



Arizona Administrative REGISTER

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DIRECTOR
Administrative Rules Division
Scott Cancelosi

PUBLISHER
Secretary of State
KATIE HOBBS

RULES MANAGING EDITOR
Arizona Administrative Register
Rhonda Paschal

From the Publisher

ABOUT THIS PUBLICATION

The paper copy of the *Administrative Register* (A.A.R.) is the official publication for rules and rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The Office of the Secretary of State does not interpret or enforce rules published in the *Arizona Administrative Register* or *Code*. Questions should be directed to the state agency responsible for the promulgation of the rule as provided in its published filing.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains the full text of the Governor's Executive Orders and Proclamations of general applicability, summaries of Attorney General opinions, notices of rules terminated by the agency, and the Governor's appointments of state officials and members of state boards and commissions.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rules activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA.

Rulemakings initiated under the APA as effective on and after January 1, 1995, include the full text of the rule in the *Register*. New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE REGISTER?

The *Arizona Administrative Code* (A.A.C.) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The printed *Code* is the official publication of a rule in the A.A.C., and is prima facie evidence of the making, amendment, or repeal of that rule as provided by A.R.S. § 41-1012. Paper copies of rules are available by full Chapter or by subscription. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking

Every document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a page.

Arizona Administrative REGISTER

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PUBLISHER
SECRETARY OF STATE
Katie Hobbs

ADMINISTRATIVE RULES STAFF
DIRECTOR
Scott Cancelosi

RULES MANAGING EDITOR
Rhonda Paschal

ADMINISTRATIVE REGISTER
This publication is available online for free at www.azsos.gov.

ADMINISTRATIVE CODE
A price list for the *Arizona Administrative Code* is available online. You may also request a paper price list by mail. To purchase a paper Chapter, contact us at (602) 364-3223.

PUBLICATION DEADLINES
Publication dates are published in the back of the *Register*. These dates include file submittal dates with a three-week turnaround from filing to published document.

CONTACT US
Administrative Rules Division
Office of the Secretary of State
1700 W. Washington Street, Fl. 2
Phoenix, AZ 85007
(602) 364-3223

The Office of the Secretary of State is an equal opportunity employer.



Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register*. Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

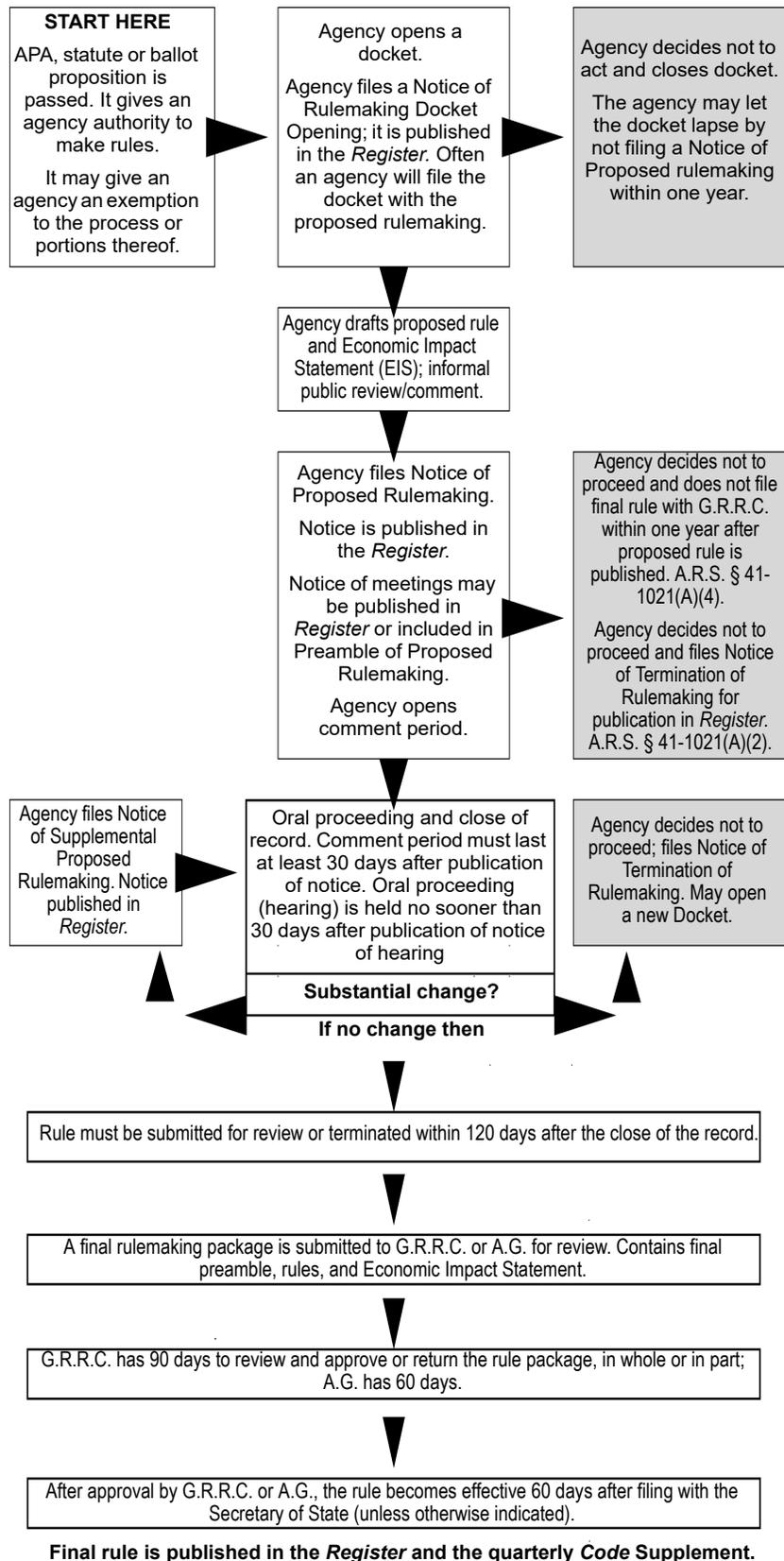
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process



