drill.
- B. An administrator shall:
 1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the fire inspection report, and
 3. Maintain documentation of a current fire inspection.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1710. Food Services

If food services are provided, an administrator shall ensure:

1. Food is obtained, handled, and stored to prevent contamination, spoilage, or a threat to the health of a patient;
2. Three nutritionally balanced meals are served each day;
3. Nutritious snacks are available between meals;
4. Food served meets any special dietary needs of a patient as prescribed by the patient's physician or dietitian; and
5. Chemicals and detergents are not stored with food.

Historical Note

Adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-1711. Emergency and Safety Standards

A. An administrator shall ensure that:

1. A first aid kit is available at a health care institution;
2. If a firearm or ammunition for a firearm are stored at a health care institution:
 - a. The firearm is stored separate from the ammunition for the firearm; and
 - b. The firearm and the ammunition for the firearm are:
 - i. Stored in a locked closet, cabinet, or container; and
 - ii. Inaccessible to a patient;
3. If applicable, there is a smoke detector installed in:
 - a. A bedroom used by a patient,
 - b. A hallway in a health care institution, and
 - c. A health care institution's kitchen;
4. A smoke detector required in subsection (A)(3):
 - a. Is maintained in operable condition; and
 - b. Is battery operated or, if hard-wired into the electrical system of a health care institution, has a back-up battery;

Historical Note

Adopted effective July 24, 1978 (Supp. 78-4). Section repealed; new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1712. Physical Plant, Environmental Services, and Equipment Standards

A. If applicable, an administrator shall ensure that a health care institution:

1. Is in a building that:
 - a. Has a certificate of occupancy from the local jurisdiction; and
 - b. Is free of any plumbing, electrical, ventilation, mechanical, or structural hazard that may jeopardize the health or safety of a patient;
2. Has a living room accessible at all times to a patient;
3. Has a dining area furnished for group meals that is accessible to the provider, patients, and any other individuals present in the health care institution;
4. Has:
 - a. At least one bathroom for every six individuals residing in the health care institution, including patients; and
 - b. A bathroom accessible for use by a patient that contains:
 - i. A working sink with running water, and
 - ii. A working toilet that flushes and has a seat; and
5. Has equipment and supplies to maintain a patient's personal hygiene that are accessible to the patient.

B. An administrator shall ensure that:

1. A health care institution's premises are:
 - a. Sufficient to provide the health care institution's scope of services;

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- b. Cleaned and disinfected according to the health care institution's policies and procedures to prevent, minimize, and control illness and infection;
 - c. Clean and free from accumulations of dirt, garbage, and rubbish; and
 - d. Free from a condition or situation that may cause an individual to suffer physical injury;
2. If a health care institution collects urine or stool specimens from a patient, the health care institution has at least one bathroom that:
- a. 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 means of ventilation; and
 - b. Is for the exclusive use of the health care institution;
3. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
4. If pets or animals are allowed in the health care institution, pets or animals are:
- a. Controlled to prevent endangering the patients and to maintain sanitation;
 - b. Licensed consistent with local ordinances; and
 - c. For a dog or a cat, vaccinated against rabies;
5. A smoke-free environment is maintained on the premises;
6. A refrigerator used to store a medication is:
- a. Maintained in working order, and
 - b. Only used to store medications;
7. Equipment at the health care institution is:
- a. Sufficient to provide the health care institution's scope of service;
 - b. Maintained in working condition;
 - c. Used according to the manufacturer's recommendations; and
 - d. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in policies and procedures;
8. Documentation of an equipment test, calibration, and repair is maintained for at least 12 months after the date of testing, calibration, or repair; and
9. Combustible or flammable liquids and hazardous materials stored by the health care institution are stored in the original labeled containers or safety containers in a storage area that is locked and inaccessible to patients.

Historical Note

Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2). Amended by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1713. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3). Section repealed by exempt rulemaking at 19 A.A.R. 2015, effective October 1, 2013 (Supp. 13-2).

R9-10-1714. Reserved**R9-10-1715. Repealed****Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1716. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1717. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1718. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1719. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1720. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1721. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1722. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1723. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1724. Reserved**R9-10-1725. Reserved****R9-10-1726. Reserved****R9-10-1727. Reserved****R9-10-1728. Reserved****R9-10-1729. Reserved****R9-10-1730. Reserved**

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R9-10-1731. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1732. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1733. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Corrections: R9-10-1733(B)(2), correction in spelling, “architectural”; R9-10-1733(C)(1)(d), 100 square feet, corrected to read “1000” square feet, as certified effective July 24, 1978 (Supp. 87-2). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1734. Repealed**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

ARTICLE 18. ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES**R9-10-1801. Definitions**

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

1. “Acceptance” means, after a referral from a collaborating health care institution, an individual begins to live in and receive services from a provider in an adult behavioral health therapeutic home.
2. “Backup provider” means an individual designated by a provider to be present in an adult behavioral health therapeutic home, when a provider is not present, who ensures that a resident receives the behavioral health services and ancillary services in the resident’s treatment plan.
3. “Provider” means an individual who lives in an adult behavioral health therapeutic home and ensures that a resident receives the behavioral health services and ancillary services in the resident’s treatment plan.
4. “Release” means a documented termination of services to a resident by a provider that is authorized by a collaborating health care institution.
5. “Resident” means an individual referred by a collaborating health care institution to and accepted by an adult behavioral health therapeutic home.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1802. Supplemental Application Requirements; Exemption

A. In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, an applicant shall include, in a format provided by the Department:

1. The name of the backup provider; and
2. For the adult behavioral health therapeutic home’s collaborating health care institution:
 - a. Name,
 - b. Address,

- c. Class or subclass,
- d. License number, and
- e. Name and contact information for an individual assigned by the collaborating health care institution to monitor the adult behavioral health therapeutic home.

B. An adult behavioral health therapeutic home is exempt from complying with building codes or zoning standards required in 9 A.A.C. 10, Article 1 specified in A.R.S. § 36-421.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 28 A.A.R. 871 (April 29, 2022), with an immediate effective date of April 8, 2022 (Supp. 22-2).

R9-10-1803. Administration

A. A governing authority of an adult behavioral health therapeutic home:

1. Consists of no more than two providers, who live in the adult behavioral health therapeutic home;
2. Has the authority and responsibility to manage the adult behavioral health therapeutic home;
3. Has a documented agreement with a collaborating health care institution that establishes the responsibilities of the adult behavioral health therapeutic home and the collaborating health care institution, consistent with the requirements in this Chapter;
4. Shall establish, in writing, the adult behavioral health therapeutic home’s scope of services, which are approved by the collaborating health care institution;
5. Shall designate a back-up provider to be present in the adult behavioral health therapeutic home and accountable for services provided by the adult behavioral health therapeutic home when the provider is not present at the adult behavioral health therapeutic home; and
6. Shall ensure that:
 - a. No more than three residents are accepted by the adult behavioral health therapeutic home;
 - b. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - c. When documentation or information is required by this Chapter to be submitted on behalf of the adult behavioral health therapeutic home, the documentation or information is provided to the unit in the Department that is responsible for licensing the adult behavioral health therapeutic home.

B. A provider or back-up provider:

1. Is at least 21 years of age;
2. Holds current certification in cardiopulmonary resuscitation and first aid training applicable to the ages of residents;
3. Has the skills and knowledge established by the collaborating health care institution as specified in R9-10-118;
4. Has documentation of completion of training in assistance in the self-administration of medication as specified in R9-10-118; and
5. Has documentation of evidence of freedom from infectious tuberculosis:
 - a. On or before the date the provider or back-up provider begins providing services at or on behalf of the adult behavioral health therapeutic home, and
 - b. As specified in R9-10-113.

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- C. A provider shall ensure that policies and procedures are:
1. Established, documented, and implemented to protect the health and safety of a resident that cover:
 - a. Recordkeeping;
 - b. Resident acceptance and release;
 - c. Resident rights;
 - d. The provision of services, including coordinating the provision of behavioral health services;
 - e. Residents' medical records, including electronic medical records;
 - f. Assistance in the self-administration of medication;
 - g. Infection control; and
 - h. How a provider will respond to a resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual;
 2. Approved, in writing, by an adult behavioral health therapeutic home's collaborating health care institution before implementation and when the policies and procedures are reviewed or updated; and
 3. Reviewed by the provider and an adult behavioral health therapeutic home's collaborating health care institution at least once every three years and updated as needed.
- D. A provider shall provide written notification to the Department and the adult behavioral health therapeutic home's collaborating health care institution of a resident's:
1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
 2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- E. If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was accepted or while the resident is not at an adult behavioral health therapeutic home and not receiving services from the adult behavioral health therapeutic home, a provider shall report the alleged or suspected abuse, neglect, or exploitation of the resident according to A.R.S. § 46-454.
- F. If a provider has a reasonable basis, according to A.R.S. § 46-454, to believe abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving adult behavioral health therapeutic services, the provider shall:
1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 2. Immediately report the suspected abuse, neglect, or exploitation of the resident as follows:
 - a. To the adult behavioral health therapeutic home's collaborating health care institution; and
 - b. According to A.R.S. § 46-454;
 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the provider to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- G. A provider shall maintain a record for each provider and backup provider that includes:
1. For the provider and the backup provider:
 - a. Name;
 - b. Date of birth;
 - c. Contact telephone number; and
 - d. Documentation of:
 - i. Verification of skills and knowledge, completed by the adult behavioral health therapeutic home's collaborating health care institution;
 - ii. Certification in cardiopulmonary resuscitation and first aid training;
 - iii. Completion of training in assistance in the self-administration of medication, provided by the adult behavioral health therapeutic home's collaborating health care institution;
 - iv. If the provider or backup provider provides behavioral health services, clinical oversight as required in R9-10-1805(C); and
 - v. Evidence of freedom from infectious tuberculosis; and
 2. For the backup provider, home address.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1804. Resident Rights

- A. A provider shall ensure that:
1. A resident is treated with dignity, respect, and consideration;
 2. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by:
 - i. An adult behavioral health therapeutic home's provider or backup provider, or
 - ii. An individual other than a resident residing in the adult behavioral health therapeutic home; and
 3. A resident or the resident's representative:
 - a. Is informed of the resident complaint process;

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- b. Consents to photographs of the resident before the resident is photographed, except that the resident may be photographed when accepted by an adult behavioral health therapeutic home for identification and administrative purposes; and
- c. Except as otherwise permitted by law, provides written consent to the release of information in the resident's medical record.

B. A resident has the following rights:

- 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- 2. To receive services that support and respect the resident's individuality, choices, strengths, and abilities;
- 3. To receive privacy in care for personal needs;
- 4. To review, upon written request, the resident's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
- 5. To receive a referral to another health care institution if the provider is not authorized or not able to provide physical health services or behavioral health services needed by the resident; and
- 6. To receive assistance from a family member, resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1805. Providing Services

- A.** A provider shall ensure that behavioral health services and ancillary services are provided to a resident according to the resident's treatment plan obtained from the adult behavioral health therapeutic home's collaborating health care institution.
- B.** A provider shall submit documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition and the action taken by the provider to address the resident's changing needs to the adult behavioral health therapeutic home's collaborating health care institution or, if applicable, the resident's case manager.
- C.** A provider who provides behavioral health services to a resident:
 - 1. For the purpose of an exception to licensing in A.R.S. § 32-3271, is considered a behavioral health technician; and
 - 2. Shall comply with the requirements for clinical oversight for a behavioral health technician in R9-10-115.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1806. Assistance in the Self-Administration of Medication

- A.** If a provider provides assistance in the self-administration of medication, the provider shall ensure that:
 - 1. If a resident is receiving assistance in the self-administration of medication, the resident's medication is stored by the provider;
 - 2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container or medication organizer for the resident;

- c. Observing the resident while the resident removes the medication from the medication container or medication organizer;
- d. Verifying that the medication is taken as ordered by the resident's medical practitioner by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label,
 - ii. The resident is taking the dosage of the medication as stated on the medication container label, and
 - iii. The resident is taking the medication at the time stated on the medication container label; or
- e. Observing the resident while the resident takes the medication; and
- 3. Assistance in the self-administration of medication provided to a resident is documented in the resident's medical record.

B. When medication is stored by a provider, the provider shall ensure that:

- 1. A locked cabinet, closet, or self-contained unit is used for medication storage;
- 2. Medication is stored according to the instructions on the medication container; and
- 3. Medication, including expired medication, that is no longer being used is discarded.

C. A provider shall immediately report a medication error or a resident's adverse reaction to a medication to the:

- 1. Medical practitioner who ordered the medication, or
- 2. Contact individual at an adult behavioral health therapeutic home's collaborating health care institution.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1807. Medical Records**A. A provider shall ensure that:**

- 1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
- 2. An entry in a resident's medical record is:
 - a. Only recorded by the provider or individual designated by the provider to record an entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
- 3. A resident's medical record is available to an individual:
 - a. Authorized by policies and procedures to access the resident's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law; and
- 4. A resident's medical record is protected from loss, damage, or unauthorized use.

B. If a provider maintains residents' medical records electronically, the provider shall ensure that safeguards exist to prevent unauthorized access.**C. A provider shall ensure that a resident's medical record contains:**

- 1. Resident information that includes:
 - a. The resident's name,
 - b. The resident's date of birth,

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- c. Any known allergies, and
 - d. Medication information for the resident;
2. The names, addresses, and telephone numbers of:
 - a. The resident's medical practitioner;
 - b. The resident's case manager, if applicable;
 - c. The behavioral health professional assigned to the resident by the adult behavioral health therapeutic home's collaborating health care institution; and
 - d. An individual to be contacted in the event of an emergency;
3. The date of the resident's acceptance by the adult behavioral health therapeutic home and, if applicable, the date of the resident's release from the adult behavioral health therapeutic home;
4. If applicable, the name and contact information of the resident's representative and:
 - a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
5. A copy of the resident's treatment plan and any updates to the resident's treatment plan, obtained from the adult behavioral health therapeutic home's collaborating health care institution;
6. For a resident receiving assistance in the self-administration of medication, documentation that includes for each medication:
 - a. The date and time of assistance;
 - b. The name, strength, dosage, and route of administration;
 - c. The provider's signature or first and last initials; and
 - d. Any adverse reaction the resident has to the medication;
7. Documentation of the resident's refusal of a medication, if applicable;
8. Documentation of any significant change in a resident's behavior or physical, cognitive, or functional condition and the action taken by a provider to address the resident's changing needs;
9. If applicable, documentation of any actions taken to control the resident's sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual; and
10. If applicable, a written notice of termination of residency.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1808. Food Services

A provider shall ensure that:

1. Food is obtained, handled, and stored to prevent contamination, spoilage, or a threat to the health of a resident;
2. Three nutritionally balanced meals are served each day;
3. Nutritious snacks are available between meals;

4. Food served meets any special dietary needs of a resident as prescribed by the resident's physician or registered dietitian; and
5. Chemicals or detergents are not stored with food.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1809. Emergency and Safety Standards

A provider shall ensure that:

1. A first aid kit is available at an adult behavioral health therapeutic home sufficient to meet the needs of residents;
2. If a firearm or ammunition for a firearm is stored at an adult behavioral health therapeutic home:
 - a. The firearm is stored separate from the ammunition for the firearm; and
 - b. The firearm and the ammunition for the firearm are:
 - i. Stored in a locked closet, cabinet, or container; and
 - ii. Inaccessible to a resident;
3. A smoke detector is installed in:
 - a. A bedroom used by a resident,
 - b. A hallway in an adult behavioral health therapeutic home, and
 - c. An adult behavioral health therapeutic home's kitchen;
4. A smoke detector required in subsection (3):
 - a. Is maintained in operable condition; and
 - b. Is battery operated or, if hard-wired into the electrical system of an adult behavioral health therapeutic home, has a back-up battery;
5. An adult behavioral health therapeutic home has a portable fire extinguisher that is labeled 1A-10-BC by the Underwriters Laboratory and available in the adult behavioral health therapeutic home's kitchen;
6. A portable fire extinguisher required in subsection (5) is:
 - a. If a disposable fire extinguisher, replaced when the fire extinguisher's indicator reaches the red zone; or
 - b. Serviced at least once every 12 months and has a tag attached to the fire extinguisher that includes the date of service;
7. A written evacuation plan is maintained and available for use by the provider and any resident in an adult behavioral health therapeutic home;
8. An evacuation drill is conducted at least once every six months; and
9. A record of an evacuation drill required in subsection (8) is maintained for at least one year after the date of the evacuation drill.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2).

R9-10-1810. Physical Plant, Environmental Services, and Equipment Standards

A. A provider shall ensure that an adult behavioral health therapeutic home:

1. Is in a building that:
 - a. Is arranged, designed, and used for the living, sleeping, and housekeeping activities for one family on a permanent basis; and

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- b. Is free of any plumbing, electrical, ventilation, mechanical, chemical, or structural hazard that may jeopardize the health or safety of a resident;
 - 2. Has a living room accessible at all times to a resident;
 - 3. Has a dining area furnished for group meals that is accessible to the provider, residents, and any other individuals present in the adult behavioral health therapeutic home;
 - 4. For each six individuals residing in the adult behavioral health therapeutic home, including residents, has at least one bathroom equipped with:
 - a. A working toilet that flushes and has a seat; and
 - b. A sink with running water accessible for use by a resident;
 - 5. Has equipment and supplies to maintain a resident's personal hygiene that are accessible to the resident;
 - 6. Is clean and free from accumulations of dirt, garbage, and rubbish; and
 - 7. Implements a pest control program that complies with A.A.C. R3-8-201(C)(4) to minimize the presence of insects and vermin at the adult behavioral health therapeutic home.
- B.** A provider shall ensure that pets and animals are:
 - 1. Controlled to prevent endangering the residents and to maintain sanitation;
 - 2. Licensed consistent with local ordinances; and
 - 3. For a dog or cat, vaccinated against rabies.
- C.** If a swimming pool is located on the premises, a provider shall ensure that:
 - 1. The swimming pool is equipped with the following:
 - a. An operational water circulation system that clarifies and disinfects the swimming pool water continuously and that includes at least:
 - i. A removable strainer,
 - ii. Two swimming pool inlets located on opposite sides of the swimming pool, and
 - iii. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed without using tools; and
 - b. An operational cleaning system;
 - 2. The swimming pool is enclosed by a wall or fence that:
 - a. Is at least five feet in height as measured on the exterior of the wall or fence;
 - b. Has no vertical openings greater than four inches across;
 - c. Has no horizontal openings, except as described in subsection (C)(2)(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 swimming pool,
 - ii. Has a latch located at least 54 inches from the ground, and
 - iii. Is locked when the swimming pool is not in use; and
 - 3. A life preserver or shepherd's crook is available and accessible in the pool area.
- D.** A provider shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (C)(2) is covered and locked when not in use.
- E.** A provider shall ensure that:
 - 1. A bedroom for use by a resident:
 - a. Is separated from a hall, corridors, or other habitable room by floor-to-ceiling walls containing no interior openings except doors and is not used as a passageway to another bedroom or habitable room;
 - b. Provides sufficient space for an individual in the bedroom to have unobstructed access to the bedroom door;
 - c. Contains for each resident using the bedroom:
 - i. A separate, adult-sized, single bed or larger bed with a clean mattress in good repair;
 - ii. Clean bedding appropriate for the season; and
 - iii. An individual dresser and closet for storage of personal possessions and clothing; and
 - d. If used for:
 - i. Single occupancy, contains at least 60 square feet of floor space; or
 - ii. Double occupancy, contains at least 100 square feet of floor space; and
 - 2. A mirror is available to a resident for grooming;
 - 3. A resident does not share a bedroom with an individual who is not a resident;
 - 4. No more than two residents share a bedroom;
 - 5. If two residents share a bedroom, each resident agrees, in writing, to share the bedroom; and
 - 6. A resident's bedroom is not used to store anything other than the furniture and articles used by the resident and the resident's belongings.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 1409, pursuant to Laws 2013, Ch. 10, § 13; effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 25 A.A.R. 259, effective January 8, 2019 (Supp. 19-1).

ARTICLE 19. COUNSELING FACILITIES**R9-10-1901. Repealed****Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Repealed by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1902. Supplemental Application Requirements

In addition to the license application requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1, a governing authority applying for a license as a counseling facility shall submit, in a format provided by the Department:

- 1. The days and hours of clinical operation and, if different from the days and hours of clinical operation, the days and hours of administrative operation;
- 2. If applicable, a request to provide one of the following:
 - a. DUI screening,
 - b. DUI education,
 - c. DUI treatment, or
 - d. Misdemeanor domestic violence offender treatment;
- 3. Whether the counseling facility has an affiliated outpatient treatment center;
- 4. If the counseling facility has an affiliated outpatient treatment center:
 - a. The affiliated outpatient treatment center's name; and
 - b. Either:

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- i. The license number assigned to the affiliated outpatient treatment center by the Department; or
- ii. If the affiliated outpatient treatment center is not currently licensed, the:
 - (1) Street address of the affiliated outpatient treatment center, and
 - (2) Date the affiliated outpatient treatment center submitted to the Department an application for a health care institution license;
- 5. Whether the counseling facility is sharing administrative support with an affiliated counseling facility; and
- 6. If the counseling facility is sharing administrative support with an affiliated counseling facility, for each affiliated counseling facility sharing administrative support with the counseling facility:
 - a. The affiliated counseling facility's name; and
 - b. Either:
 - i. The license number assigned to the affiliated counseling facility by the Department; or
 - ii. If the affiliated counseling facility is not currently licensed, the:
 - (1) Street address of the affiliated counseling facility, and
 - (2) Date the affiliated counseling facility submitted to the Department an application for a health care institution license.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final rulemaking at 25 A.A.R. 1583, effective October 1, 2019 (Supp. 19-3).

R9-10-1903. Administration

- A.** A governing authority shall:
 - 1. Consist of one of more individuals accountable for the organization, operation, and administration of a counseling facility;
 - 2. Establish, in writing:
 - a. A counseling facility's scope of services, and
 - b. Qualifications for an administrator;
 - 3. Designate, in writing, an administrator who has the qualifications established in subsection (A)(2)(b);
 - 4. Adopt a quality management program according to R9-10-1904;
 - 5. Review and evaluate the effectiveness of the quality management program in R9-10-1904 at least once every 12 months;
 - 6. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on the premises for more than 30 calendar days, or
 - b. Not present on the premises for more than 30 calendar days; and
 - 7. Except as provided in subsection (A)(6), notify the Department according to A.R.S. § 36-425(I) when there is a change in an administrator and identify the name and qualifications of the new administrator.
- B.** An administrator:
 - 1. Is directly accountable to the governing authority for the daily operation of the counseling facility and all services provided by or at the counseling facility;
 - 2. Has the authority and responsibility to manage the counseling facility; and
 - 3. Except as provided in subsection (A)(6), designates in writing, an individual who is present on the counseling facility's premises and accountable for the counseling facility when the administrator is not available.
- C.** An administrator or the administrator of the counseling facility's affiliated outpatient treatment center shall establish policies and procedures to protect the health and safety of a patient that:
 - 1. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience, for personnel members, employees, volunteers, and students;
 - 2. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - 3. Include how a personnel member may submit a complaint relating to services provided to a patient;
 - 4. Cover the requirements in Title 36, Chapter 4, Article 11;
 - 5. Cover patient screening, admission, assessment, discharge planning, and discharge;
 - 6. Cover medical records;
 - 7. Cover the provision of counseling and any services listed in the counseling facility's scope of services;
 - 8. Include when general consent and informed consent are required;
 - 9. Cover telehealth, if applicable;
 - 10. Cover specific steps for:
 - a. A patient or a patient's representative to file a complaint, and
 - b. A counseling facility to respond to a complaint; and
 - 11. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual.
- D.** An administrator shall ensure that:
 - 1. Policies and procedures established according to subsection (C) are documented and implemented;
 - 2. Counseling facility policies and procedures are:
 - a. Reviewed at least once every three years and updated as needed, and
 - b. Available to personnel members and employees;
 - 3. Unless otherwise stated:
 - a. Documentation required by this Article is maintained and provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a counseling facility, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the counseling facility;
 - 4. The following are conspicuously posted:
 - a. The current license for the counseling facility issued by the Department;
 - b. The name, address, and telephone number of the Department;
 - c. A notice that a patient may file a complaint with the Department about the counseling facility;
 - d. A list of patient rights;
 - e. A map for evacuating the facility; and

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- f. A notice identifying the location on the premises where current license inspection reports required in A.R.S. § 36-425(H), with patient information redacted, are available;
- 5. Patient follow-up instructions are:
 - a. Provided, orally or in written form, to a patient or the patient's representative before the patient leaves the counseling facility unless the patient leaves against a personnel member's advice; and
 - b. Documented in the patient's medical record; and
- 6. Cardiopulmonary resuscitation training includes a demonstration of the individual's ability to perform cardiopulmonary resuscitation.
- E. If abuse, neglect, or exploitation of a patient is alleged or suspected to have occurred before the patient was admitted or while the patient is not on the premises and not receiving services from a counseling facility's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the patient as follows:
 - 1. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
 - 2. For a patient under 18 years of age, according to A.R.S. § 13-3620.
- F. If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a patient is receiving services from a counseling facility's employee or personnel member, an administrator shall:
 - 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the patient as follows:
 - a. For a patient 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a patient under 18 years of age, according to A.R.S. § 13-3620;
 - 3. Document:
 - a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (F)(1); and
 - c. The report in subsection (F)(2);
 - 4. Maintain the documentation in subsection (F)(3) for at least 12 months after the date of the report in subsection (F)(2);
 - 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (F)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the patient related to the suspected abuse or neglect and any change to the patient's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
 - 6. Maintain a copy of the documented information required in subsection (F)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1904. 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 services provided to patients;
 - 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 change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-1905. Contracted Services

An administrator shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-1906. Personnel

An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of counseling expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients expected to be receiving the counseling from the personnel member

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- according to the established job description; and
- b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the counseling listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the counseling listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the counseling listed in the established job description;
- 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides counseling, and
 - b. According to policies and procedures;
- 3. Sufficient personnel members are present on a counseling facility's premises during hours of clinical operation with the qualifications, skills, and knowledge necessary to:
 - a. Provide the counseling in the counseling facility's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient;
- 4. At least one personnel member with cardiopulmonary resuscitation training is present on a counseling facility's premises during hours of clinical operation;
- 5. At least one personnel member with first aid training is present on a counseling facility's premises during hours of clinical operation;
- 6. A personnel member only provides counseling the personnel member is qualified to provide;
- 7. A plan is developed, documented, and implemented to provide orientation specific to the duties of personnel members, employees, volunteers, and students;
- 8. A personnel member completes orientation before providing counseling to a patient;
- 9. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
- 10. A plan is developed, documented, and implemented to provide in-service education specific to the duties of a personnel member;
- 11. A personnel member's in-service education is documented, to include:
 - a. The personnel member's name,
 - b. The date of the in-service education, and
 - c. The subject or topics covered in the in-service education;
- 12. A personnel member who is a behavioral health technician or behavioral health paraprofessional complies with the applicable requirements in R9-10-115;
- 13. A record for a personnel member, an employee, a volunteer, or a student is maintained that includes:
 - a. The individual's name, date of birth, and contact telephone number;
 - b. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
- c. Documentation of:
 - i. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - ii. The individual's education and experience applicable to the individual's job duties;
 - iii. The individual's completed orientation and in-service education as required by policies and procedures;
 - iv. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - v. If the individual is a behavioral health technician, clinical oversight required in R9-10-115;
 - vi. The individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03, if applicable;
 - vii. If applicable, cardiopulmonary resuscitation training; and
 - viii. If applicable, first aid training; and
- 14. The record in subsection (13) is:
 - a. Maintained while an individual provides services for or at the counseling facility and for at least 24 months after the last date the individual provided services for or at the counseling facility; and
 - b. If the ending date of employment or volunteer service was 12 or more months before the date of the Department's request, provided to the Department within 72 hours after the Department's request.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-1907. 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 subsection (B) and the patient rights in subsection (C).
- B.** An administrator shall ensure that:
 - 1. A patient is treated with dignity, respect, and consideration;
 - 2. A patient as not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Restraint or seclusion;
 - i. Retaliation for submitting a complaint to the Department or another entity; or
 - j. Misappropriation of personal and private property by a counseling facility's personnel member, employee, volunteer, or student; and
 - 3. A patient or the patient's representative:
 - a. Either consents to or refuses counseling;
 - b. May refuse or withdraw consent for receiving counseling before counseling is initiated;
 - c. Is informed of the following:
 - i. The counseling facility's policy on health care directives, and
 - ii. The patient complaint process;

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- d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a counseling facility for identification and administrative purposes; and
- e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.
- C. A patient has the following rights:
 - 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 - 2. To receive counseling that supports and respects the patient's individuality, choices, strengths, and abilities;
 - 3. To receive privacy during counseling;
 - 4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 - 5. To receive a referral to another health care institution if the counseling facility is not authorized or not able to provide the behavioral health services needed by the patient;
 - 6. To participate or have the patient's representative participate in the development of, or decisions concerning, the counseling provided to the patient;
 - 7. To participate or refuse to participate in research or experimental treatment; and
 - 8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
- b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
- c. As permitted by law; and
- 6. A patient's medical record is protected from loss, damage, or unauthorized use.
- B. If a counseling facility maintains patients' medical records electronically, an administrator shall ensure that:
 - 1. Safeguards exist to prevent unauthorized access, and
 - 2. The date and time of an entry in a 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 and address, and
 - b. The patient's date of birth;
 - 2. A diagnosis or reason for counseling;
 - 3. Documentation of general consent and, if applicable, informed consent for counseling by the patient or the patient's representative;
 - 4. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 - 5. Documentation of medical history;
 - 6. Orders;
 - 7. Assessment;
 - 8. Interval notes;
 - 9. Progress notes;
 - 10. Documentation of counseling provided to the patient;
 - 11. The name of each individual providing counseling;
 - 12. Disposition of the patient upon discharge;
 - 13. Documentation of the patient's follow-up instructions provided to the patient;
 - 14. A discharge summary; and
 - 15. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-1908. Medical Records

- A. An administrator shall ensure that:
 - 1. A medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
 - 2. An entry in a patient's medical record is:
 - a. Recorded only by a personnel member authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
 - 3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4).

R9-10-1909. Counseling

- A. An administrator of a counseling facility shall ensure that:
 - 1. Counseling provided at the counseling facility is provided under the direction of a behavioral health professional;
 - 2. A personnel member who provides counseling is at least 18 years old; and
 - 3. If a counseling facility provides counseling to a patient who is less than 18 years of age, an employee or a volunteer and the owner comply with the fingerprint clearance card requirements in A.R.S. § 36-425.03.
- B. An administrator of a counseling facility shall ensure that:

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1. Before counseling for a patient is initiated, there is a behavioral health assessment for the patient that complies with the requirements in this Section that is:
 - a. Available:
 - i. In the patient's medical record maintained by the counseling facility;
 - ii. If the counseling facility is an affiliated counseling facility, in the patient's integrated medical record; or
 - iii. If the counseling facility has an affiliated outpatient treatment center, in the patient's integrated medical record maintained by the counseling facility's affiliated outpatient treatment center; and
 - b. Either:
 - i. Completed by a personnel member at the counseling facility; or
 - ii. Obtained from a behavioral health provider other than the counseling facility;
2. A behavioral health assessment, obtained from a behavioral health provider other than the counseling facility or available in a medical record or integrated medical record, was completed within 12 months before the date of the patient's current admission;
3. If a behavioral health assessment is obtained from a behavioral health provider other than the counseling facility or is available as stated in subsection (B)(1)(a), the information in the behavioral health assessment is reviewed and updated if additional information that affects the patient's behavioral health assessment is identified;
4. The review and update of the patient's assessment information in subsection (B)(3) is documented in the patient's medical record within 48 hours after the review is completed;
5. If a behavioral health assessment is conducted by a:
 - a. Behavioral health technician or a registered nurse, within 72 hours after the behavioral health assessment is conducted, a behavioral health professional certified or licensed to provide the counseling needed by the patient reviews and signs the behavioral health assessment to ensure that the behavioral health assessment identifies the counseling needed by the patient; or
 - b. Behavioral health paraprofessional, a behavioral health professional certified or licensed to provide the counseling needed by the patient supervises the behavioral health paraprofessional during the completion of the behavioral health assessment and signs the behavioral health assessment to ensure that the assessment identifies the counseling needed by the patient;
6. A behavioral health assessment:
 - a. Documents a patient's:
 - i. Presenting issue;
 - ii. Substance use history;
 - iii. Co-morbidity;
 - iv. Medical condition and history;
 - v. Legal history, including:
 - (1) Custody,
 - (2) Guardianship, and
 - (3) Pending litigation;
 - vi. Criminal justice record;
 - vii. Family history;
 - viii. Behavioral health treatment history; and
 - ix. Symptoms reported by the patient or the patient's representative and referrals needed by the patient, if any;
 - b. Includes:
 - i. Recommendations for further assessment or examination of the patient's needs;
 - ii. A description of the counseling, including type, frequency, and number of hours, that will be provided to the patient; and
 - iii. The signature and date signed of the personnel member conducting the behavioral health assessment; and
 - c. Is documented in patient's medical record;
7. A patient is referred to a medical practitioner if a determination is made that the patient requires immediate physical health services or the patient's behavioral health issue may be related to the patient's medical condition;
8. A request for participation in a patient's behavioral health assessment is made to the patient or the patient's representative;
9. An opportunity for participation in the patient's behavioral health assessment is provided to the patient or the patient's representative;
10. Documentation of the request in subsection (B)(8) and the opportunity in subsection (B)(9) is in the patient's medical record;
11. A patient's behavioral health assessment information is documented in the medical record within 48 hours after completing the assessment;
12. If information in subsection (B)(6)(a) is obtained about a patient after the patient's behavioral health assessment is completed, an interval note, including the information, is documented in the patient's medical record within 48 hours after the information is obtained;
13. Counseling is:
 - a. Offered as described in the counseling facility's scope of services;
 - b. Provided according to the type, frequency, and number of hours identified in the patient's assessment; and
 - c. Provided by a behavioral health professional or a behavioral health technician;
14. A personnel member providing counseling to address a specific type of behavioral health issue has the skills and knowledge necessary to provide the counseling that addresses the specific type of behavioral health issue; and
15. Each counseling session is documented in the patient's medical record to include:
 - a. The date of the counseling session;
 - b. The amount of time spent in the counseling session;
 - c. Whether the counseling was individual counseling, family counseling, or group counseling;
 - d. The treatment goals addressed in the counseling session; and
 - e. The signature of the personnel member who provided the counseling and the date signed.
- C. An administrator may provide any of the following, according to the applicable requirements in 9 A.A.C. 20, to individuals required to attend by a referring court, if approved by the Department to provide the services:
 1. DUI screening,
 2. DUI education,
 3. DUI treatment, or

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4. Misdemeanor domestic violence offender treatment.
- D.** An administrator of a counseling facility authorized to provide the services in subsection (C):
1. Shall comply with the requirements for the specific service in 9 A.A.C. 20, and
 2. May have a behavioral health technician who has the appropriate skills and knowledge established in policies and procedures provide the services.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-1910. Physical Plant, Environmental Services, and Safety Standards

- A.** An administrator shall ensure that a counseling facility has either:
1. Both of the following:
 - a. A smoke detector installed in each hallway of the counseling facility that is:
 - i. Maintained in an operable condition;
 - ii. Either battery operated or, if hard-wired into the electrical system of the outpatient treatment center, has a back-up battery; and
 - iii. Tested monthly; and
 - b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
 - i. Is available at the counseling facility;
 - ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;
 - iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
 - iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person; or
 2. Both of the following that are tested and serviced at least once every 12 months:
 - a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01, that is in working order; and
 - b. A sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01, that is in working order.
- B.** An administrator shall ensure that documentation of a test required in subsection (A) is maintained for at least 12 months after the date of the test.
- C.** An administrator shall ensure that on a counseling facility's premises:
1. Exit signs are illuminated, if the local fire jurisdiction requires illuminated exit signs;

2. Corridors and exits are kept clear of any obstructions;
 3. A patient can exit through any exit during hours of clinical operation;
 4. An extension cord is not used instead of permanent electrical wiring; and
 5. Each electrical outlet and electrical switch has a cover plate that is in good repair.
- D.** An administrator shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the fire inspection report, and
 3. Maintain documentation of a current fire inspection.
- E.** An administrator shall ensure that:
1. A counseling facility's premises are:
 - a. Sufficient to provide the counseling facility's scope of services;
 - b. Cleaned and disinfected to prevent, minimize, and control illness and infection; and
 - c. Free from a condition or situation that may cause an individual to suffer physical injury;
 2. If a bathroom is on the premises, the bathroom contains:
 - a. A working sink with running water,
 - b. A working toilet that flushes and has a seat,
 - c. Toilet tissue,
 - d. Soap for hand washing,
 - e. Paper towels or a mechanical air hand dryer,
 - f. Lighting, and
 - g. A means of ventilation;
 3. If a bathroom is not on the premises, a bathroom is:
 - a. Available for a patient's use,
 - b. Located in a building in contiguous proximity to the counseling facility, and
 - c. Free from a condition or situation that may cause an individual using the bathroom to suffer a physical injury; and
 4. A tobacco smoke-free environment is maintained on the premises.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4). Amended by final expedited rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R9-10-1911. Integrated Information

- A.** An administrator of an affiliated outpatient treatment center may maintain the following information, required in this Article for a counseling facility for which the affiliated outpatient treatment center provides administrative support, integrated with information required in 9 A.A.C. 10, Article 10 for the outpatient treatment center:
1. Quality management plan, documented incidents, and reports required in R9-10-1904;
 2. Contracted services information in R9-10-1905;
 3. Orientation plan, in-service education plan, and personnel records in R9-10-1906; and
 4. Medical records in R9-10-1908.
- B.** An administrator of an affiliated counseling facility that shares administrative support with one or more other affiliated coun-

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selling facilities may maintain the information in subsections (A)(1) through (A)(4) integrated with information maintained by the other affiliated counseling facilities.

- C. If an administrator of an affiliated outpatient treatment center or an affiliated counseling facility maintains integrated information according to subsection (A) or (B), the administrator shall develop, document, and implement a method to ensure that:

1. If the quality management plan is integrated, the incidents documented, concerns identified, and changes or actions taken are identified for each facility;
2. If a person provides contracted services at more than one facility, the types of services the person provides at each facility is identified in the contract information;
3. If an orientation plan is applicable to more than one facility, the orientation a personnel member is expected to obtain for each facility is identified in the orientation plan;
4. If an in-service education plan is applicable to more than one facility, the in-service education a personnel member is expected to obtain for each facility is identified in the in-service education plan;
5. If a personnel member provides counseling at more than one facility, the following is identified in the personnel member's record:
 - a. The days and hours the personnel member provides counseling for each facility;
 - b. If the personnel member's job description is different for each facility:
 - i. Each job description for the personnel member, and
 - ii. Verification of the skills and knowledge to provide counseling according to each of the personnel member's job descriptions; and
 - c. If a personnel member is a behavioral health technician, documentation of the clinical oversight provided to the personnel member, based on the number and acuity of the patients to whom the personnel member provided counseling at each facility; and
6. If a patient receives counseling at more than one facility, the counseling received and any information related to the counseling received at each facility is identified in the patient's medical record.

- D. An administrator of a counseling facility receiving administrative support from an affiliated outpatient treatment center or an affiliated counseling facility shall ensure that if the counseling facility:

1. Has integrated information, the integrated information is provided to the Department for review within two hours after the Department's request:
 - a. In a written or electronic format at the counseling facility's premises; or
 - b. Electronically directly to the Department.
2. No longer receives or shares administrative support that includes integrating the information in subsection (A), the information for the counseling facility required in this Article is maintained by the counseling facility and provided to the Department according to the requirements in this Article.

Historical Note

New Section made by exempt rulemaking at 20 A.A.R. 3535, pursuant to Laws 2014, Ch. 233, § 5; effective January 1, 2015 (Supp. 14-4). Amended by final expedited

rulemaking at 26 A.A.R. 3041, with an immediate effective date of November 3, 2020 (Supp. 20-4).

ARTICLE 20. PAIN MANAGEMENT CLINICS**R9-10-2001. Definitions**

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

1. "Order" means to issue written, verbal, or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.
2. "Physician" means an individual licensed as a physician according to A.R.S. Title 32, Chapter 13, 14, or 17.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

R9-10-2002. Application and Documentation Submission Requirements

- A. An applicant shall submit an application for licensure that meets the requirements in A.R.S. § 36-422 and 9 A.A.C. 10, Article 1.
- B. An applicant or licensee shall submit to the Department:
1. The applicable fees required in R9-10-106(C), and
 2. The documentation required according to A.R.S. § 36-448.02(C).