Definitions

Arizona Administrative Code (A.A.C.): Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

Arizona Administrative Register (A.A.R.): The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are compiled by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.," and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – *Arizona Administrative Register*

APA – *Administrative Procedure Act*

A.R.S. – *Arizona Revised Statutes*

CFR – *Code of Federal Regulations*

EIS – *Economic, Small Business, and Consumer Impact Statement*

FR – *Federal Register*

G.R.R.C. – *Governor's Regulatory Review Council*

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.



NOTICES OF PROPOSED RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Proposed Rulemaking.

A proposed rulemaking is filed by an agency upon completion and submittal of a Notice of Rulemaking Docket Opening. Often these two documents are filed at the same time and published in the same *Register* issue.

When an agency files a Notice of Proposed Rulemaking under the *Administrative Procedure Act* (APA), the notice is published in the *Register* within three weeks of filing. See the publication schedule in the back of each issue of the *Register* for more information.

Under the APA, an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any oral proceedings for making, amending, or repealing any rule (A.R.S. §§ 41-1013 and 41-1022).

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed rules should be addressed to the agency that promulgated the rules. Refer to item #4 below to contact the person charged with the rulemaking and item #10 for the close of record and information related to public hearings and oral comments.

**NOTICE OF PROPOSED RULEMAKING
TITLE 2. ADMINISTRATION
CHAPTER 8. STATE RETIREMENT SYSTEM BOARD**

[R19-84]

PREAMBLE

- | | |
|---|---------------------------------|
| <u>1. Article, Part, or Section Affected (as applicable)</u> | <u>Rulemaking Action</u> |
| R2-8-301 | Amend |
| R2-8-302 | Amend |
| R2-8-303 | Amend |
| R2-8-304 | Amend |
| R2-8-807 | Amend |
- 2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
 Authorizing statute: A.R.S. § 38-714(E)(4)
 Implementing statute: A.R.S. §§ 38-797 et seq.
- 3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rules:**
 Notice of Rulemaking Docket Opening: 25 A.A.R. 1270, May 17, 2019 (*in this issue*)
- 4. The agency’s contact person who can answer questions about the rulemaking:**
 Name: Jessica A.R. Thomas, Rules Writer
 Address: Arizona State Retirement System
 3300 N. Central Ave., Suite 1400
 Phoenix, AZ 85012-0250
 Telephone: (602) 240-2039
 E-mail: JessicaT@azasrs.gov
- 5. An agency’s justification and reason why a rule should be made, amended, repealed, or renumbered, to include an explanation about the rulemaking:**
 A.R.S. § 38-797.07(A)(7) requires the ASRS to stop paying LTD benefits to a member if the member “ceases to be under the direct care of a doctor.” The ASRS needs to clarify what it means to be under the “direct care of a doctor” for purposes of LTD benefits. Similarly, the ASRS needs to clarify the six month waiting period and minimum benefit payments when there is an overpayment or no compensation on file.
- 6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material.**
 None
- 7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
 Not applicable
- 8. The preliminary summary of the economic, small business, and consumer impact:**
 The ASRS promulgates rules that allow the agency to provide for the proper administration of the state retirement trust fund. ASRS rules affect ASRS members and ASRS employers regarding how they contribute to, and receive benefits from, the ASRS. The ASRS effectively administrates how public-sector employers and employees participate in the ASRS. As such, the ASRS does not issue permits or licenses, or charge fees, and its rules have little to no economic impact on private-sector businesses, with the