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). For clarity, the citation to Arizona Revised Statutes in subsection (B)(2) has been corrected to include "A.R.S." and the § (section) symbol (Supp. 21-2). Amended by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).

R9-10-2003. Administration

- A. A licensee is responsible for the organization and management of a pain management clinic.
- B. A licensee shall:
1. Adopt policies and procedures for the administration and operation of a pain management clinic;
 2. Designate a medical director who is licensed:
 - a. As a physician according to A.R.S. Title 32, Chapter 13 or 17; or
 - b. As a nurse practitioner according to A.R.S. Title 32, Chapter 15 with advanced pain management certification from a nationally recognized accreditation or certification entity;
 3. Ensure that there are a sufficient number of personnel members and employees with the required knowledge and qualifications to:
 - a. Meet the requirements of this Article,
 - b. Ensure the health and safety of a patient, and
 - c. Meet the needs of a patient based on the patient's medical evaluation; and
 4. Ensure the following are conspicuously posted on the premises:
 - a. The current pain management clinic license issued by the Department;
 - b. The current telephone number and address of the unit in the Department responsible for licensing the pain management clinic;
 - c. An evacuation map posted in all hallways; and

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- d. A phone number for:
 - i. An opioid assistance and referral hotline, and
 - ii. A poison control hotline.
- C. A medical director shall ensure that:
 - 1. Pain management services are provided under the direction of:
 - a. A physician, or
 - b. A nurse practitioner licensed according to A.R.S. Title 32, Chapter 15 with advanced pain management certification from a nationally recognized accreditation or certification entity;
 - 2. A record that includes cardiopulmonary resuscitation training is maintained for each personnel member, employee, volunteer, or student who is required by policies and procedures to obtain cardiopulmonary resuscitation training; and
 - 3. A personnel member certified in cardiopulmonary resuscitation is available on the pain management clinic's premises while patients are present.
- D. A medical director shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - 1. Cover personnel member qualifications, duties, and responsibilities, including who may order, prescribe, or administer an opioid and the required knowledge and qualifications of those personnel members;
 - 2. Cover cardiopulmonary resuscitation training, including:
 - a. The method and content of cardiopulmonary resuscitation training, including a demonstration of an individual's ability to perform cardiopulmonary resuscitation;
 - b. The qualifications required for an individual to provide cardiopulmonary resuscitation training;
 - c. The time-frame for renewal of cardiopulmonary resuscitation training; and
 - d. The documentation that verifies that an individual has received cardiopulmonary resuscitation training;
 - 3. Cover the storage, accessibility, disposal, and documentation of a medication;
 - 4. Cover the prescribing or ordering of an opioid:
 - a. Including how, when, and by whom:
 - i. A patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database is reviewed;
 - ii. An assessment is conducted of a patient's substance use risk;
 - iii. The potential risks, adverse outcomes, and complications, including death, associated with the use of opioids are explained to a patient or the patient's representative;
 - iv. Alternatives to a prescribed or ordered opioid are explained to a patient or the patient's representative;
 - v. Informed consent is obtained from a patient or the patient's representative;
 - vi. A patient receiving an opioid is monitored; and
 - vii. The actions taken according to subsections (D)(4)(a)(i) through (vi) are documented;
 - b. Addressing conditions that may impose a higher risk to a patient when prescribing or ordering an opioid, including:
 - i. Concurrent use of a benzodiazepine or other sedative-hypnotic medication,
 - ii. History of substance use disorder,
 - iii. Co-occurring behavioral health issue, or
 - iv. Pregnancy;
- e. Addressing the criteria for co-prescribing a short-acting opioid antagonist for a patient;
- d. Including the frequency of the following for a patient prescribed an opioid for longer than a 30-calendar-day period:
 - i. Face-to-face interactions with the patient,
 - ii. Assessment of a patient's substance use risk,
 - iii. Urine drug testing,
 - iv. Renewal of an opioid prescription without a face-to-face interaction with the patient, and
 - v. Monitoring the effectiveness of the treatment;
- e. If applicable according to A.R.S. § 36-2608, including documenting a dispensed opioid in the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
- f. Addressing the criteria and procedures for tapering opioid prescription or ordering;
- g. Addressing the criteria and procedures for offering or referring a patient for treatment for substance use disorder; and
- h. If opioids are administered at the pain management clinic, including how, when, and by whom:
 - i. A patient's need for opioid administration is assessed,
 - ii. A patient receiving an opioid is monitored, and
 - iii. The actions taken according to subsections (D)(4)(h)(i) and (ii) are documented;
- 5. Cover accessibility and security of medical records;
- 6. Cover infection control, including methods for sterilizing equipment and supplies and methods for identifying, storing, and disposing of biohazardous medical waste; and
- 7. Cover emergency treatment, including:
 - a. A list of the medications, supplies, and equipment kept on the premises to provide treatment in response to an emergency caused by a procedure or medication administered at the pain management clinic;
 - b. A requirement that a cart or a container is available for emergency treatment that contains the medications, supplies, and equipment specified in the policies and procedures according to subsection (D)(7)(a);
 - c. A method to verify and document that the contents of the cart or container are available for emergency treatment; and
 - d. A method for ensuring a patient is transferred to a hospital or other health care institution to receive treatment for a medical emergency that the pain management clinic is not authorized or not able to provide.
- E. As applicable and except when contrary to medical judgment for a patient, a medical director shall ensure that the policies and procedures in subsection (D)(4) are consistent with the Arizona Opioid Prescribing Guidelines or national opioid-prescribing guidelines, such as guidelines developed by the:
 - 1. Centers for Disease Control and Prevention, or
 - 2. The U.S. Department of Veterans Affairs and the U.S. Department of Defense.
- F. A medical director shall, except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, ensure that:
 - 1. If an opioid may have contributed to a patient's death:

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- a. Written notification of the patient's death is provided to the Department in a Department-provided format if:
 - i. A personnel member of the pain management clinic prescribed, ordered, or administered the opioid that may have contributed to the patient's death; or
 - ii. The patient's death occurred while the patient was on the premises of the pain management clinic; and
- b. The written notification required by subsection (F)(1)(a)(i) is provided within one working day:
 - i. After the patient's death, if an opioid administered as part of treatment may have contributed to the death; or
 - ii. After a personnel member of the pain management clinic learns of the patient's death, if a prescribed opioid may have contributed to the patient's death; and
- c. The written notification required by subsection (F)(1)(a)(ii) is provided according to R9-4-602; and

2. Written notification of a suspected opioid overdose is provided to the Department according to R9-4-602.

G. If the Department requests a patient's medical record for review, the licensee:

- 1. May provide the patient medical record to the Department either in paper or in an electronic format that is acceptable to the Department; and
- 2. Shall ensure that documentation required by this Article is provided to the Department within two hours after a Department request.

H. The Department may take enforcement action as specified in R9-10-111 if a pain management clinic:

- 1. Is not in substantial compliance with applicable requirements in 9 A.A.C. 10, Article 1 or this Article; or
- 2. Is in substantial compliance, but refuses to carry out a plan of correction acceptable to the Department.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).

R9-10-2004. Quality Management

A medical director 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 opioid-related adverse reactions or other incidents;
 - b. A method to collect data on services provided to patients;
 - c. A method to use the data to identify concerns about the delivery of services related to patient care;
 - d. A method to make changes or take action in response to a concern identified according to subsection (1)(c); and
 - e. The frequency with which the documented report required in subsection (2) will be submitted to the licensee;
- 2. A documented report is submitted to the licensee that includes:
 - a. Each concern about the delivery of services related to patient care, and

- b. Any changes made or actions taken in response to that concern; and

- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the licensee.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

R9-10-2005. Patient Rights

A. The licensee shall ensure that:

- 1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
- 2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
- 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
 - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
 - b. Where patient rights are posted as required in subsection (A)(1).

B. A licensee shall ensure that:

- 1. A patient is treated with dignity, respect, and consideration;
- 2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Retaliation for submitting a complaint to the Department or another entity; or
 - i. Misappropriation of personal and private property by a pain management clinic's personnel member, employee, volunteer, or student; and
- 3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Is informed of the following:
 - i. The pain management clinic's policy on health care directives, and
 - ii. The patient complaint process;
 - d. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to a pain management clinic for identification and administrative purposes; and
 - e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.

C. A patient has the following rights:

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1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
 3. To receive privacy in treatment and care for personal needs;
 4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
 5. To receive a referral to another health care institution if the pain management clinic is not authorized or not able to provide rehabilitation services or counseling services needed by the patient;
 6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
 7. To participate or refuse to participate in research or experimental treatment; and
 8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
- D.** A medical director shall ensure that before an opioid is prescribed or ordered for a patient, a medical practitioner obtains informed consent from the patient or patient's representative that includes:
1. The patient's:
 - a. Name,
 - b. Date of birth or other patient identifier, and
 - c. Condition for which an opioid is being prescribed or ordered;
 2. That an opioid is being prescribed or ordered;
 3. The potential risks, adverse reactions, complications, and medication interactions associated with the use of an opioid;
 4. If applicable, the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;
 5. Alternatives to a prescribed or ordered opioid;
 6. The name and signature of the individual explaining the use of an opioid to the patient; and
 7. The signature of the patient or the patient's representative and the date signed.
- Historical Note**
- New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Section R9-10-2005 renumbered to R9-10-2007; new Section R9-10-2005 renumbered from R9-10-2007 and amended by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).
- R9-10-2006. Medical Records**
- A.** A medical director shall ensure that a medical record is established and maintained for a patient that contains:
1. Patient identification, including:
 - a. The patient's name, address, and date of birth;
 - b. The patient's representative, if applicable; and
 - c. The name and telephone number of an individual to contact in an emergency;
 2. The patient's medical history;
 3. The patient's physical examination;
 4. Laboratory test results;
 5. The patient's diagnosis, including co-occurring disorders;
 6. The patient's treatment plan;
 7. If applicable:
 - a. The effectiveness of the patient's current treatment,
 - b. The duration of the current treatment,
 - c. Alternative treatments tried by or planned for the patient, and
 - d. The expected benefit of a new treatment compared with continuing the current treatment;
 8. Each consent form signed by the patient or the patient's representative;
 9. The patient's medication information, including:
 - a. The patient's age and weight;
 - b. The medications and herbal supplements the patient is currently taking; and
 - c. Allergies or sensitivities to medications, antiseptic solutions, or latex;
 10. Prescriptions ordered for the patient and, if an opioid is prescribed or ordered:
 - a. The nature and intensity of the patient's pain,
 - b. The specific opioid and the reason for the prescription or order,
 - c. The objectives used to determine whether the patient is being successfully treated, and
 - d. Other factors relevant to prescribing or ordering an opioid for the patient;
 11. Medications administered to the patient and, if an opioid is administered:
 - a. The patient's need for the opioid before the opioid was administered, and
 - b. The effect of the opioid administered; and
 12. A record of services provided to the patient.
- B.** A licensee shall ensure that:
1. A medical record is accessible only to the Department or personnel members authorized by policies and procedures;
 2. Medical record information is confidential and released only with the written informed consent of a patient or the patient's representative or as otherwise permitted by law; and
 3. A medical record is protected from loss, damage, or unauthorized use and is retained according to A.R.S. § 12-2297.
- C.** A medical director shall ensure that:
1. Only personnel authorized by policies and procedures record or sign an entry in a medical record;
 2. An entry in a medical record is dated and legible;
 3. An entry is authenticated;
 4. An entry is not changed after it has been recorded, but additional information related to an entry may be recorded in the medical record;
 5. When a verbal or telephone order is entered in the medical record, the entry is authenticated according to policies and procedures by the individual who issued the order;
 6. If a rubber-stamp signature or an electronic signature is used:
 - a. An individual's rubber-stamp or electronic signature is not used by another individual; and
 - b. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature; and

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7. If a pain management clinic maintains medical records electronically, the date and time of an entry is recorded by the computer's internal clock.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Section R9-10-2006 renumbered to R9-10-2008; new Section R9-10-2006 renumbered from R9-10-2008 by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).

R9-10-2007. Medication Services

A medical director shall ensure that:

1. Medications are stored in a locked area on the premises;
2. Only personnel members designated by policies and procedures have access to the locked area containing medications;
3. Expired, mislabeled, or unusable medications are disposed of according to policies and procedures;
4. If an opioid is administered at a pain management clinic, an opioid antagonist is available on the premises;
5. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is:
 - a. Immediately reported to the medical director and licensee,
 - b. Recorded in the patient's medical record; and
6. Medication information for a patient is maintained in the patient's medical record; and
7. If applicable, policies and procedures are established that comply with donated medicine according to A.R.S. § 32-1909.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Section R9-10-2007 renumbered to R9-10-2005; new Section R9-10-2007 renumbered from R9-10-2005 and amended by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).

R9-10-2008. Pain Management Services

- A. A medical director shall ensure that a medical practitioner or nurse anesthetist remains on the premises until all patients who received a procedure at the pain management clinic are discharged.
- B. A medical director shall ensure that, if a procedure other than the administration of an opioid is used to provide pain management services:
 1. Before the procedure is initially used on a patient, the patient is evaluated by:
 - a. A medical practitioner or
 - b. A nurse anesthetist, according to A.R.S. § 32-1634.04;
 2. The procedure is performed by a personnel member qualified according to policies and procedures to perform the procedure; and
 3. The following information is included in the patient's medical record:
 - a. The evaluation of the patient required in subsection (B)(1),
 - b. A record of the procedure, and
 - c. Any adverse reaction to the procedure and any measures taken to address an adverse reaction.

- C. Except as provided in subsection (E), a medical director shall ensure that a medical practitioner:
 1. Before prescribing an opioid for a patient of the pain management clinic:
 - a. Conducts a physical examination of the patient;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with use of an opioid;
 - e. Explains alternatives to a prescribed opioid; and
 - f. Obtains informed consent from the patient or the patient's representative that meets the requirements in R9-10-2007(B), including the potential risks, adverse outcomes, and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication, if the patient:
 - i. Is also prescribed or ordered a sedative-hypnotic medication, or
 - ii. Has been prescribed a sedative-hypnotic medication by another medical practitioner;
 2. Before ordering an opioid for a patient of the pain management clinic:
 - a. Conducts a physical examination of the patient;
 - b. Except as exempted by A.R.S. § 36-2606(G), reviews the patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
 - c. Conducts an assessment of the patient's substance use risk;
 - d. Explains to the patient or the patient's representative the risks and benefits associated with the use of opioids or ensures that the patient or the patient's representative understands the risks and benefits associated with the use of an opioid as explained to the patient or the patient's representative by an individual licensed under A.R.S. Title 32 and authorized by policies and procedures to explain to the patient or the patient's representative the risks and benefits associated with the use of an opioid;
 - e. If applicable, explains alternatives to an ordered opioid; and
 - f. Obtains informed consent from the patient or the patient's representative, according to R9-10-2007(B);
 3. When administering or causing administration of an opioid to a patient:
 - a. Before administration, identifies the patient's need for the opioid; and
 - b. Monitors the patient's response to the opioid; and
 4. Documents the pain management services provided in the patient's medical record according to R9-10-2006.

- D. A medical practitioner is exempt from the requirements in subsection (C)(2), if:
 1. An order for an opioid is part of treatment for a patient in an emergency;
 2. The order is issued according to policies and procedures that include procedures for;

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- a. Providing treatment without obtaining the consent of a patient or the patient's representative,
 - b. Ordering and administering an opioid in an emergency situation, and
 - c. Complying with the requirements in subsection (C)(2) after the emergency is resolved; and
 - 3. The emergency situation is documented in the patient's medical record.
 - E.** The requirements in subsections (C)(1), (2), and (3), as applicable, do not apply when:
 - 1. A personnel member of a pain management clinic prescribes, orders, or administers an opioid as part of treatment for a patient with an end-of-life condition or pain associated with an active malignancy; or
 - 2. A prescription for an opioid changes only the type or dosage of an opioid previously prescribed to the patient according to subsection (C)(1):
 - a. Before a pharmacist dispenses the opioid for the patient; or
 - b. If changing the opioid because the patient experienced an adverse reaction to the opioid, within 72 hours after a pharmacist dispensed the opioid for the patient.
- Historical Note**
- New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Section R9-10-2008 renumbered to R9-10-2006; new Section R9-10-2008 renumbered from R9-10-2006 and amended by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).
- R9-10-2009. Equipment and Safety Standards**
- A.** A medical director shall ensure that:
 - 1. The equipment is:
 - a. Sufficient to accommodate:
 - i. The services stated in the pain management clinic's scope of services, and
 - ii. An individual accepted as a patient by the pain management clinic;
 - b. Maintained in working order;
 - c. Tested and calibrated at least once every 12 months or according to the manufacturer's recommendations; and
 - d. Used according to the manufacturer's recommendations;
 - 2. Documentation of each equipment test, calibration, and repair is maintained on the premises for at least 12 months after the date of the testing, calibration, or repair;
 - 3. Equipment and supplies are clean and, if applicable, sterile before each use;
 - 4. Personnel members wash hands after each direct patient contact and after handling soiled linen, soiled clothing, or biohazardous medical waste; and
 - 5. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures.
 - B.** A medical director shall establish an infection control program and ensure that:
 - 1. The infection control program includes:
 - a. A method to identify and document infections that occur at the pain management clinic;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the pain management clinic;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the pain management clinic; and
 - d. Documentation of infection control activities, including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases; and
 - 2. Infection control documentation is maintained for at least 12 months after the date of documentation.
 - C.** A medical director shall ensure that soiled linen and clothing are kept:
 - 1. In a covered container, and
 - 2. Separate from clean linen and clothing.
 - D.** A licensee shall:
 - 1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal;
 - 2. Make and document any repairs or corrections stated on the fire inspection report;
 - 3. Maintain documentation of a current fire inspection;
 - 4. Ensure that a written emergency plan is established, documented, and implemented that includes procedures for protecting the health and safety of patients and other individuals if circumstances arise in the pain management clinic that immediately threaten the life or health of patients and other individuals, such as a fire, natural disaster, loss of electrical power, or threat or incidence of violence; and
 - 5. Ensure that an evacuation drill is conducted at least once every six months that includes all personnel members on the premises on the day of the evacuation drill.
 - E.** A licensee shall ensure that a pain management clinic has either:
 - 1. Both of the following that are tested and serviced at least once every 12 months:
 - a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, as specified in R9-10-104.01, that is in working order; and
 - b. A sprinkler system installed according to the National Fire Protection Association 13 Standard for the Installation of Sprinkler Systems, as specified in R9-10-104.01, that is in working order; or
 - 2. Both of the following:
 - a. A smoke detector installed in each hallway of the pain management clinic that is:
 - i. Maintained in an operable condition;
 - ii. Either battery operated or, if hard-wired into the electrical system of the pain management clinic, has a back-up battery; and
 - iii. Tested monthly; and
 - b. A portable, operable fire extinguisher, labeled as rated at least 2A-10-BC by the Underwriters Laboratories, that:
 - i. Is available at the pain management clinic;
 - ii. Is mounted in a fire extinguisher cabinet or placed on wall brackets so that the top handle of the fire extinguisher is not over five feet from the floor and the bottom of the fire extinguisher is at least four inches from the floor;

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- iii. If a disposable fire extinguisher, is replaced when its indicator reaches the red zone; and
- iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months and has a tag attached to the fire extinguisher that specifies the date of the last servicing and the name of the servicing person.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4). Amended by final rulemaking at 32 A.A.R. 504 (February 27, 2026, Issue 9), effective April 6, 2026 (Supp. 26-1).

R9-10-2010. Environmental and Physical Plant Standards

- A.** A licensee shall ensure that the premises:
 - 1. Provide lighting and ventilation to ensure the health and safety of a patient;
 - 2. Are maintained in a clean condition;
 - 3. Are free from a condition or situation that may cause a patient to suffer physical injury;
 - 4. Are maintained free from insects and vermin;
 - 5. Are smoke-free; and
 - 6. Are sufficient to accommodate:
 - a. The services stated in the pain management center's scope of services; and
 - b. An individual accepted as a patient by the pain management center.
- B.** A licensee shall ensure that if a pain management clinic collects urine specimens from a patient, the pain management clinic has at least one bathroom on the premises that:
 - 1. Contains:
 - a. A working sink with running water,
 - b. A working toilet that flushes and has a seat,
 - c. Toilet tissue,
 - d. Soap for hand washing,
 - e. Paper towels or a mechanical air hand dryer,
 - f. Lighting, and
 - g. A means of ventilation; and
 - 2. Is for the exclusive use of the pain management clinic.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 3020, effective January 1, 2019 (Supp. 18-4).

ARTICLE 21. RECOVERY CARE CENTERS**R9-10-2101. Definitions**

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

"Recovery care services" has the same meaning as in A.R.S. § 36-448.51.

Historical Note

New Section R9-10-2101 renumbered from R9-10-501 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2102. Administration

- A.** A governing authority shall:
 - 1. Consist of one or more individuals responsible for the organization, operation, and administration of a recovery care center;
 - 2. Establish in writing:
 - a. A recovery care center's scope of services; and
 - b. Qualifications for an administrator;
 - 3. Designate an administrator, in writing, who has the qualifications established in subsection (A)(2)(b);
- 4. Grant, deny, suspend, or revoke the clinical privileges of a medical staff member according to medical staff bylaws;
- 5. Adopt a quality management program according to R9-10-2103;
- 6. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
- 7. Designate, in writing, an acting administrator who has the qualifications established in subsection (A)(2)(b) if the administrator is:
 - a. Expected not to be present on a recovery care center's premises for more than 30 calendar days; or
 - b. Not present on a recovery care center's premises for more than 30 calendar days; and
- 8. Except as provided in subsection (A)(7), notify the Department according to A.R.S. § 36-425(I) when there is a change in the administrator and identify the name and qualifications of the new administrator.
- B.** An administrator:
 - 1. Is directly accountable to the governing authority of a recovery care center for the daily operation of the recovery care center and all services provided by or at the recovery care center;
 - 2. Has the authority and responsibility to manage a recovery care center; and
 - 3. Except as provided in subsection (A)(7), designates, in writing, an individual who is present on the recovery care center's premises and accountable for the recovery care center when the administrator is not present on the recovery care center premises.
- C.** An administrator shall ensure that:
 - 1. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover job descriptions, duties, and qualifications including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - c. Include how a personnel member may submit a complaint relating to patient care;
 - d. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - e. Cover cardiopulmonary resuscitation training required in R9-10-2105(G) including:
 - i. The method and content of cardiopulmonary resuscitation training,
 - 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 an individual has received cardiopulmonary resuscitation training;
 - f. Cover first aid training;
 - g. Include a method to identify a patient to ensure the patient receives services as ordered;
 - h. Cover patient rights including assisting a patient who does not speak English or who has a disability to become aware of patient rights;
 - i. Cover specific steps for:
 - i. A patient to file a complaint, and

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- ii. The recovery care center to respond to a patient's complaint;
 - j. Cover health care directives;
 - k. Cover medical records, including electronic medical records;
 - l. Cover a quality management program, including incident reports and supporting documentation;
 - m. Cover contracted services;
 - n. Cover tissue and organ procurement and transplant; and
 - o. Cover when an individual may visit a patient in a recovery care center;
2. Policies and procedures for recovery care services are established, documented, and implemented to protect the health and safety of a patient that:
 - a. Cover patient screening, admission, transfer, discharge planning, and discharge;
 - b. Cover the provision of recovery care services;
 - c. Include when general consent and informed consent are required;
 - d. Cover prescribing a controlled substance to minimize substance abuse by a patient;
 - e. Cover dispensing, administering, and disposing of medications;
 - f. Cover how personnel members will respond to a patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 - g. Cover infection control; and
 - h. Cover environmental services that affect patient care;
 3. Policies and procedures are reviewed at least once every three years and updated as needed;
 4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
 5. Unless otherwise stated:
 - a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a recovery care center, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the recovery care center.

Historical Note

New Section R9-10-2102 renumbered from R9-10-502 and amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2103. Quality Management

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 services provided to patients;
 - 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 change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section R9-10-2103 renumbered from R9-10-503 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2104. Contracted Services

An administrator shall ensure that:

1. Contracted services are provided according to the requirements in this Article, and
2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section R9-10-2104 renumbered from R9-10-504 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2105. Personnel

A. An administrator shall ensure that:

1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services or behavioral health services expected to be provided by the personnel member according to the established job description, and
 - ii. The acuity of the patients receiving physical health services or behavioral health services from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services and behavioral health services listed in the established job description,
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description, and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services or behavioral health services listed in the established job description;
2. A personnel member's skills and knowledge are verified and documented:

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- a. Before the personnel member provides physical health services or behavioral health services, and
 - b. According to policies and procedures; and
3. Sufficient personnel members are present on a recovery care center's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the recovery care center's scope of services,
 - b. Meet the needs of a patient, and
 - c. Ensure the health and safety of a patient.
- B.** 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 4 A.A.C. 6, Article 1.
- C.** An administrator shall ensure that a personnel member, or an employee or a volunteer who has or is expected to have direct interaction with a patient, provides evidence of freedom from infectious tuberculosis:
 1. On or before the date the individual begins providing services at or on behalf of the recovery care center, and
 2. As specified in R9-10-113.
- D.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
 1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications, including skills and knowledge applicable to the employee's job duties;
 - b. The individual's education and experience applicable to the employee's job duties;
 - c. The individual's completed orientation and in-service education as required by policies and procedures;
 - d. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - e. The individual's compliance with the requirements in A.R.S. § 36-411;
 - f. Cardiopulmonary resuscitation training, if required for the individual, according to R9-10-2102(C)(1)(e);
 - g. First aid training, if the individual is required to have according to this Article and policies and procedures; and
 - h. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (C).
- E.** An administrator shall ensure that personnel records are:
 1. Maintained:
 - a. Throughout the individual's period of providing services in or for the recovery care center, and
 - b. For at least 24 months after the last date the individual provided services in or for the recovery care center; and
 2. For a personnel member who has not provided physical health services or behavioral health services at or for the recovery care center during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- F.** An administrator shall ensure that:
 1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
 2. A personnel member completes orientation before providing behavioral health services or physical health services;
 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 4. A director of nursing develops, documents, and implements a plan to provide in-service education specific to the duties of a personnel member;
 5. A personnel member's in-service education 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; and
 6. A work schedule of each personnel member is developed and maintained at the recovery care center for at least 12 months from the date of the work schedule.
- G.** An administrator shall ensure that a nursing personnel member:
 1. Is 18 years of age or older,
 2. Is certified in cardiopulmonary resuscitation within the first month of employment,
 3. Maintains current certification in cardiopulmonary resuscitation, and
 4. Attends additional orientation that includes patient care and infection control policies and procedures.

Historical Note

New Section R9-10-2105 renumbered from R9-10-505 and amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2106. Medical Staff

- A.** A governing authority shall require that:
 1. The organized medical staff is directly accountable to the governing authority for the quality of care provided by a medical staff member to a patient in a recovery care center;
 2. The medical staff bylaws and medical staff regulations are approved according to the medical staff bylaws and governing authority requirements;
 3. A medical staff member complies with medical staff bylaws and medical staff regulations;
 4. The medical staff includes at least two physicians who have clinical privileges to admit patients to the recovery care center;
 5. A medical staff member is available to direct patient care;
 6. Medical staff bylaws or medical staff regulations are established, documented, and implemented for the process of:
 - a. Conducting peer review according to A.R.S. Title 36, Chapter 4, Article 5;
 - b. Appointing members to the medical staff, subject to approval by the governing authority;
 - c. Establishing committees, including identifying the purpose and organization of each committee;
 - d. Appointing one or more medical staff members to a committee;
 - e. Requiring that each patient has a medical staff member who coordinates the patient's care;

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- f. Defining the responsibilities of a medical staff member to provide medical services to the medical staff member's patient;
 - g. Defining a medical staff member's responsibilities for the transfer of a patient;
 - h. Specifying requirements for oral, telephone, and electronic orders, including which orders require identification of the time of the order;
 - i. Establishing a time-frame for a medical staff member to complete a patient's medical record; and
 - j. Establishing criteria for granting, denying, revoking, and suspending clinical privileges; and
7. The organized medical staff reviews the medical staff bylaws and the medical staff regulations at least once every three years and updates the bylaws and regulations as needed.
- B.** An administrator shall ensure that:
- 1. A medical staff member provides evidence of freedom from infectious tuberculosis as specified in R9-10-113 before providing services at the recovery care center and at least once every 12 months thereafter;
 - 2. A record for each medical staff member is established and maintained that includes:
 - a. A completed application for clinical privileges,
 - b. The dates and lengths of appointment and reappointment of clinical privileges,
 - c. The specific clinical privileges granted to the medical staff member including revision or revocation dates for each clinical privilege, and
 - d. A verification of current Arizona health care professional active license according to A.R.S. Title 32; and
 - 3. Except for documentation of peer review conducted according to A.R.S. § 36-445, a record under subsection (B)(2) is provided to the Department for review:
 - a. For a current medical staff member, within 2 hours after the Department's request, or
 - b. Within 72 hours after the time of the Department's request if the individual is no longer a current medical staff member.

Historical Note

New Section R9-10-2106 renumbered from R9-10-506 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2107. Admission

- A.** An administrator shall ensure that a physician only admits patients to the recovery care center who require recovery care services, as defined in A.R.S. § 36-448.51.
- B.** An administrator shall ensure that the following documents are in a patient's medical record at the time the patient is admitted to the recovery care center:
- 1. A medical history and physical examination performed or approved by a member of the recovery care center's medical staff within 30 calendar days before the patient's admission to the recovery care center,
 - 2. A discharge summary from the referring health care institution or physician,
 - 3. Physician orders, and
 - 4. Documentation concerning health care directives.

Historical Note

New Section R9-10-2107 renumbered from R9-10-507 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2108. Discharge

- A.** For a patient, an administrator shall ensure that discharge planning:
- 1. Identifies the specific needs of the patient after discharge, if applicable;
 - 2. If a discharge date has been determined, identifies the anticipated discharge date;
 - 3. Includes the participation of the patient or the patient's representative;
 - 4. Is completed before discharge occurs;
 - 5. Provides the patient or the patient's representative with written information identifying classes or subclasses of health care institutions and the level of care that the health care institutions provide that may meet the patient's assessed and anticipated needs after discharge, if applicable; and
 - 6. Is documented in the patient's medical record.
- B.** For a patient discharge or a transfer of the patient, an administrator shall ensure that:
- 1. A discharge summary is developed that includes:
 - a. A description of the patient's medical condition and the medical services provided to the patient, and
 - b. The signature of the medical practitioner coordinating the patient's medical services;
 - 2. A discharge order for the patient is received from a medical practitioner coordinating the patient's medical services before discharge, unless the patient leaves the recovery care center against a medical staff member's advice;
 - 3. Discharge instructions are developed and documented; and
 - 4. The patient or the patient's representative is provided with a copy of the discharge instructions.

Historical Note

New Section R9-10-2108 renumbered from R9-10-508 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2109. Transfer

Except for a transfer of a patient due to an emergency, an administrator shall ensure that:

- 1. A personnel member coordinates the transfer and the services provided to the patient;
- 2. According to policies and procedures:
 - a. An evaluation of the patient is conducted before the transfer;
 - b. Information from the patient's medical record, including orders that are in effect at the time of the transfer, is provided to a receiving health care institution; and
 - c. A personnel member explains risks and benefits of the transfer to the patient or the patient's representative; and
- 3. Documentation in the patient's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the patient during a transfer.

Historical Note

New Section R9-10-2109 renumbered from R9-10-509 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

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R9-10-2110. Patient Rights**A.** An administrator shall ensure:

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
 - a. How and when a patient or the patient's representative is informed of the patient rights in subsection (C), and
 - b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Sexual abuse;
 - g. Sexual assault;
 - h. Seclusion;
 - i. Restraint;
 - j. Retaliation for submitting a complaint to the Department or another entity; or
 - k. Misappropriation of personal and private property by a recovery care center's medical staff, personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;
 - d. Is informed of the following:
 - i. The recovery care center's policy on health care directives, and
 - ii. The patient complaint process;
 - e. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a recovery care center for identification and administrative purposes; and
 - f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
 - i. Medical record, or
 - ii. Financial records.

C. A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To have access to a telephone;

5. To be advised of the recovery care center's policy regarding health care directives;
6. To associate and communicate privately with individuals of the patient's choice;
7. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
8. To receive a referral to another health care institution if the health care institution is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
9. To participate or have the patient's representative participate in the development of, or decisions concerning treatment;
10. To participate or refuse to participate in research or experimental treatment; and
11. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Historical Note

New Section R9-10-2110 renumbered from R9-10-510 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2111. Medical Records**A.** An administrator shall ensure that:

1. A patient's medical record is established and maintained for each patient according to A.R.S. Title 12, Chapter 13, Article 7.1;
2. An entry in a patient's medical record is:
 - a. Recorded only by an individual authorized by policies and procedures to make the entry;
 - b. Dated, legible, and authenticated; and
 - c. Not changed to make the initial entry illegible;
3. An order is:
 - a. Dated when the order is entered in the patient's medical record and includes the time of the order;
 - b. Authenticated by a medical staff according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical staff issuing the order;
4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
5. A patient's medical record is available to an individual:
 - a. Authorized according to policies and procedures to access the patient's medical record;
 - b. If the individual is not authorized according to policies and procedures, with the written consent of the patient or the patient's representative; or
 - c. As permitted by law;
6. Policies and procedures that include the maximum time-frame to retrieve an onsite or off-site patient's medical record at the request of a medical staff or authorized personnel member; and
7. A patient's medical record is protected from loss, damage, or unauthorized use.

B. If a recovery care center maintains patients' medical records electronically, an administrator shall ensure that:

1. Safeguards exist to prevent unauthorized access, and
2. The date and time of an entry in a patient's medical record is recorded by the computer's internal clock.

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- 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, and
 - d. Any known allergies;
 2. The date of admission and, if applicable, the date of discharge;
 3. The admitting diagnosis;
 4. A discharge summary from the referring health care institution or physician;
 5. If applicable, documented general consent and informed consent by the patient or the patient's representative;
 6. The medical history and physical examination required in R9-10-2107(B)(1);
 7. A copy of the patient's health care directive, if applicable;
 8. The name and telephone number of the patient's medical practitioner;
 9. If applicable, the name and contact information of the patient's representative and:
 - a. If the patient is 18 years of age or older or an emancipated minor, the document signed by the patient consenting for the patient's representative to act on the patient's behalf; or
 - b. If the patient's representative:
 - i. Is a legal guardian, a copy of the court order establishing guardianship; or
 - ii. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney;
 10. Orders;
 11. Nursing assessment;
 12. Treatment plans;
 13. Progress notes;
 14. Documentation of recovery care center services provided to a patient;
 15. The disposition of the patient after discharge;
 16. The discharge plan;
 17. A discharge summary, if applicable;
 18. Transfer documentation from the referring health care institution or physician;
 19. If applicable:
 - a. A laboratory report,
 - b. A radiologic report,
 - c. A diagnostic report, and
 - d. A consultation report;
 20. If applicable, documentation of any actions taken to control the patient's sudden, intense, or out-of-control behavior to prevent harm to the patient or another individual;
 21. If applicable, documentation that evacuation from the recovery care center would cause harm to the patient; and
 22. Documentation of a medication administered to the patient that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. For a medication administered for pain on a PRN basis:
 - i. An assessment of the patient's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - d. For a psychotropic medication administered on a PRN basis:
 - i. An assessment of the patient's behavior before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - e. The signature of the individual administering or observing the patient self-administer the medication; and
 - f. Any adverse reaction a patient has to the medication.
- D. An administrator shall ensure that a patient's medical record is completed within 30 calendar days after the patient's discharge.

Historical Note

New Section R9-10-2111 renumbered from R9-10-511 and amended by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2112. Nursing Services

- A. An administrator shall appoint a registered nurse as the director of nursing who has the authority and responsibility to manage nursing services at a recovery care center.
- B. A director of nursing shall:
1. Ensure that policies and procedures are developed, documented, and implemented to protect the health and safety of a patient that cover nursing assessments;
 2. Designate, in writing, a registered nurse to manage nursing services when the director of nursing is not present on a recovery care center's premises;
 3. Ensure that a recovery care center is staffed with nursing personnel according to the number of patients and their health care needs;
 4. Ensure that a patient receives medical services, nursing services, and health-related services based on the patient's nursing assessment and the physician's orders; and
 5. Ensure that medications are administered by a nurse licensed according to A.R.S. Title 32, Chapter 15 or as otherwise provided by law.
- C. An administrator shall ensure that a registered nurse completes a nursing assessment of each patient, which addresses patient care needs, when the patient is admitted to the recovery care center.
- D. An administrator shall ensure that a licensed nurse provides a patient with written discharge instructions, based on the patient's health care needs and physician's instructions, before the patient is discharged from the recovery care center.

Historical Note

New Section R9-10-2112 renumbered from R9-10-512 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2113. Medication Services

- A. An administrator shall ensure that policies and procedures for medication services:
1. Include:
 - a. A process for providing information to a patient about medication prescribed for the patient including:
 - i. The prescribed medication's anticipated results,
 - ii. The prescribed medication's potential adverse reactions,
 - iii. The prescribed medication's potential side effects, and

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- iv. Potential adverse reactions that could result from not taking the medication as prescribed;
 - b. Procedures for preventing, responding to, and reporting:
 - i. A medication error,
 - ii. An adverse reaction to a medication, or
 - iii. A medication overdose;
 - c. Procedures for documenting medication administration; and
 - d. Procedures to ensure that a patient's medication regimen and method of administration is reviewed by a medical practitioner to ensure the medication regimen meets the patient's needs; and
2. 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. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a medical practitioner;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a patient only as prescribed; and
 - d. Cover the documentation of a patient's refusal to take prescribed medication is documented in the patient's medical record;
 - 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
 - 3. A medication administered to a patient:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the patient's medical record.
- C.** 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; and
 - 3. If pharmaceutical services are provided on the premises:
 - a. A committee, composed of at least one physician, one pharmacist, and other personnel members as determined by policies and procedures, is established to:
 - i. Develop a drug formulary,
 - ii. Update the drug formulary at least every 12 months,
 - iii. Develop medication usage and medication substitution policies and procedures, and
 - iv. Specify which medications and medication classifications are required to be stopped automatically after a specific time period unless the ordering medical staff member specifically orders otherwise;
 - b. The pharmaceutical services are provided under the direction of a pharmacist;
 - c. The pharmaceutical services comply with ARS Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23; and
 - d. A copy of the pharmacy license is provided to the Department upon request.
- D.** When medication is stored at a recovery care center, an administrator shall ensure that:
- 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and
 - 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication, including expired medication;
 - b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of patients who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
- E.** An administrator shall ensure that a personnel member immediately reports a medication error or a patient's adverse reaction to a medication to the medical practitioner who ordered the medication and, if applicable, the recovery care center's director of nursing.

Historical Note

New Section R9-10-2113 renumbered from R9-10-513 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2114. Ancillary Services

An administrator shall ensure that:

- 1. Laboratory services are provided on the premises, or are available through contract, with a laboratory that holds a certificate of accreditation or certificate of compliance issued by the U.S. Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967; and
- 2. Pharmaceutical services are provided on the premises, or are available through contract, by a pharmacy licensed according to A.R.S. Title 32, Chapter 18.

Historical Note

New Section R9-10-2114 renumbered from R9-10-514 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2115. Food Services

A. An administrator shall ensure that:

- 1. The recovery care center has a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
- 2. A copy of the recovery care center's food establishment license or permit is maintained; and
- 3. If a recovery care center contracts with a food establishment, as established in 9 A.A.C. 8, Article 1, to prepare and deliver food to the recovery care center:
 - a. A copy of the contracted food establishment's license or permit under 9 A.A.C. 8, Article 1 is maintained by the recovery care center; and
 - b. The recovery care center is able to store, refrigerate, and reheat food to meet the dietary needs of a patient.

B. An administrator shall:

- 1. Designate a food service manager who is responsible for food service in the recovery care center; and
- 2. Ensure that a current therapeutic diet reference manual is available to the food service manager.