exception of some employer partner charter schools, which have voluntarily contracted to join the ASRS. Thus, there is little to no economic, small business, or consumer impact, other than the minimal cost to the ASRS to prepare the rule package. The rule will have minimal economic impact, if any, because it merely clarifies the long term disability program. Specifically, defining what a "Direct Care of a Doctor or an Attending Physician" means.

9. The agency's contact person who can answer questions about the economic, small business, and consumer impact statement:

Name: Jessica A.R. Thomas, Rules Writer
Address: Arizona State Retirement System
3300 N. Central Ave., Suite 1400
Phoenix, AZ 85012-0250
Telephone: (602) 240-2039
E-Mail: JessicaT@azasrs.gov

10. The time, place, and nature of the proceedings for to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request and oral proceedings on the proposed rule:

An oral proceeding regarding the proposed rule will be held as follows:

Date: June 26, 2019
Time: 9:00 a.m.
Location: Arizona State Retirement System
10th Floor Board Room
3300 N. Central Ave.
Phoenix, AZ 85012-0250

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

None

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

None of the rules requires a permit.

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

There are no federal laws applicable to these rules.

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

No analysis was submitted.

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

None

13. The full text of the rules follows:

**TITLE 2. ADMINISTRATION
CHAPTER 8. STATE RETIREMENT SYSTEM BOARD**

ARTICLE 3. LONG-TERM DISABILITY

- Section R2-8-301. Definitions
- R2-8-302. Application for Long-Term Disability Benefit
- R2-8-303. Long-Term Disability Calculation
- R2-8-304. Payment of Long-Term Disability Benefit

ARTICLE 8. RECOVERY OF OVERPAYMENTS

- Section R2-8-807. Collection of Overpayments from LTD Benefit

ARTICLE 3. LONG-TERM DISABILITY

R2-8-301. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "Attending Physician" means a provider:
 - a. Who is a qualified medical provider or other legally qualified practitioner of a healing art that the claims administrator recognizes or is required by law to recognize;
 - b. Whose medical training and clinical experience are qualified to treat the member's disabling condition;



- c. Whose diagnosis and treatment is consistent with the diagnosis of the disabling condition, according to guidelines established by medical, research, and rehabilitative organizations;
 - d. Who is licensed to practice in the jurisdiction where care is being given;
 - e. Who is practicing within the scope of the license; and
 - f. Who is not related to the member by blood or marriage.
2. “Direct Care” means the member is actively receiving treatment from a provider for the member’s disability at least once per calendar year.
 - ~~1-2.~~ “Estimated Social Security disability income amount” means the same as in R2-8-801(2).
 - ~~2-3.~~ “Legal proceeding” means an appeal of an appealable agency decision at the Office of Administrative Hearings pursuant to A.R.S. § 41-1092 et seq. or an appeal of a Social Security determination at the Social Security Administration, or any other review by a formal body, which determines the rights and responsibilities of the member or survivor.
 - ~~3-4.~~ “LTD” means the Long-Term Disability program described in A.R.S. § 38-797 et seq.
 4. ~~“LTD contribution” means the amount of funds the member remits to the ASRS from the member’s compensation as payment for the LTD program.~~
 5. “LTD benefit” means the amount of funds the member receives from the ASRS or the ASRS contracted LTD claims administrator, for the period of time a member has an eligible disability as described in A.R.S. § 38-797.07(A)(11).
 6. “LTD contribution” means the amount of funds the member remits to the ASRS from the member’s compensation as payment for the LTD program.