C. A food service manager shall ensure that:

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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:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served each day,
 - c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
 3. Meals and snacks provided by the recovery care center are served according to posted menus;
 4. Meals and snacks for each day are planned using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2010.asp>;
 5. A patient is provided:
 - a. A diet that meets the patient's nutritional needs and, if applicable, the orders of the patient's physician;
 - b. Three meals a day with not more than 14 hours between the evening meal and breakfast except as provided in subsection (C)(5)(d);
 - c. The option to have a daily evening snack identified in subsection (C)(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 a patient.
- a. When, how, and where patients will be relocated, including:
 - i. Instructions for the evacuation or transfer of patients,
 - ii. Assigned responsibilities for each employee and personnel member, and
 - iii. A plan for providing continuing services to meet patient's needs;
 - b. How each patient's medical record will be available to individuals 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 recovery care center or the recovery care center's relocation site during a disaster;
2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (C)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 5. An evacuation drill for employees and patients:
 - a. Is conducted at least once every six months;
 - b. Includes all individuals on the premises except for:
 - i. A patient whose medical record contains documentation that evacuation from the recovery care center would cause harm to the patient, and
 - ii. Sufficient personnel members to ensure the health and safety of patients not evacuated according to subsection (C)(5)(b)(i);
 6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and patients to evacuate to a designated area;
 - c. If applicable:
 - i. An identification of patients needing assistance for evacuation, and
 - ii. An identification of patients who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
 7. An evacuation path is conspicuously posted on each hallway of each floor of the recovery care center.

Historical Note

New Section R9-10-2115 renumbered from R9-10-515 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2116. Emergency and Safety Standards

- A. An administrator shall ensure that policies and procedures for providing emergency treatment are established, documented, and implemented that protect the health and safety of patients and include:
 1. Basic life support procedures, including the administration of oxygen and cardiopulmonary resuscitation; and
 2. Transfer arrangements for patients who require care not provided by the recovery care center.
- B. An administrator shall ensure that emergency treatment is provided to a patient admitted to the recovery care center according to policies and procedures.
- C. An administrator shall ensure that:
 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. When, how, and where patients will be relocated, including:
 - i. Instructions for the evacuation or transfer of patients,
 - ii. Assigned responsibilities for each employee and personnel member, and
 - iii. A plan for providing continuing services to meet patient's needs;
 - b. How each patient's medical record will be available to individuals 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 recovery care center or the recovery care center's relocation site during a disaster;
 2. The disaster plan required in subsection (C)(1) is reviewed at least once every 12 months;
 3. Documentation of a disaster plan review required in subsection (C)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
 4. A disaster drill for employees is conducted on each shift at least once every three months and documented;
 5. An evacuation drill for employees and patients:
 - a. Is conducted at least once every six months;
 - b. Includes all individuals on the premises except for:
 - i. A patient whose medical record contains documentation that evacuation from the recovery care center would cause harm to the patient, and
 - ii. Sufficient personnel members to ensure the health and safety of patients not evacuated according to subsection (C)(5)(b)(i);
 6. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the evacuation drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and patients to evacuate to a designated area;
 - c. If applicable:
 - i. An identification of patients needing assistance for evacuation, and
 - ii. An identification of patients who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
 7. An evacuation path is conspicuously posted on each hallway of each floor of the recovery care center.
- D. An administrator shall:
 1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 2. Make any repairs or corrections stated on the inspection report, and
 3. Maintain documentation of a current fire inspection.

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Historical Note

New Section R9-10-2116 renumbered from R9-10-516 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2117. Environmental Standards

- A.** An administrator shall ensure the recovery care center's infection control policies and procedures include:
1. Development and implementation of a written plan for preventing, detecting, reporting, and controlling communicable diseases and infection;
 2. Handling and disposal of biohazardous medical waste; and
 3. Sterilization, disinfection, and storage of medical equipment and supplies.
- B.** An administrator shall ensure that:
1. A recovery care center's premises and equipment are:
 - a. Cleaned and disinfected according to policies and procedures or manufacturer's instructions to prevent, minimize, and control illness or infection; and
 - b. Free from a condition or situation that may cause a patient or an individual to suffer physical injury;
 2. A pest control program is implemented and documented;
 3. Equipment used to provide recovery care services 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 policies and procedures; and
 - c. Used according to the manufacturer's recommendations;
 4. Documentation of equipment testing, calibration, and repair is maintained for at least 12 months after the date of the testing, calibration, or repair;
 5. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 6. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
 7. Garbage and refuse are:
 - a. Stored in covered containers lined with plastic bags, and
 - b. Removed from the premises at least once a week;
 8. Heating and cooling systems maintain the recovery care center at a temperature between 70° F and 84° F;
 9. Common areas:
 - a. Are lighted to assure the safety of patients, and
 - b. Have lighting sufficient to allow personnel members to monitor patient activity;
 10. 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;
 11. Oxygen containers are secured in an upright position;
 12. Poisonous or toxic materials stored by the recovery care center are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to patients;
 13. Combustible or flammable liquids and hazardous materials stored by the recovery care center are stored in the

original labeled containers or safety containers in a locked area inaccessible to patients;

14. If pets or animals are allowed in the recovery care center, pets or animals are:
 - a. Controlled to prevent endangering the patients and to maintain sanitation; and
 - b. Licensed consistent with local ordinances;
 15. If a water source that is not regulated under 18 A.A.C. 4 by the Arizona Department of Environmental Quality is used:
 - a. The water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or *E. coli* bacteria;
 - b. If necessary, corrective action is taken to ensure the water is safe to drink; and
 - c. Documentation of testing is retained for at least 12 months after the date of the test; and
 16. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to applicable state laws and rules.
- C.** An administrator shall ensure that:
1. Smoking tobacco products is not permitted within a recovery care center; and
 2. Smoking tobacco products may be permitted outside a recovery care center if:
 - a. Signs designating smoking areas are conspicuously posted, and
 - b. Smoking is prohibited in areas where combustible materials are stored or in use.

Historical Note

New Section R9-10-2117 renumbered from R9-10-517 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2).

R9-10-2118. Physical Plant Standards

- A.** An administrator shall ensure that recovery care center's patient rooms and service areas comply with the applicable physical plant health and safety codes and standards, incorporated by reference in R9-10-104.01, in effect on the date the recovery care center submitted architectural plans and specifications to the Department for approval, according to R9-10-104.
- B.** An administrator shall ensure that the premises and equipment are sufficient to accommodate:
1. The services stated in the recovery care center's scope of services; and
 2. An individual accepted as a patient by the recovery care center.
- C.** An administrator shall ensure that the recovery care center does not allow more than two beds per room.

Historical Note

New Section R9-10-2118 renumbered from R9-10-518 by exempt rulemaking at 25 A.A.R. 1222, effective April 25, 2019 (Supp. 19-2). Amended by final expedited rulemaking, at 25 A.A.R. 3481 with an immediate effective date of November 5, 2019 (Supp. 19-4).

ARTICLE 22. NURSING-SUPPORTED GROUP HOMES**R9-10-2201. Definitions**

In addition to the definitions in A.R.S. § 36-401 and R9-10-101, the definitions in A.R.S. § 36-551 apply in this Article unless otherwise specified.

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Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2202. Supplementary Application Requirements and Documentation Submission Requirements

- A.** In addition to the license application requirements in A.R.S. § 36-422 and R9-10-105, an applicant for a license as a nursing-supported group home shall include:
1. In a Department-provided format, whether the applicant is requesting authorization:
 - a. To admit residents who:
 - i. Are on a ventilator,
 - ii. Have a tracheostomy tube, or
 - iii. Receive total parenteral nutrition; or
 - b. To provide:
 - i. Services to individuals under 18 years of age, including the licensed capacity requested;
 - ii. Restraint;
 - iii. Clinical laboratory services; or
 - iv. Respiratory care services; and
 2. A copy of the applicant's service provider award letter with the Division.
- B.** A licensee shall submit to the Department, with the relevant fees required in R9-10-106(C) and in a Department-provided format:
1. The information required in subsection (A)(1), as applicable; and
 2. Documentation of the licensee's service provider contract with the Division.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2203. Administration

- A.** A governing authority shall:
1. Consist of one or more individuals responsible for the organization, operation, and administration of a nursing-supported group home;
 2. Establish, in writing, the nursing-supported group home's scope of services;
 3. Designate, in writing, an administrator for the nursing-supported group home who:
 - a. Is at least 21 years old; and
 - b. Meets one of the following:
 - i. Is a registered nurse,
 - ii. Is a nursing care institution administrator, or
 - iii. Has a minimum of three-years' experience working as an administrator or personnel member in a nursing-supported group home or other health care institution licensed under this Chapter;
 4. Adopt a quality management program according to R9-10-2204;
 5. Review and evaluate the effectiveness of the quality management program at least once every 12 months;
 6. Designate, in writing, an acting administrator who meets the requirements in subsection (A)(3), if the administrator is:
 - a. Expected not to be present on the premises of the nursing-supported group home for more than 30 calendar days, or

- b. Not present on the premises of the nursing-supported group home for more than 30 calendar days; and
7. Except as permitted in subsection (A)(6), when there is a change of administrator:
 - a. Notify the Department according to A.R.S. § 36-425(I), and
 - b. Submit to the Department a copy of documentation demonstrating the new administrator's compliance with the requirements in subsection (A)(3).
- B.** An administrator:
1. Is directly accountable to the governing authority of a nursing-supported group home for the daily operation of the nursing-supported group home and all services provided by or at the nursing-supported group home;
 2. Has the authority and responsibility to manage the nursing-supported group home;
 3. Except as provided in subsection (A)(6), designates, in writing, an individual who is present on the premises of the nursing-supported group home and accountable for the nursing-supported group home when the administrator is not present on the nursing-supported group home's premises; and
 4. Ensures the nursing-supported group home's compliance with A.R.S. § 36-411 and, as applicable, A.R.S. § 8-804 or § 46-459.
- C.** An administrator shall ensure that:
1. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students;
 - b. Cover the process for checking on a personnel member through the adult protective services registry, established according to A.R.S. § 46-459, or the central registry, established according to A.R.S. § 8-804, as applicable;
 - c. Cover orientation and in-service education for personnel members, employees, volunteers, and students;
 - d. Include methods to prevent abuse or neglect of a resident, including:
 - i. Training of personnel members, at least annually, on how to recognize the signs and symptoms of abuse or neglect; and
 - ii. Reporting of abuse or neglect of a resident;
 - e. Include how a personnel member may submit a complaint relating to resident care;
 - f. Cover the requirements in A.R.S. Title 36, Chapter 4, Article 11;
 - g. Cover cardiopulmonary resuscitation training including:
 - i. Which personnel members are required to obtain cardiopulmonary resuscitation training;
 - ii. The method and content of cardiopulmonary resuscitation training, which includes a demonstration of the ability to perform cardiopulmonary resuscitation;
 - iii. The qualifications for an individual to provide cardiopulmonary resuscitation training;
 - iv. The time-frame for renewal of cardiopulmonary resuscitation training; and

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- v. The documentation that verifies an individual has received cardiopulmonary resuscitation training;
 - h. Cover first aid training;
 - i. Include a method to identify a resident to ensure the resident receives physical health services, habilitation services, and behavioral care as ordered;
 - j. Cover resident rights, including assisting a resident who does not speak English or who has a disability to become aware of resident rights;
 - k. Cover specific steps for:
 - i. A resident to file a complaint, and
 - ii. The nursing-supported group home to respond to a resident's complaint;
 - l. Cover health care directives;
 - m. Cover medical records, including electronic medical records;
 - n. Cover a quality management program, including incident reports and supporting documentation;
 - o. Cover contracted services;
 - p. Cover resident's personal accounts;
 - q. Cover petty cash funds;
 - r. If the nursing-supported group home may admit a resident who is not placed in the nursing-supported group home by the Division, cover:
 - i. Fees and the process for receiving a fee for a resident,
 - ii. The reasons and process for terminating residency, and
 - iii. The process for refunding a fee for a resident;
 - s. Cover smoking and the use of tobacco products on the premises;
 - t. Cover the storage and use of alcoholic beverages on the premises; and
 - u. Cover when an individual may visit a resident in a nursing-supported group home;
2. Policies and procedures for physical health services, habilitation services, and behavioral care are established, documented, and implemented to protect the health and safety of a resident that:
- a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge;
 - b. Cover the provision of physical health services, habilitation services, and behavioral care;
 - c. Cover acuity, including a process for obtaining sufficient nursing personnel and other personnel members to meet the needs of residents;
 - d. Include when general consent and informed consent are required;
 - e. Cover storing, dispensing, administering, and disposing of medication, including provisions for inventory control and preventing diversion of controlled substances;
 - f. Cover infection control;
 - g. Cover interventions to address a resident's inappropriate behavior, including:
 - i. The hierarchy for use;
 - ii. Use of time-outs for inappropriate behavior; and
 - iii. Except in an emergency, require positive techniques for behavior modification to be used before more restrictive methods are used;
 - h. Cover restraints, both chemical restraints and physical restraints if applicable, that:
 - i. Require an order, including the frequency of monitoring and assessing the restraint; and
 - ii. Are necessary to prevent imminent harm to self or others, including how personnel members will respond to a resident's sudden, intense, or out-of-control behavior;
 - i. Cover telehealth, if applicable;
 - j. Cover environmental services that affect resident care;
 - k. Cover the security of a resident's possessions that are allowed on the premises;
 - l. Cover methods to encourage participation of a resident's family or friends or other individuals in activities planned according to R9-10-2210(B);
 - m. Include a method for obtaining an advocate for a resident, if necessary;
 - n. Cover resident outings;
 - o. Cover the process for obtaining resident preferences for social, recreational, or rehabilitative activities and meals and snacks; and
 - p. Cover whether pets and 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 residents or the public;
3. Policies and procedures are reviewed at least once every three years and updated as needed;
4. Policies and procedures are available to personnel members, employees, volunteers, and students; and
5. Unless otherwise stated:
- a. Documentation required by this Article is provided to the Department within two hours after a Department request; and
 - b. When documentation or information is required by this Chapter to be submitted on behalf of a nursing-supported group home, the documentation or information is provided to the unit in the Department that is responsible for licensing and monitoring the nursing-supported group home.
- D. If abuse, neglect, or exploitation of a resident is alleged or suspected to have occurred before the resident was admitted or while the resident is not on the premises and not receiving services from a nursing-supported group home's employee or personnel member, an administrator shall report the alleged or suspected abuse, neglect, or exploitation of the resident as follows:
- 1. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - 2. For a resident under 18 years of age, according to A.R.S. § 13-3620.
- E. If an administrator has a reasonable basis, according to A.R.S. §§ 13-3620 or 46-454, to believe that abuse, neglect, or exploitation has occurred on the premises or while a resident is receiving services from a nursing-supported group home's employee or personnel member, an administrator shall:
- 1. If applicable, take immediate action to stop the suspected abuse, neglect, or exploitation;
 - 2. Report the suspected abuse, neglect, or exploitation of the resident as follows:
 - a. For a resident 18 years of age or older, according to A.R.S. § 46-454; or
 - b. For a resident under 18 years of age, according to A.R.S. § 13-3620;
 - 3. Document:

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- a. The suspected abuse, neglect, or exploitation;
 - b. Any action taken according to subsection (E)(1); and
 - c. The report in subsection (E)(2);
- 4. Maintain the documentation in subsection (E)(3) for at least 12 months after the date of the report in subsection (E)(2);
- 5. Initiate an investigation of the suspected abuse, neglect, or exploitation and document the following information within five working days after the report required in subsection (E)(2):
 - a. The dates, times, and description of the suspected abuse, neglect, or exploitation;
 - b. A description of any injury to the resident related to the suspected abuse or neglect and any change to the resident's physical, cognitive, functional, or emotional condition;
 - c. The names of witnesses to the suspected abuse, neglect, or exploitation; and
 - d. The actions taken by the administrator to prevent the suspected abuse, neglect, or exploitation from occurring in the future; and
- 6. Maintain a copy of the documented information required in subsection (E)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- F.** An administrator shall:
 - 1. Allow a resident advocate to assist a resident or the resident's representative with a request or recommendation, and document in writing any complaint submitted to the nursing-supported group home;
 - 2. Ensure that a monthly schedule of recreational activities for residents is developed, documented, and implemented; and
 - 3. Ensure that the following are conspicuously posted on the premises:
 - a. The current nursing-supported group home license issued by the Department;
 - b. The name, address, and telephone number of:
 - i. The Department's Bureau of Assisted Living Facilities Licensing;
 - ii. Adult Protective Services of the Department of Economic Security; and
 - iii. If applicable, Child Protective Services of the Department of Child Safety;
 - c. A notice that a resident may file a complaint with the Department concerning the nursing-supported group home;
 - d. The monthly schedule of recreational activities; and
 - e. One of the following:
 - i. A copy of the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect; or
 - ii. A notice that the current license survey report with information identifying residents redacted, any subsequent reports issued by the Department, and any plan of correction that is in effect are available for review upon request.
- G.** An administrator shall provide written notification to the Department of a resident's:
 - 1. Death, if the resident's death is required to be reported according to A.R.S. § 11-593, within one working day after the resident's death; and
- 2. Self-injury, within two working days after the resident inflicts a self-injury that requires immediate intervention by an emergency medical services provider.
- H.** An administrator shall:
 - 1. Notify a resident's representative, family member, or other individual designated by the resident within one calendar day after:
 - a. The resident's death,
 - b. There is a significant change in the resident's medical condition, or
 - c. The resident has an illness or injury that requires immediate intervention by an emergency medical services provider or treatment by a health care provider; and
 - 2. For an illness or injury in subsection (H)(1)(c), document the following:
 - a. The date and time of the illness or injury;
 - b. A description of the illness or injury;
 - c. If applicable, the names of individuals who observed the injury;
 - d. The actions taken by personnel members, according to policies and procedures;
 - e. The individuals notified by the personnel members; and
 - f. Any action taken to prevent the illness or injury from occurring in the future.
- I.** If an administrator administers a resident's personal account at the request of the resident or the resident's representative, the administrator shall:
 - 1. Comply with policies and procedures established according to subsection (C)(1)(p);
 - 2. Designate a personnel member who is responsible for the personal accounts;
 - 3. Maintain a complete and separate accounting of each personal account;
 - 4. Obtain written authorization from the resident or the resident's representative for a personal account transaction;
 - 5. Document an account transaction and provide a copy of the documentation to the resident or the resident's representative upon request and at least every three months;
 - 6. Transfer all money from the resident's personal account in excess of \$50.00 to an interest-bearing account and credit the interest to the resident's personal account; and
 - 7. Within 30 calendar days after the resident's death, transfer, or discharge, return all money in the resident's personal account and a final accounting to the resident, the resident's representative, or the probate jurisdiction administering the resident's estate.
- J.** If a petty cash fund is established for use by residents, the administrator shall ensure that:
 - 1. The policies and procedures established according to subsection (C)(1)(q) include:
 - a. A prescribed cash limit of the petty cash fund, and
 - b. The hours of the day a resident may access the petty cash fund; and
 - 2. A resident's written acknowledgment is obtained for a petty cash transaction.
- K.** An administrator shall ensure that an acuity plan is developed, documented, and implemented for the nursing-supported group home that:
 - 1. Includes:
 - a. A method that establishes the types and numbers of personnel members that are required in the nursing-

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- supported group home to ensure resident health and safety, and
- b. A policy and procedure stating the steps the nursing-supported group home will take to obtain or assign the necessary personnel members to address resident acuity;
- 2. Is used when making assignments for resident treatment; and
- 3. Is reviewed and updated, as necessary, at least once every 12 months.
- L. An administrator shall establish and document the criteria for determining when a resident's absence is unplanned, including the criteria for a resident who:
 - 1. Is absent against medical advice,
 - 2. Is under the age of 18, or
 - 3. Does not return to the nursing-supported group home at the expected time after a planned absence.
- M. An administrator shall ensure that documentation of the most recent monitoring of the nursing-supported group home, conducted by the Arizona Department of Economic Security under A.R.S. § 36-557(G)(2), is on the premises of the nursing-supported group home.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-2204. 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 services provided to residents;
 - c. A method to evaluate the data collected to identify a concern about the delivery of services related to resident 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 resident 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 resident care, and
 - b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to resident care; and
- 3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date the report is submitted to the governing authority.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2205. Contracted Services

An administrator shall ensure that:

- 1. Contracted services are provided according to the requirements in this Article, and
- 2. Documentation of current contracted services is maintained that includes a description of the contracted services provided.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2206. Personnel

A. An administrator shall ensure that:

- 1. A personnel member is:
 - a. At least 21 years old, or
 - b. At least 18 years old and is licensed or certified under A.R.S. Title 32 and providing services within the personnel member's scope of practice;
- 2. An employee is at least 18 years old;
- 3. A student is at least 18 years old; and
- 4. A volunteer is at least 21 years old.

B. An administrator shall ensure that:

- 1. The qualifications, skills, and knowledge required for each type of personnel member:
 - a. Are based on:
 - i. The type of physical health services, habilitation services, or behavioral care expected to be provided by the personnel member according to the established job description; and
 - ii. The acuity of the residents receiving physical health services, habilitation services, or behavioral care from the personnel member according to the established job description; and
 - b. Include:
 - i. The specific skills and knowledge necessary for the personnel member to provide the expected physical health services, habilitation services, or behavioral care listed in the established job description;
 - ii. The type and duration of education that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services, habilitation services, or behavioral care listed in the established job description; and
 - iii. The type and duration of experience that may allow the personnel member to have acquired the specific skills and knowledge for the personnel member to provide the expected physical health services, habilitation services, or behavioral care listed in the established job description;
- 2. A personnel member's skills and knowledge are verified and documented:
 - a. Before the personnel member provides physical health services, habilitation services, or behavioral care; and
 - b. According to policies and procedures; and
- 3. Sufficient personnel members are present on a nursing-supported group home's premises with the qualifications, skills, and knowledge necessary to:
 - a. Provide the services in the nursing-supported group home's scope of services,
 - b. Meet the needs of a resident, and

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- c. Ensure the health and safety of a resident.
- C.** An administrator shall ensure that an organizational chart of the nursing-supported group home is established, updated as necessary, and maintained on the premises:
1. Outlining the roles, responsibilities, and relationships within the nursing-supported group home; and
 2. Including the name and, if applicable, the license or certification credential of each individual shown on the organizational chart.
- D.** An administrator shall ensure that, if a personnel member provides services that require a license under A.R.S. Title 32 or 36, the personnel member is licensed under A.R.S. Title 32 or 36, as applicable.
- E.** An administrator shall ensure that an individual who is a licensed 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 4 A.A.C. 6, Article 1.
- F.** An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis:
1. On or before the date the individual begins providing services at or on behalf of the nursing-supported group home, and
 2. As specified in R9-10-113.
- G.** An administrator shall ensure that:
1. The types and numbers of nurses and other personnel members required according to the acuity plan in R9-10-2203(K) are present in the nursing-supported group home;
 2. Documentation of the nurses and other personnel members present on the nursing-supported group home's premises each day is maintained and includes:
 - a. The date;
 - b. The number of residents;
 - c. The name, license or certification credential if applicable, and assigned duties of each nurse or other personnel member who worked that day; and
 - d. The actual number of hours each nurse or other personnel member worked that day; and
 3. The documentation of nurses and other personnel members required in subsection (G)(2) is maintained for at least 12 months after the date of the documentation.
- H.** An administrator shall ensure that a personnel member is on duty, on the premises, awake, and able to respond, according to policies and procedures, to injuries, symptoms of illness, or fire or other emergencies on the premises.
- I.** An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes:
1. The individual's name, date of birth, and contact telephone number;
 2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
 3. Documentation of:
 - a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
 - b. The individual's education and experience applicable to the individual's job duties;
 - c. The individual's compliance with the requirements in A.R.S. § 36-411;
 - d. The nursing-supported group home's check on the individual in the adult protective services registry, established according to A.R.S. § 46-459, or the central registry, established according to A.R.S. § 8-804, as applicable;
 - e. Orientation and in-service education as required by policies and procedures;
 - f. Training in preventing, recognizing, and reporting abuse or neglect, required according to R9-10-2203(C)(1)(d)(i);
 - g. The individual's license or certification, if the individual is required to be licensed or certified in this Article or policies and procedures;
 - h. If applicable, the individual's qualifications and ongoing training for each type of restraint used, as required in R9-10-2217;
 - i. Cardiopulmonary resuscitation training, if required for the individual according to R9-10-2203(C)(1)(g);
 - j. First aid training, if required for the individual according to this Article or policies and procedures;
 - k. Evidence of freedom from infectious tuberculosis, if required for the individual according to subsection (F); and
 - l. The individual's compliance with the requirements in A.R.S. § 36-420.01 regarding fall prevention and fall recovery training.
- J.** An administrator shall ensure that personnel records are:
1. Maintained:
 - a. Throughout the individual's period of providing services in or for the nursing-supported group home, and
 - b. For at least 24 months after the last date the individual provided services in or for the nursing-supported group home; and
 2. For a personnel member who has not provided physical health services, habilitation services, or behavioral care at or for the nursing-supported group home during the previous 12 months, provided to the Department within 72 hours after the Department's request.
- K.** An administrator shall ensure that:
1. A plan to provide orientation specific to the duties of a personnel member, an employee, a volunteer, and a student is developed, documented, and implemented;
 2. A personnel member completes orientation before providing physical health services, habilitation services, or behavioral care;
 3. An individual's orientation is documented, to include:
 - a. The individual's name,
 - b. The date of the orientation, and
 - c. The subject or topics covered in the orientation;
 4. A plan to provide in-service education specific to the duties of a personnel member is developed, documented, and implemented;
 5. A personnel member's in-service education 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; and
 6. A work schedule of each personnel member is developed and maintained at the nursing-supported group home for at least 12 months after the date of the work schedule.
- L.** An administrator shall ensure that a fall prevention and fall recovery program that complies with requirements in A.R.S. § 36-420.01 is developed, documented, and implemented.

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Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-2207. Admissions

An administrator shall ensure that:

1. A resident is admitted only:
 - a. On a physician's order or based on a placement evaluation by the Division;
 - b. If the resident has or is at risk for having a developmental disability or cognitive disability;
 - c. If the resident's placement evaluation indicates that the resident requires continuous nursing services;
 - d. If the resident's placement evaluation indicates that the resident's needs can be met by the nursing-supported group home; and
 - e. Except when the resident's placement evaluation states that the resident would benefit from being part of a group that includes residents of different ages or social needs, if the resident can be assigned to a room within the nursing-supported group home with other residents of similar ages or social needs;
2. The physician's admitting order or placement evaluation documentation in subsection (1)(a) includes the physical health services, habilitation services, and behavioral care required to meet the immediate needs of a resident, including medication and food services;
3. At the time of a resident's admission, a registered nurse conducts or coordinates an initial assessment on a resident to determine the resident's acuity and ensure the resident's immediate needs are met;
4. The resident's individual service and program plan, as required by A.A.C. R6-6-602, accompanies the resident;
5. A resident's needs do not exceed the medical services, rehabilitation services, and nursing services available at the nursing-supported group home as established in the nursing-supported group home's scope of services;
6. A resident is assigned to the nursing-supported group home based, as applicable, on the patient's:
 - a. Documented diagnosis,
 - b. Treatment needs,
 - c. Developmental level,
 - d. Social skills,
 - e. Verbal skills, and
 - f. Acuity;
7. A resident does not share any space, participate in any activity or treatment, or verbally or physically interact with any other resident that, based on the other resident's documented diagnosis, treatment needs, developmental level, social skills, verbal skills, and personal history, may present a threat to the resident's health and safety;
8. Within 30 calendar days before admission or 10 working days after admission, a medical history and physical examination is completed on a resident by:
 - a. A medical practitioner designated for the resident, or
 - b. A physician assistant or a registered nurse practitioner designated by the resident's designated medical practitioner;
9. Compliance with the requirements in subsection (8) is documented in the resident's medical record;
10. Except as specified in subsection (11), a resident provides evidence of freedom from infectious tuberculosis:

- a. Before or within seven calendar days after the resident's admission, and
 - b. As specified in R9-10-113; and
11. A resident who transfers from a nursing care institution or another nursing-supported group home to the nursing-supported group home is not required to be rescreened for tuberculosis as specified in R9-10-113 if:
 - a. Fewer than 12 months have passed since the resident was screened for tuberculosis, and
 - b. The documentation of freedom from infectious tuberculosis required in subsection (10) accompanies the resident at the time of transfer.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2208. Transfer; Discharge

A. An administrator, in coordination with the Division if applicable, shall ensure that:

1. A resident is transferred or discharged if:
 - a. The nursing-supported group home is not authorized or not able to meet the needs of the resident,
 - b. The resident no longer requires continuous nursing services, or
 - c. The resident's behavior is a threat to the health or safety of the resident or other individuals at the nursing-supported group home; and
2. Documentation of a resident's transfer or discharge includes:
 - a. The date of the transfer or discharge,
 - b. The reason for the transfer or discharge,
 - c. A notation by a physician or the physician's designee if the transfer or discharge is due to any of the reasons listed in subsection (A)(1), and
 - d. If applicable, actions taken by a personnel member to protect the resident or other individuals if the resident's behavior is a threat to the health and safety of the resident or other individuals in the nursing-supported group home and beyond the nursing-supported group home's scope of services.

B. Except for a transfer of a resident due to an emergency, an administrator shall ensure that:

1. A registered nurse coordinates the transfer and the services provided to the resident;
2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before the transfer;
 - b. Information from the resident's medical record, including the following, is provided to a receiving health care institution;
 - i. Orders that are in effect at the time of the transfer; and
 - ii. The resident's need for nursing services, rehabilitation services, or habilitation services at the time of transfer; and
 - c. A personnel member explains risks and benefits of the transfer to the resident or the resident's representative; and
3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transfer;
 - c. The mode of transportation; and

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- d. If applicable, the name of the personnel member accompanying the resident during a transfer.
- C. Except in an emergency, a registered nurse shall ensure that before a resident is discharged:
 - 1. Written follow-up instructions are developed with the resident or the resident's representative that include:
 - a. Information necessary to meet the resident's need for medical services and nursing services, including specific care instructions and whether the resident requires any durable medical equipment or supplies; and
 - b. The state long-term care ombudsman's name, address, and telephone number;
 - 2. A copy of the written follow-up instructions is provided to the resident or the resident's representative; and
 - 3. A discharge summary:
 - a. Is developed by a registered nurse;
 - b. Authenticated by the resident's designated medical practitioner or designee; and
 - c. Includes:
 - i. The resident's need for nursing services, rehabilitation services, or habilitation services at the time of discharge;
 - ii. The resident's need for medical services;
 - iii. The resident's developmental, behavioral, social, and nutritional status;
 - iv. The resident's medical and psychosocial history;
 - v. The date of the discharge; and
 - vi. The location of the resident after discharge.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2209. Transport

- A. Except as provided in subsections (B) and (C), an administrator shall ensure that:
 - 1. A personnel member authorized by policies and procedures coordinates the transport and the services provided to the resident;
 - 2. According to policies and procedures:
 - a. An evaluation of the resident is conducted before and after the transport,
 - b. Information from the resident's medical record is provided to a receiving health care institution, and
 - c. A personnel member explains risks and benefits of the transport to the resident or the resident's representative; and
 - 3. Documentation in the resident's medical record includes:
 - a. Communication with an individual at a receiving health care institution;
 - b. The date and time of the transport;
 - c. The mode of transportation; and
 - d. If applicable, the name of the personnel member accompanying the resident during a transport.
- B. If the transport of a resident is to provide the resident with rehabilitation services or habilitation services off the premises, an administrator shall ensure that:
 - 1. The rehabilitation services or habilitation services are included in the resident's individual program plan,
 - 2. A registered nurse coordinates the transport and the services provided to the resident, and
 - 3. The resident is transported according to R9-10-2210(A).

- C. Subsection (A) does not apply to:
 - 1. Except as provided in subsection (B), transportation according to R9-10-2210 to a location other than a licensed health care institution;
 - 2. Transportation provided for a resident by the resident or the resident's representative;
 - 3. Transportation provided by an outside entity that was arranged for a resident by the resident or the resident's representative; or
 - 4. A transport to another licensed health care institution in an emergency.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2210. Transportation; Resident Outings

- A. An administrator of a nursing-supported group home that uses a vehicle owned or leased by the nursing-supported group home to provide transportation to a resident shall ensure that:
 - 1. The vehicle:
 - a. Is safe and in good repair,
 - b. Contains a first aid kit,
 - c. Contains drinking water sufficient to meet the needs of each resident present in the vehicle, and
 - d. Contains a working heating and air conditioning system;
 - 2. Documentation of current vehicle insurance and a record of maintenance performed or a repair of the vehicle is maintained;
 - 3. A driver of the vehicle:
 - a. Is 21 years of age or older;
 - b. Has a valid driver license and no driving restriction on the driver's documentation of compliance with the requirements in A.R.S. § 36-411;
 - c. Operates the vehicle in a manner that does not endanger a resident in the vehicle;
 - d. Does not leave in the vehicle an unattended:
 - i. Child;
 - ii. Resident who may be a threat to the health, safety, or welfare of the resident or another individual; or
 - iii. Resident who is incapable of independent exit from the vehicle; and
 - e. Ensures the safe and hazard-free loading and unloading of residents; and
 - 4. Transportation safety is maintained as follows:
 - a. An individual in the vehicle is sitting in a seat, which may include the seat of a wheel chair, and wearing a working seat belt while the vehicle is in motion; and
 - b. Each seat in the vehicle is securely fastened to the vehicle and provides sufficient space for a resident's body.
- B. An administrator shall ensure that an outing is consistent with the age, physical ability, medical condition, and treatment needs of each resident participating in the outing.
- C. An administrator shall ensure that:
 - 1. A sufficient number of personnel members are present on an outing to ensure the health and safety of a resident on the outing;
 - 2. Each personnel member on the outing has documentation of current training in cardiopulmonary resuscitation according to R9-10-2203(C)(1)(g) and first aid training;

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3. Documentation is developed before an outing that includes:
 - a. The name of each resident 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 a vehicle used to provide transportation for the outing;
4. The documentation described in subsection (C)(3) 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
5. Emergency information for a resident participating in the outing is maintained by a personnel member participating in the outing or in the vehicle used to provide transportation for the outing and includes:
 - a. The resident's name;
 - b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the resident during the anticipated duration of the outing;
 - c. The resident's allergies; and
 - d. The name and telephone number of a designated individual, who is present on the nursing-supported group home's premises, to notify in case of an emergency.
- f. Sexual abuse;
- g. Sexual assault;
- h. Seclusion;
- i. Except as allowed in R9-10-2217, restraint;
- j. Retaliation for submitting a complaint to the Department or another entity;
- k. Misappropriation of personal and private property by a nursing-supported group home's personnel members, employees, volunteers, or students; or
- l. Segregation solely on the basis of the resident's disability; and
4. A resident or the resident's representative:
 - a. Except in an emergency, either consents to or refuses treatment;
 - b. May refuse or withdraw consent for treatment before treatment is initiated;
 - c. Except in an emergency, is informed of proposed alternatives to psychotropic medication and the associated risks and possible complications of the psychotropic medication;
 - d. Is informed of the following:
 - i. The health care institution's policy on health care directives;
 - ii. If applicable, the policies in R9-10-2203(C)(1)(r); and
 - iii. The resident complaint process;
 - e. Consents to photographs of the resident before the resident is photographed, except that the resident may be photographed when admitted to a nursing-supported group home for identification and administrative purposes;
 - f. May manage the resident's financial affairs;
 - g. Has access to and may communicate with any individual, organization, or agency;
 - h. Except as provided in the resident's individual program plan, has privacy:
 - i. In interactions with other residents or visitors to the nursing-supported group home,
 - ii. In the resident's mail, and
 - iii. For telephone calls made by or to the resident;
 - i. May review the nursing-supported group home's current license survey report and, if applicable, plan of correction in effect;
 - j. May review the resident's financial records within two working days and medical record within one working day after the resident's or the resident's representative's request;
 - k. May obtain a copy of the resident's financial records and medical record within two working days after the resident's request and in compliance with A.R.S. § 12-2295;
 - l. Except as otherwise permitted by law, consents, in writing, to the release of information in the resident's:
 - i. Medical record, and
 - ii. Financial records;
 - m. May select a pharmacy of choice if the pharmacy complies with policies and procedures and does not pose a risk to the resident;
 - n. Is informed of the method for contacting the resident's designated medical practitioner;
 - o. Is informed of the resident's overall physical and psychosocial well-being, as determined by the resident's comprehensive assessment;

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2211. Resident Rights

- A. An administrator shall ensure that:
 1. The requirements in subsection (B) and the resident rights in subsection (C) are conspicuously posted on the premises;
 2. At the time of admission, a resident or the resident's representative receives a written copy of the requirements in subsection (B) and the resident rights in subsection (C); and
 3. Policies and procedures include:
 - a. How and when a resident or the resident's representative is informed of resident rights in subsection (C), and
 - b. Where resident rights are posted as required in subsection (A)(1).
- B. An administrator shall ensure that:
 1. A resident has privacy in:
 - a. Treatment,
 - b. Bathing and toileting,
 - c. Room accommodations, and
 - d. Visiting or meeting with another resident or an individual;
 2. A resident is treated with dignity, respect, and consideration;
 3. A resident is not subjected to:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;

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- p. Is provided with a copy of those sections of the resident's medical record that are required for continuity of care free of charge, according to A.R.S. § 12-2295, if the resident is transferred or discharged; and
 - q. Except in the event of an emergency, is informed orally or in writing before the nursing-supported group home makes a change in a resident's room or roommate assignment and notification is documented in the resident's medical record.
 - C. In addition to the rights in A.R.S. § 36-551.01, a resident has the following rights:
 - 1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
 - 2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;
 - 3. To choose activities and schedules consistent with the resident's interests that do not interfere with other residents;
 - 4. To participate in social, religious, political, and community activities that do not interfere with other residents;
 - 5. To retain personal possessions including furnishings and clothing as space permits unless use of the personal possession infringes on the rights or health and safety of other residents;
 - 6. To share a room with the resident's spouse if space is available and the spouse consents;
 - 7. To receive a referral to another health care institution if the nursing-supported group home is not authorized or not able to provide physical health services, habilitation services, and behavioral care needed by the resident;
 - 8. To participate or have the resident's representative participate in the development of the resident's individual program plan or decisions concerning treatment;
 - 9. To participate or refuse to participate in research or experimental treatment; and
 - 10. To receive assistance from a family member, the resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.
- Historical Note**
- New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).
- R9-10-2212. Medical Records**
- A. An administrator shall ensure that:
 - 1. A medical record is established and maintained for each resident according to A.R.S. Title 12, Chapter 13, Article 7.1;
 - 2. An entry in a resident's medical record is:
 - a. Recorded only by an individual authorized by 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 resident's medical record and includes the time of the order;
 - b. Authenticated by a medical practitioner or behavioral health professional according to policies and procedures; and
 - c. If the order is a verbal order, authenticated by the medical practitioner or behavioral health professional issuing the order;
 - 4. If a rubber-stamp signature or an electronic signature is used to authenticate an order, the individual whose signature the rubber-stamp signature or electronic signature represents is accountable for the use of the rubber-stamp signature or electronic signature;
 - 5. A resident's medical record is available to an individual:
 - a. Authorized to access the resident's medical record according to policies and procedures;
 - b. If the individual is not authorized to access the resident's medical record according to policies and procedures, with the written consent of the resident or the resident's representative; or
 - c. As permitted by law; and
 - 6. A resident's medical record is protected from loss, damage, or unauthorized use.
 - B. If a nursing-supported group home maintains residents' medical records electronically, an administrator shall ensure that:
 - 1. Safeguards exist to prevent unauthorized access, and
 - 2. The date and time of an entry in a resident's medical record is recorded by the computer's internal clock.
 - C. An administrator shall ensure that a resident's medical record contains:
 - 1. Resident information that includes:
 - a. The resident's name;
 - b. The resident's date of birth; and
 - c. Any known allergies, including medication allergies;
 - 2. The admission date and, if applicable, the date of discharge;
 - 3. The admitting diagnosis or presenting symptoms;
 - 4. Documentation of the resident's placement evaluation;
 - 5. Documentation of the resident's individual service and program plan, as required by A.A.C. R6-6-602;
 - 6. Documentation of:
 - a. The resident's last periodic evaluation, conducted according to A.A.C. R6-6-604, before the resident's admission; and
 - b. Each periodic evaluation, conducted according to A.A.C. R6-6-604, while the resident was admitted to the nursing-supported group home;
 - 7. Documentation of general consent and, if applicable, informed consent;
 - 8. If applicable, the name and contact information of the resident's representative and:
 - a. The document signed by the resident consenting for the resident's representative to act on the resident's behalf; or
 - b. If the resident's representative:
 - i. Has a health care power of attorney established under A.R.S. § 36-3221 or a mental health care power of attorney executed under A.R.S. § 36-3282, a copy of the health care power of attorney or mental health care power of attorney; or
 - ii. Is a legal guardian, a copy of the court order establishing guardianship;
 - 9. The name and contact information of an individual to be contacted under R9-10-2203(H)(1);
 - 10. Documentation of the initial assessment required in R9-10-2207(3) to determine acuity;
 - 11. The medical history and physical examination required in R9-10-2215(A)(2);
 - 12. A copy of the resident's living will or other health care directive, if applicable;

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13. The name and telephone number of the resident's designated medical practitioner;
 14. Orders;
 15. Documentation of the resident's comprehensive assessment;
 16. Individual program plans, including nursing care plans or medical care plans, if applicable;
 17. Documentation of physical health services, habilitation services, and behavioral care provided to the resident;
 18. Progress notes, including data needed to evaluate the effectiveness of the methods, schedule, and strategies being used to accomplish the goals in the resident's individual program plan;
 19. If applicable, documentation of restraint;
 20. If applicable, documentation of any actions other than restraint taken to control or address the resident's behavior to prevent harm to the resident or another individual or to improve the resident's social interactions;
 21. If applicable, documentation that evacuation from the nursing-supported group home would cause harm to the resident;
 22. The disposition of the resident after discharge;
 23. The discharge plan;
 24. The discharge summary;
 25. Transfer documentation;
 26. If applicable:
 - a. A laboratory report,
 - b. A radiologic report,
 - c. A diagnostic report, and
 - d. A consultation report;
 27. Documentation of freedom from infectious tuberculosis required in R9-10-2207(10);
 28. Documentation of a medication administered to the resident that includes:
 - a. The date and time of administration;
 - b. The name, strength, dosage, and route of administration;
 - c. The type of vaccine, if applicable;
 - d. For a medication administered for pain on a PRN basis:
 - i. An evaluation of the resident's pain before administering the medication, and
 - ii. The effect of the medication administered;
 - e. For a psychotropic medication administered on a PRN basis:
 - i. An evaluation of the resident's symptoms before administering the psychotropic medication, and
 - ii. The effect of the psychotropic medication administered;
 - f. The identification, signature, and professional designation of the individual administering the medication; and
 - g. Any adverse reaction a resident has to the medication; and
 29. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.
- A. An administrator shall ensure that:
 1. Nursing services are provided 24 hours a day in a nursing-supported group home;
 2. A director of nursing is appointed who:
 - a. Is a registered nurse, and
 - b. Is responsible for the direction of nursing services;
 3. The director of nursing or an individual designated by the administrator participates in the quality management program; and
 4. If the director of nursing is responsible for nursing services for 30 or more residents, the director of nursing does not provide direct care to residents on a regular basis.
 - B. A director of nursing shall ensure that:
 1. A method is established and documented that identifies the types and numbers of nursing personnel that are necessary to provide nursing services to residents based on the residents' comprehensive assessments; orders for physical health services, rehabilitation services, and behavioral care; and individual program plans and the nursing-supported group home's scope of services;
 2. Sufficient nursing personnel, as determined by the method in subsection (B)(1), are assigned to be on the nursing-supported group home premises to meet the needs of a resident for nursing services;
 3. At least one nurse is present on the nursing-supported group home's premises;
 4. As soon as possible but not more than 24 hours after one of the following events occur, a nurse notifies a resident's designated medical practitioner and, if applicable, the resident's representative, if the resident:
 - a. Is injured,
 - b. Is involved in an incident that may require medical services, or
 - c. Has a significant change in condition; and
 5. Only a medication required by an order is administered to a resident.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2214. Individual Program Plan

- A. An administrator shall ensure that:
 1. A comprehensive assessment of a resident:
 - a. Is conducted or coordinated by the director of nursing, in collaboration with an interdisciplinary team that includes:
 - i. The resident's designated medical practitioner or designee;
 - ii. A registered nurse;
 - iii. If the resident is receiving medications as part of physical health services or behavioral care, a pharmacist; and
 - iv. Personnel members qualified to provide each type of habilitation services or rehabilitation services identified in a placement evaluation in R9-10-2207(1)(a) or the initial assessment required in R9-10-2207(3);
 - b. Is completed for the resident within 30 calendar days after the resident's admission to a nursing-supported group home;
 - c. Is updated:

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2213. Nursing Services

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- i. No later than 12 months after the date of the resident's last comprehensive assessment, and
- ii. When the resident experiences a significant change;
- d. Includes the following information for the resident:
 - i. Identifying information;
 - ii. An evaluation of the resident's hearing, speech, and vision;
 - iii. An evaluation of the resident's ability to understand and recall information;
 - iv. An evaluation of the resident's mental status;
 - v. Whether the resident demonstrates inappropriate behavior;
 - vi. Preferences for customary routine and activities;
 - vii. An evaluation of the resident's ability to perform activities of daily living;
 - viii. Need for a mobility device;
 - ix. An evaluation of the resident's ability to control the resident's bladder and bowels;
 - x. Any diagnosis that impacts rehabilitation services or other physical health services or behavioral care that the resident may require;
 - xi. Any medical conditions that impact the resident's functional status, quality of life, or need for nursing services;
 - xii. An evaluation of the resident's ability to maintain adequate nutrition and hydration;
 - xiii. An evaluation of the resident's oral and dental status;
 - xiv. An evaluation of the condition of the resident's skin;
 - xv. Identification of any medication or treatment administered to the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
 - xvi. Identification of any treatment or medication ordered for the resident;
 - xvii. Identification of interventions that may support the resident towards independence;
 - xviii. Identification of any assistive devices needed by the resident;
 - xix. Identification of the physical health services needed by the resident, including physical health services not provided by the nursing-supported group home;
 - xx. Identification of measurable goals and behavioral objective for the physical health services, habilitation services, and behavioral care, in priority order, with time limits for attainment;
 - xxi. Identification of the methods, schedule, and strategies to accomplish the goals in subsection (A)(1)(d)(xviii), including the personnel member responsible;
 - xxii. Evaluation procedures for determining if the methods and strategies in subsection (A)(1)(d)(xix) are working, including the type of data required and frequency of collection;
 - xxiii. Whether any restraints have been used for the resident during a seven-day calendar period that includes the time the comprehensive assessment was conducted;
- xxiv. If the resident demonstrates inappropriate behavior, as reported according to subsection (A)(1)(d)(v), identification of the methods, schedule, and strategies for replacement of the inappropriate behavior with appropriate behavioral expressions, including the hierarchy for use;
- xxv. If restraint is included in subsection (A)(1)(d)(xxiv), the specific restraints that may be used because of the resident's inappropriate behavior;
- xxvi. A description of the resident or resident's representative's participation in the comprehensive assessment;
- xxvii. The name and title of the interdisciplinary team members who participated in the resident's comprehensive assessment;
- xxviii. Potential for rehabilitation, including the resident's strengths and specific developmental or behavioral health needs; and
- xxix. Potential for discharge;
- e. Is signed and dated by the director of nursing; and
- f. Is used to determine or update the resident's acuity;
- 2. If any of the conditions in subsection (A)(1)(d)(v) are answered in the affirmative during the comprehensive assessment or review, a behavioral health professional reviews a resident's comprehensive assessment or review and individual program plan to ensure that the resident's needs for behavioral care are being met;
- 3. A new comprehensive assessment is not required for a resident who is hospitalized and readmitted to a nursing-supported group home unless a physician, an individual designated by the physician, or a registered nurse determines the resident has a significant change in condition; and
- 4. A resident's comprehensive assessment is reviewed at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition by:
 - a. The director of nursing;
 - b. A registered nurse providing nursing services to the resident; and
 - c. If there is a significant change in the resident's ability to maintain adequate nutrition and hydration, a registered dietitian.
- B. An administrator shall ensure that an individual program plan for a resident:
 - 1. Is developed, documented, and implemented for the resident within seven calendar days after completing the resident's comprehensive assessment required in subsection (A)(1);
 - 2. Includes the acuity of the resident;
 - 3. Is reviewed at least annually by the interdisciplinary team required in subsection (A)(1)(a) and revised based on any change to the resident's comprehensive assessment; and
 - 4. Ensures that a resident is provided physical health services, rehabilitation services, habilitation services, and other services or behavioral care that:
 - a. Address any medical condition or behavioral care issue identified in the resident's comprehensive assessment, and

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- b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2215. Physical Health Services**A.** An administrator shall ensure that:

1. A resident has a designated medical practitioner;
2. A physical examination is performed on a resident by the resident's designated medical practitioner or by a physician, physician assistant, or registered nurse practitioner designated by the resident's designated medical practitioner:
 - a. If indicated, based on the resident's placement evaluation or comprehensive assessment; and
 - b. At least once every 12 months after the date of admission, including an assessment of the acuity of the resident's medical condition;
3. The resident's designated medical practitioner, in conjunction with the director of nursing, develops a medical care plan of treatment for the resident, which is integrated into the resident's individual program plan; and
4. Vaccinations for influenza and pneumonia are available to each resident at least once every 12 months unless:
 - a. The resident's designated medical practitioner provides documentation that the vaccination is medically contraindicated;
 - b. The resident or the resident's representative refuses the vaccination or vaccinations and documentation is maintained in the resident's medical record that the resident or the resident's representative has been informed of the risks and benefits of a vaccination refused; or
 - c. The resident or the resident's representative provides documentation that the resident received a pneumonia vaccination within the last five years or the current recommendation from the U.S. Department of Health and Human Services, Center for Disease Control and Prevention.

B. A director of nursing shall ensure that:

1. A registered nurse participates in the development, review, and updating of a resident's nursing care plan or medical care plan;
2. Personnel members providing direct care to a resident with a nursing care plan or medical care plan receive direction from a nurse; and
3. Nursing personnel provide education and training to:
 - a. Residents on hygiene and other behaviors that promote health; and
 - b. Personnel members on:
 - i. Detecting signs of illness or injury or significant changes in condition,
 - ii. First aid, and
 - iii. Basic skills for caring for residents.

C. An administrator shall ensure that:

1. A resident's need for dental services is determined as part of the resident's initial assessment in R9-10-2207(3);
2. Unless a resident's eligibility for third-party payment for dental services is determined before the resident's initial comprehensive assessment in R9-10-2214(A)(1)(b) due to the resident's immediate need for dental services, the

resident's eligibility for third-party payment for dental services is determined as part of the resident's comprehensive assessment;

3. Within one month after the initial comprehensive assessment in R9-10-2214(A)(1)(b), a personnel member coordinates for a resident the scheduling of a dental examination and, if needed, dental treatment:
 - a. If the resident is eligible for third-party payment for dental services, and
 - b. Unless the nursing-supported group home has documentation that the resident received a dental examination within 12 months before admission;
4. If a resident is eligible for third-party payment for dental services:
 - a. A dental examination is scheduled for the resident according to guidelines by the entity providing third-party payment for dental services and at least once every 12 months, and
 - b. Dental treatment is scheduled according to guidelines by the entity providing third-party payment for dental services and as needed;
5. Except as provided in subsection (C)(6), if a dental examination of a resident indicates a need for dental treatment, the resident's individual program plan includes the scheduling of dental treatment for the resident when the resident is eligible for third-party payment for dental services;
6. If needed, a resident is provided with emergency dental services;
7. A resident is provided with education and training in oral hygiene; and
8. A resident's medical record contains documentation of:
 - a. Each dental examination of the resident,
 - b. All dental treatment received by the resident, and
 - c. The resident's education and training in oral hygiene.

D. An administrator shall ensure that:

1. A resident's vision and hearing are assessed as part of the resident's comprehensive assessment in R9-10-2214(A)(1)(b) and, if applicable, as part of the update of the comprehensive assessment in R9-10-2214(A)(1)(c); and
2. If an issue is identified with the resident's vision or hearing:
 - a. The issue is included in the resident's individual program plan,
 - b. A personnel member contacts and coordinates with applicable entities to determine any vision or hearing benefits for which the resident may be eligible, and
 - c. The nursing-supported group home makes reasonable accommodations to address the issue in compliance with applicable federal and state disability laws.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2216. Behavioral Care**A.** An administrator shall ensure that:

1. A resident who receives behavioral care from the nursing-supported group home is evaluated by a behavioral health professional or medical practitioner:

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- a. Within 30 calendar days before the resident is admitted to the nursing-supported group home or before the resident begins receiving behavioral care, and
 - b. At least once every six months throughout the duration of the resident's need for behavioral care;
 2. A behavioral health professional or medical practitioner:
 - a. Documents that the behavioral care needed by the resident is within the nursing-supported group home's scope of services, and
 - b. Includes measurable objectives for the behavioral care and the methods for meeting the objectives in the resident's individual program plan; and
 3. The documentation in subsection (A)(2) is included in the resident's medical record.
 - B.** If a resident of a nursing-supported group home requires behavioral health services provided by a behavioral health professional on an intermittent basis as part of behavioral care, an administrator shall ensure that:
 1. The behavioral health services are provided by a behavioral health professional licensed or certified to provide the type of behavioral health services required by the resident; and
 2. Except for a psychotropic drug used as a chemical restraint or administered according to an order from a court of competent jurisdiction, informed consent is obtained from a resident or the resident's representative for a psychotropic drug and documented in the resident's medical record before the psychotropic drug is administered to the resident.
- Historical Note**
- New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).
- R9-10-2217. Restraint**
- If a nursing-supported group home is authorized to provide restraint, an administrator shall ensure that:
1. Policies and procedures for providing restraint are established, documented, and implemented to protect the health and safety of a resident that:
 - a. Establish the process for resident assessment, including identification of a resident's medical conditions and criteria for the on-going monitoring of any identified medical condition;
 - b. Identify each type of restraint used and include for each type of restraint used:
 - i. The qualifications of a personnel member who can:
 - (1) Order the restraint,
 - (2) Place a resident in the restraint,
 - (3) Monitor a resident in the restraint,
 - (4) Evaluate a resident's physical and psychological well-being after being placed in the restraint and when released from the restraint, or
 - (5) Renew the order for restraint;
 - ii. On-going training requirements for a personnel member who has direct resident contact while the resident is in a restraint; and
 - iii. Criteria for monitoring and assessing a resident including:
 - (1) Frequencies of monitoring and assessment based on a resident's medical condition and risks associated with the specific restraint;
 2. For the renewal of an order for restraint, whether an assessment is required before the order is renewed and, if an assessment is required, who may conduct the assessment;
 3. Assessment content, which may include, depending on a resident's condition, the resident's vital signs, respiration, circulation, hydration needs, elimination needs, level of distress and agitation, mental status, cognitive functioning, neurological functioning, and skin integrity;
 4. If a mechanical restraint is used, how often the mechanical restraint is loosened; and
 5. A process for meeting a resident's nutritional needs and elimination needs;
- c. Establish the criteria and procedures for renewing an order for restraint;
 - d. Establish procedures for internal review of the use of restraint; and
 - e. Establish medical record and personnel record documentation requirements for restraint, if applicable;
2. An order for restraint is:
 - a. Obtained from a physician or registered nurse practitioner, and
 - b. Not written as a standing order or on an as-needed basis;
3. Restraint is:
 - a. Not used as a means of coercion, discipline, convenience, or retaliation;
 - b. Only used when all of the following conditions are met:
 - i. Except as provided in subsection (4), after obtaining an order for the restraint;
 - ii. For the management of a resident's aggressive, violent, or self-destructive behavior;
 - iii. When less restrictive interventions have been determined to be ineffective; and
 - iv. To ensure the immediate physical safety of the resident, to prevent imminent harm to the resident or another individual, or to stop physical harm to another individual; and
 - c. Discontinued at the earliest possible time;
4. If as a result of a resident's aggressive, violent, or self-destructive behavior, harm to the resident or another individual is imminent or the resident or another individual is being physically harmed, a personnel member:
 - a. May initiate an emergency application of restraint for the resident before obtaining an order for the restraint, and
 - b. Obtains an order for the restraint of the resident during the emergency application of the restraint;
5. An order for restraint includes:
 - a. The name of the physician or registered nurse practitioner ordering the restraint;
 - b. The date and time that the restraint was ordered;
 - c. The specific restraint 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 without an additional order; and

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- f. The maximum duration authorized for the restraint;
6. An order for restraint is limited to the duration of the emergency situation and does not exceed three continuous hours;
7. If an order for restraint of a resident is not provided by the resident's designated medical practitioner, the resident's designated medical practitioner is notified as soon as possible;
8. A medical practitioner or personnel member does not participate in restraint, assess or monitor a resident during restraint, or evaluate a resident after restraint, and a physician or registered nurse practitioner does not order restraint, until the medical practitioner or personnel member, completes education and training that:
 - a. Includes:
 - i. Techniques to identify medical practitioner, personnel member, and resident behaviors, events, and environmental factors that may trigger circumstances that require restraint;
 - 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 resident's medical or behavioral health condition;
 - iv. The safe use of restraint, including training in how to recognize and respond to signs of physical and psychological distress in a resident who is restrained or secluded;
 - v. Clinical identification of specific behavioral changes that indicate that the restraint is no longer necessary;
 - vi. Monitoring and assessing a resident while the resident is in restraint according to policies and procedures; and
 - vii. Except for the medical practitioner, training exercises in which the 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 to policies and procedures;
9. When a resident is placed in restraint:
 - a. The restraint is conducted according to policies and procedures;
 - b. The restraint is proportionate and appropriate to the severity of the resident's behavior and the resident'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 is available for consultation throughout the duration of the restraint;
 - d. The resident is monitored and assessed according to policies and procedures;
 - e. A physician or registered nurse assesses the resident within one hour after the resident is placed in the restraint and determines:
 - i. The resident's current behavior,
 - ii. The resident's reaction to the restraint used,
 - iii. The resident's medical and behavioral condition, and
 - iv. Whether to continue or terminate the restraint;
 - f. The resident is given the opportunity:
 - i. To eat during mealtime, and
 - ii. To use the toilet; and
 - g. The restraint is discontinued at the earliest possible time, regardless of the length of time identified in the order;
10. A medical practitioner or personnel member documents the following information in a resident's medical record before the end of the shift in which the resident is placed in restraint or, if the resident's restraint does not end during the shift in which it began, during the shift in which the resident's restraint ends:
 - a. The emergency situation that required the resident to be restrained,
 - b. The times the resident's restraint actually began and ended,
 - c. The monitoring required in subsection (9)(d),
 - d. The time of the assessment required in subsection (9)(e),
 - e. The names of the medical practitioners and personnel members with direct resident contact while the resident was in the restraint,
 - f. The times the resident was given the opportunity to eat or use the toilet according to subsection (9)(f), and
 - g. The resident evaluation required in subsection (12);
11. If an emergency situation continues beyond the time limit of an order for restraint, the order is renewed according to policies and procedures that include:
 - a. The specific criteria for release from restraint without an additional order, and
 - b. The maximum duration authorized for the restraint; and
12. A resident is evaluated after restraint is no longer being used for the resident.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2218. Rehabilitation Services

If rehabilitation services are provided on a nursing-supported group home's premises, an administrator shall ensure that:

1. Rehabilitation services are provided:
 - a. Under the direction of an individual qualified according to policies and procedures,
 - b. By an individual licensed to provide the rehabilitation services, and
 - c. According to an order; and
2. The medical record of a resident receiving rehabilitation services includes:
 - a. An order for rehabilitation services that includes the name of the ordering individual and a referring diagnosis,
 - b. A documented individual program plan that is developed in coordination with the ordering individual

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- and the individual providing the rehabilitation services,
- c. The rehabilitation services provided,
- d. The resident's response to the rehabilitation services, and
- e. The authentication of the individual providing the rehabilitation services.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2219. Clinical Laboratory Services

If clinical laboratory services are authorized to be provided on a nursing-supported group home's premises, an administrator shall ensure that:

1. Clinical laboratory services and pathology services are provided through a laboratory that holds a certificate of accreditation, certificate of compliance, or certificate of waiver issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967;
2. A copy of the certificate of accreditation, certificate of compliance, or certificate of waiver in subsection (1) is provided to the Department for review upon the Department's request;
3. The nursing-supported group home:
 - a. Is able to provide the clinical laboratory services delineated in the nursing-supported group home's scope of services when needed by the residents,
 - b. Obtains specimens for the clinical laboratory services delineated in the nursing-supported group home's scope of services without transporting the residents from the nursing-supported group home's premises, and
 - c. Has the examination of the specimens performed by a clinical laboratory;
4. Clinical laboratory and pathology test results are:
 - a. Available to the ordering physician:
 - i. Within 24 hours after the test is complete with results if the test is performed at a laboratory on the nursing-supported group home's premises, or
 - ii. Within 24 hours after the test result is received if the test is performed at a laboratory outside of the nursing-supported group home's premises; and
 - b. Documented in a resident's medical record;
5. If a test result is obtained that indicates a resident may have an emergency medical condition, as established in policies and procedures, a personnel member notifies:
 - a. The ordering physician,
 - b. A registered nurse in the nursing-supported group home,
 - c. The nursing-supported group home's administrator, or
 - d. The director of nursing;
6. If a clinical laboratory report is completed on a resident, a copy of the report is included in the resident's medical record;
7. If the nursing-supported group home provides blood or blood products, policies and procedures are established, documented, and implemented for:

- a. Procuring, storing, transfusing, and disposing of blood or blood products;
 - b. Blood typing, antibody detection, and blood compatibility testing; and
 - c. Investigating transfusion adverse reactions that specify a process for review through the quality management program; and
8. Expired laboratory supplies are discarded according to policies and procedures.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2220. Respiratory Care Services

If respiratory care services are authorized to be provided on a nursing-supported group home's premises, an administrator shall ensure that:

1. Respiratory care services are provided under the direction of a resident's designated medical practitioner;
2. Respiratory care services are provided according to an order that includes:
 - a. The resident's name;
 - b. The name and signature of the ordering individual;
 - c. The type, frequency, and, if applicable, duration of treatment;
 - d. The type and dosage of medication and diluent; and
 - e. The oxygen concentration or oxygen liter flow and method of administration;
3. Respiratory care services provided to a resident are documented in the resident's medical record and include:
 - a. The date and time of administration;
 - b. The type of respiratory care services provided;
 - c. The effect of the respiratory care services;
 - d. The resident's adverse reaction to the respiratory care services, if any; and
 - e. The authentication of the individual providing the respiratory care services; and
4. Any area or unit that performs blood gases or clinical laboratory tests complies with the requirements in R9-10-2219.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2221. Medication Services

- A. An administrator shall ensure that policies and procedures for medication services:
 1. Include:
 - a. A process for providing information to a resident or the resident's representative about medication prescribed for the resident including:
 - 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:
 - i. A medication error,
 - ii. An adverse response to a medication, or

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- iii. A medication overdose;
 - c. Procedures to ensure that a pharmacist reviews a resident's medications at least once every three months and provides documentation to the resident's designated medical practitioner and the director of nursing indicating potential medication problems such as incompatible or duplicative medications;
 - d. Procedures for documenting medication services; and
 - e. Procedures for assisting a resident in obtaining medication; and
 - 2. 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. Policies and procedures for medication administration:
 - a. Are reviewed and approved by a pharmacist;
 - b. Specify the individuals who may:
 - i. Order medication, and
 - ii. Administer medication;
 - c. Ensure that medication is administered to a resident only as prescribed; and
 - d. Cover the documentation of a resident's refusal to take prescribed medication in the resident's medical record;
 - 2. Verbal orders for medication services are taken by a nurse, unless otherwise provided by law;
 - 3. A medication administered to a resident:
 - a. Is administered in compliance with an order, and
 - b. Is documented in the resident's medical record; and
 - 4. If a psychotropic medication is administered to a resident, the psychotropic medication:
 - a. Is only administered to a resident for a diagnosed medical condition; and
 - b. Unless clinically contraindicated or otherwise ordered by the resident's designated medical practitioner or the designated medical practitioner's designee, is gradually reduced in dosage while the resident is simultaneously provided with interventions such as behavior and environment modification in an effort to discontinue the psychotropic medication, unless a dose reduction is attempted and the resident displays behavior justifying the need for the psychotropic medication, and the designated medical practitioner documents the necessity for the continued use and dosage.
- C.** If a nursing-supported group home provides assistance in the self-administration of medication, an administrator shall ensure that:
- 1. A resident's medication is stored by the nursing-supported group home;
 - 2. The following assistance is provided to a resident:
 - a. A reminder when it is time to take the medication;
 - b. Opening the medication container for the resident;
 - c. Observing the resident while the resident removes the medication from the container;
 - d. Verifying that the medication is taken as ordered by the resident's designated medical practitioner by confirming that:
 - i. The resident taking the medication is the individual stated on the medication container label,
 - ii. The resident is taking the dosage of the medication stated on the medication container label or according to an order from the resident's designated medical practitioner dated later than the date on the medication container label, and
 - iii. The resident is taking the medication at the time stated on the medication container label or according to an order from the resident's designated medical practitioner dated later than the date on the medication container label; or
 - e. Observing the resident while the resident takes the medication;
3. Policies and procedures for assistance in the self-administration of medication are reviewed and approved by the resident's designated medical practitioner or a registered nurse;
4. Training for a personnel member, other than a physician, physician assistant, or registered nurse, in assistance in the self-administration of medication:
- a. Is provided by the resident's designated medical practitioner; another physician, physician assistant, or registered nurse; or an individual trained by a physician, physician assistant, or registered nurse; and
 - b. Includes:
 - i. A demonstration of the personnel member's skills and knowledge necessary to provide assistance in the self-administration of medication,
 - ii. Identification of medication errors and medical emergencies related to medication that require emergency medical intervention, and
 - iii. The process for notifying the appropriate entities when an emergency medical intervention is needed;
5. A personnel member, other than a physician, physician assistant, or registered nurse, completes the training in subsection (C)(4) before the personnel member provides assistance in the self-administration of medication; and
6. Assistance in the self-administration of medication provided to a resident:
- a. Is in compliance with an order, and
 - b. Is documented in the resident's medical record.
- D.** An administrator shall ensure that:
- 1. A current drug reference guide is available for use by personnel members; and
 - 2. 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.
- E.** When medication is stored at a nursing-supported group home, an administrator shall ensure that:
- 1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;
 - 2. Medication is stored according to the instructions on the medication container; and
 - 3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for:
 - a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;

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- b. Discarding or returning prepackaged and sample medication to the manufacturer if the manufacturer requests the discard or return of the medication;
 - c. A medication recall and notification of residents who received recalled medication; and
 - d. Storing, inventorying, and dispensing controlled substances.
 - e. If applicable, donated medicine according to A.R.S. § 32-1909.
- F. An administrator shall ensure that a personnel member immediately reports a medication error or a resident's adverse reaction to a medication to the resident's designated medical practitioner or the physician who ordered the medication and the nursing-supported group home's director of nursing.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2). Amended by final rulemaking at 31 A.A.R. 2457 (July 25, 2025), effective August 30, 2025 (Supp. 25-3).

R9-10-2222. Infection Control

An administrator shall ensure that:

1. An infection control program is established, under the direction of an individual qualified according to policies and procedures, to prevent the development and transmission of infections and communicable diseases including:
 - a. A method to identify and document infections occurring at the nursing-supported group home;
 - b. Analysis of the types, causes, and spread of infections and communicable diseases at the nursing-supported group home;
 - c. The development of corrective measures to minimize or prevent the spread of infections and communicable diseases at the nursing-supported group home; and
 - d. Documentation of infection control activities including:
 - i. The collection and analysis of infection control data,
 - ii. The actions taken related to infections and communicable diseases, and
 - iii. Reports of communicable diseases to the governing authority and state and county health departments;
2. Infection control documentation is maintained for at least 12 months after the date of the documentation;
3. Policies and procedures are established, documented, and implemented that cover:
 - a. Handling and disposal of biohazardous medical waste;
 - b. Sterilization, disinfection, and storage of medical equipment and supplies;
 - c. Using personal protective equipment such as aprons, gloves, gowns, masks, or face protection when applicable;
 - d. Cleaning of an individual's hands when the individual's hands are visibly soiled and before and after providing a service to a resident;
 - e. Cleaning of a resident's bedroom, furniture, and bedding after the resident's discharge before the bedroom is reassigned to another resident;
 - f. Training of personnel members, employees, and volunteers in infection control practices; and

- g. Work restrictions for a personnel member with a communicable disease or infected skin lesion;
4. Biohazardous medical waste is identified, stored, and disposed of according to 18 A.A.C. 13, Article 14 and policies and procedures;
 5. Soiled linen and clothing are:
 - a. Collected in a manner to minimize or prevent contamination;
 - b. Bagged at the site of use; and
 - c. Maintained separate from clean linen and clothing and away from food storage, kitchen, or dining areas;
 6. A resident's personal laundry is washed separately from towels, sheets, and bedding; and
 7. A personnel member, an employee, or a volunteer washes hands or uses a hand disinfection product after a resident contact and after handling soiled linen, soiled clothing, or potentially infectious material.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2223. Food Services

A. An administrator shall ensure that a registered nurse who is part of the interdisciplinary team for a resident requiring a modified or special diet:

1. Consults with a registered dietitian or the resident's designated medical practitioner, as needed, about the resident's modified or special diet;
2. Reviews a food menu before the food menu is used to ensure that the resident's nutritional needs are being met;
3. Documents the review of a food menu; and
4. Is available for consultation regarding the resident's nutritional needs.

B. An administrator shall ensure that:

1. Food is prepared:
 - a. Using methods that conserve nutritional value, flavor, and appearance;
 - b. Taking into consideration the food allergies and preferences of the residents;
 - c. Including for a resident the modified or special diet for the resident; and
 - d. In a form to meet the needs of a resident, such as cut, chopped, ground, pureed, or thickened;
2. A food menu:
 - a. Is prepared at least one week in advance,
 - b. Includes the foods to be served on each day,
 - c. Is conspicuously posted at least one day before the first meal on the food menu will be served,
 - d. Includes any food substitution no later than the morning of the day of meal service with a food substitution, and
 - e. Is maintained for at least 60 calendar days after the last day included in the food menu;
3. Meals and snacks for each day are planned and served using the applicable guidelines in <http://www.health.gov/dietaryguidelines/2015.asp>;
4. A resident is provided:
 - a. A diet that meets the resident's nutritional needs as specified in the resident's comprehensive assessment and individual program plan;

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- b. Food served in sufficient quantities to meet the resident's nutritional needs and at an appropriate temperature;
- c. Three meals a day with not more than 14 hours between the evening meal and breakfast; and
- d. The opportunity to have additional food between meals, unless a restrictive diet is specified in the resident's individual program plan;
- 5. A resident is provided with food substitutions of similar nutritional value if:
 - a. The resident refuses to eat the food served, or
 - b. The resident requests a substitution;
- 6. Recommendations and preferences are requested from a resident or the resident's representative for meal planning;
- 7. If food is used as a part of a program to manage a resident's inappropriate behavior:
 - a. A special diet is included as part of the resident's individual program plan, and
 - b. The special diet is reviewed and evaluated by a physician and a dietitian to ensure the special diet meets the resident's nutritional needs;
- 8. Meals are served to residents at tables in a dining area and in a manner that allows the resident to eat from an upright position, unless otherwise specified in the resident's individual program plan or by the resident's designated medical practitioner;
- 9. A resident requiring assistance to eat is provided with assistance that recognizes the resident's nutritional, physical, and social needs, including the use of adaptive eating equipment or utensils;
- 10. Personnel members supervise meals in dining areas to:
 - a. Direct a resident's self-help dining procedures,
 - b. Ensure a resident consumes enough food to meet the resident's nutritional needs, and
 - c. Ensure that a resident eats in a manner consistent with the resident's developmental level;
- 11. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair; and
- 12. Water is available and accessible to residents.
- e. A plan to ensure a resident's medications will be available to administer to the resident during a disaster;
- f. A plan to ensure a resident is provided nursing services, rehabilitation services, and other services required by the resident during a disaster; and
- g. A plan for obtaining food and water for individuals present in the nursing-supported group home or the nursing-supported group home's relocation site during a disaster;
- 2. Personnel members receive training on the content and use of the disaster plan required in subsection (A)(1);
- 3. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
- 4. Documentation of a disaster plan review required in subsection (A)(3) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
 - a. The date and time of the disaster plan review;
 - b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
 - c. A critique of the disaster plan review; and
 - d. If applicable, recommendations for improvement;
- 5. A disaster drill for employees is conducted on each shift at least once every three months and documented;
- 6. An evacuation drill for employees is conducted on each shift at least once every three months and documented;
- 7. An evacuation drill for residents:
 - a. Is conducted at least once each year on each shift and documented; and
 - b. Includes all residents on the premises except for:
 - i. A resident whose medical record contains documentation that evacuation from the nursing-supported group home would cause harm to the resident, and
 - ii. Sufficient personnel members to ensure the health and safety of residents not evacuated according to subsection (A)(7)(b)(i);
- 8. Documentation of each evacuation drill is created, is maintained for at least 12 months after the date of the drill, and includes:
 - a. The date and time of the evacuation drill;
 - b. The amount of time taken for employees and residents to evacuate to a designated area;
 - c. If applicable:
 - i. An identification of residents needing assistance for evacuation, and
 - ii. An identification of residents who were not evacuated;
 - d. Any problems encountered in conducting the evacuation drill; and
 - e. Recommendations for improvement, if applicable; and
- 9. An evacuation path is conspicuously posted on each hallway of each floor of the nursing-supported group home.

B. An administrator shall ensure that a nursing-supported group home has either:

- 1. A fire alarm system and a sprinkler system meeting the following requirements installed and in working order:
 - a. A fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm and Signaling Code, incorporated by reference in R9-10-104.01; and

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2224. Emergency and Safety Standards

A. An administrator shall ensure that:

- 1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
 - a. A floor plan of the facility showing emergency protection equipment, evacuation routes, and exits;
 - b. When, how, and where residents will be relocated, including:
 - i. Instructions for the evacuation or transfer of residents,
 - ii. Assigned responsibilities for each employee and personnel member, and
 - iii. A plan for continuing to provide services to meet a resident's needs;
 - c. How a resident's medical record will be available to individuals providing services to the resident during a disaster;
 - d. A plan for back-up power and water supply;

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- b. A sprinkler system installed according to the National Fire Protection Association 13: Standard for the Installation of Sprinkler Systems, incorporated by reference in R9-10-104.01; or
- 2. Both of the following:
 - a. A fire extinguisher that is:
 - i. Labeled as rated at least 2A-10-BC by the Underwriters Laboratories;
 - ii. Accessible to personnel members and inaccessible to residents;
 - iii. If a disposable fire extinguisher, replaced when its indicator reaches the red zone; and
 - iv. If a rechargeable fire extinguisher, is serviced at least once every 12 months, as documented by a tag attached to the fire extinguisher that specifies the date of the last servicing and the identification of the person who serviced the fire extinguisher; and
 - b. Smoke detectors that are:
 - i. Installed in each bedroom, hallway that adjoins a bedroom, storage room, laundry room, attached garage, and room or hallway adjacent to the kitchen, and other places recommended by the manufacturer;
 - ii. Either battery operated or, if hard-wired into the electrical system of the nursing-supported group home, have a back-up battery;
 - iii. Capable of alerting all residents in the nursing-supported group home, including a resident with a mobility or sensory impairment;
 - iv. In working order; and
 - v. Tested at least once a month, with documentation of the test maintained for at least 12 months after the date of the test.
- C. An administrator shall:
 - 1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
 - 2. Make any repairs or corrections stated on the fire inspection report, and
 - 3. Maintain documentation of a current fire inspection.
- D. An administrator shall ensure that, if applicable, a sign is placed at the entrance to a room or area indicating that oxygen is in use.
 - b. Are appropriate to the contents of each container;
 - c. If appropriate based on a resident's disability, are locked; and
 - d. Are stored in a separate location from food or medicine;
- 5. Combustible or flammable materials are not stored within three feet of a furnace, heater, water heater, or usable fireplace;
- 6. Unused furniture, equipment, fabrics, or devices are removed from the facility or maintained in a covered area on the premises that is designated by the licensee for storage in a manner that does not create a hazard; and
- 7. There are no firearms or ammunition on the premises;
- B. An administrator shall ensure that:
 - 1. A pest control program that complies with A.A.C. R3-8-201(C)(4) is implemented and documented;
 - 2. The premises and its structures and furnishings are:
 - a. In a clean condition,
 - b. Free of odors, such as urine or rotting food; and
 - c. In sufficiently good repair that no object, equipment, or condition present constitutes a hazard; and
 - 3. Standing water is not allowed to accumulate on the premises, except in an area or vessel the purpose of which is to hold standing water.
- C. An administrator shall ensure that:
 - 1. An unvented space heater or open-flame space heater is not used on the premises;
 - 2. An electric portable heater or electric radiant heater is not used on the premises unless the electric portable heater or electric radiant heater:
 - a. Has:
 - i. Either a non-porous casing or a grill with a mesh small enough to prevent cloth or a child's finger from entering the casing,
 - ii. A tilt switch that shuts off power to the electric portable heater if the electric portable heater tips over,
 - iii. An automatic shutoff control to prevent overheating, and
 - iv. A thermostat control; and
 - b. Is plugged directly into a wall outlet; and
 - 3. A vented space heater used on the premises is:
 - a. Safety-approved;
 - b. Professionally installed in accordance with the requirements of the local jurisdiction; and
 - c. Mounted as a permanent fixture in a wall, floor, or ceiling.

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2225. Environmental Standards

- A. An administrator shall ensure that:
 - 1. The premises and equipment are free from a condition or situation that may cause a resident or other individual to suffer physical injury;
 - 2. The premises are free of accumulations of garbage or refuse;
 - 3. Garbage and refuse in the facility are:
 - a. Stored in cleanable containers or in sealable plastic bags and
 - b. Removed from the facility at least once every seven days;
 - 4. Cleaning compounds and toxic substances are maintained in labeled containers that:
 - a. Are stored to prevent a hazard;

Historical Note

New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).

R9-10-2226. Physical Plant Standards

- A. An administrator shall ensure that:
 - 1. A nursing-supported group home is in compliance with applicable federal and state disability laws;
 - 2. If a nursing-supported group home has a resident with a mobility, sensory, or other physical impairment, documentation is available for review at the nursing-supported group home that:
 - a. Is provided by the Division; and
 - b. Identifies modifications, if any, needed to the premises to ensure that the premises are:
 - i. Accessible to and usable by the resident, and

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- ii. Contribute to the resident's health and safety;
 3. The premises have been modified as identified by the Division in subsection (A)(2)(b);
 4. Ramps, stairs, or steps on the premises are secured firmly to the ground or a permanent structure and have slip-resistant surfaces; and
 5. If handrails and grab bars are installed in a nursing-supported group home, handrails and grab bars are securely attached and stationary.
 - B.** An administrator shall ensure that:
 1. A method of heating and cooling maintains the nursing-supported group home between 65° F and 85° F in areas of the nursing-supported group home occupied by residents;
 2. A usable fireplace is covered by a protective screen or covering at all times;
 3. Ventilation is provided by an openable window, air conditioning, or other mechanical device;
 4. Working, safe appliances for cooling and cooking food are provided in the nursing-supported group home that:
 - a. Are safety-approved;
 - b. If used to refrigerate food, maintain the food at a temperature of 40° F or below at all times; and
 - c. If used to freeze food, maintain the food at a temperature of 0° F or below at all times;
 5. Hot water temperatures in the nursing-supported group home are maintained between 95° F and 120° F; and
 6. Bathtubs and showers contain slip-resistant strips, rubber bath mats, or slip-resistant surfaces.
 - C.** An administrator shall ensure that:
 1. Electrical lighting is contained in each room in the nursing-supported group home;
 2. Electrical devices and equipment on the premises are safety-approved, safe, and in working order;
 3. Electrical outlets on the premises are safe, covered with a faceplate, and installed in accordance with the requirements of the local jurisdiction;
 4. Any electrical outlet located within 3 feet of a water source includes a ground fault circuit interrupt (GFCI);
 5. An appliance, light, or other device with a frayed or spliced electrical cord is not used on the premises; and
 6. An electrical cord, including an extension cord, on the premises is not:
 - a. Used as a substitute for permanent wiring,
 - b. Run under a rug or carpeting,
 - c. Run over a nail, or
 - d. Run from one room to another.
 - D.** An administrator shall ensure that:
 1. A nursing-supported group home contains a safe, working plumbing system;
 2. If a nursing-supported group home's plumbing system is connected to a non-municipal sewage disposal system, the plumbing system and connective piping are free of visible leakage; and
 3. The premises do not contain unfenced or uncovered wells, ditches, or holes into which an individual may step or fall.
- Historical Note**
New Section made by exempt rulemaking at 28 A.A.R. 927 (May 6, 2022), with an immediate effective date of April 15, 2022 (Supp. 22-2).