R2-8-302. Application for Long-Term Disability Benefit

- A. In order to claim an LTD benefit, a disabled member shall submit to the disabled member’s Employer all the completed forms prescribed by the ASRS contracted LTD claims administrator within 12 months of the date the disabled member became disabled.
- B. Pursuant to A.R.S. § 38-797.07(D), in order to continue receiving an LTD benefit, a disabled member shall submit documentation regarding the disabled member’s ongoing disability and occupation as required by the ASRS contracted LTD claims administrator to determine the disabled member’s continuing eligibility for an LTD benefit.
- C. Pursuant to A.R.S. § 38-797.07(11), in order to submit an application for an LTD benefit, a member must provide objective medical evidence from an Attending Physician.
- D. Pursuant to A.R.S. § 38-797.07(7)(b)(i), in order to continue receiving an LTD benefit, the disabled member must be under the Direct Care of a doctor.

R2-8-303. Long-Term Disability Calculation

- A. The ASRS contracted LTD claims administrator shall calculate an LTD benefit for a member using the member’s monthly compensation as described in A.R.S. § 38-797(11).
- ~~B. The ASRS shall reduce a member’s LTD benefit in accordance with A.R.S. § 38-797.07(A). For a member whose monthly compensation is \$0 as of the date of disability, the ASRS shall pay a monthly benefit of \$50 unless the benefit is reduced pursuant to R2-8-807 or required to be reduced pursuant to A.R.S. § 38-797.07(A)(2).~~
- C. The ASRS shall reduce a member’s LTD benefit in accordance with A.R.S. § 38-797.07(A).

R2-8-304. Payment of Long-Term Disability Benefit

- A. The ASRS contracted LTD claims administrator shall begin providing an LTD benefit to an eligible disabled member no sooner than six months after the date the disabled member became disabled.
- B. Notwithstanding subsection (A), the ASRS contracted LTD claims administrator may begin providing an LTD benefit to an eligible disabled member sooner than six months if the disability is related to the member’s disability that occurred within six months immediately preceding the disability.
- ~~B-C.~~ The ASRS contracted LTD claims administrator may provide an eligible disabled member’s LTD benefit to a third party pursuant to A.R.S. § 38-797.09.

ARTICLE 8. RECOVERY OF OVERPAYMENTS

R2-8-807. Collection of Overpayments from LTD Benefit

Upon disability of the member, the ASRS shall reduce the amount of the disabled member’s LTD benefit by the amount of any overpayment the member received from the ASRS and has not reimbursed pursuant to this section ~~to not less than \$50.00.~~



NOTICES OF PROPOSED EXPEDITED RULEMAKING

This section of the Arizona Administrative Register contains Notices of Proposed Expedited Rulemaking. The Office of the Secretary of State is the filing office and publisher of these rules.

Questions about the interpretation of the proposed expedited rule should be addressed to the agency proposing the rule. Refer to Item #5 to contact the person charged with the rulemaking.

NOTICE OF PROPOSED EXPEDITED RULEMAKING
TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE

[R19-85]

PREAMBLE

- 1. Article, Part or Section Affected (as applicable) Rulemaking Action
2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):
3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:
4. The agency's contact person who can answer questions about the rulemaking:
5. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:
6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:
7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:
8. The preliminary summary of the economic, small business, and consumer impact:
9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:
10. The time, place, and nature of the proceedings to make, amend, repeal or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:



Comments may be posted at: public_comments@azinsurance.gov

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

Not applicable

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

The rule does not require a permit.

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

Under A.R.S. § 20-143(B), the Director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by 100 or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities and exchange act of 1934, as amended, and as may be amended.

The rule is not more stringent than the federal law.

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

Not applicable

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

R20-6-401(A) references the National Association of Insurance Commissioner's (NAIC) Model Laws, Regulations and Guidelines, Volume III, pp. 490-4-, Regulation Regarding Proxies, Consents and Authorizations of Domestic Stock Insurers, April 1995 (and no future editions or amendments). This reference is not being changed. The addresses of the Department and NAIC where the reference material can be found are being updated.

13. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 4. TYPES OF INSURANCE COMPANIES

Section

R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers

ARTICLE 4. TYPES OF INSURANCE COMPANIES

R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers

- A. The Department incorporates by reference National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through 490-40, Regulation Regarding Proxies, Consents, and Authorization of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with the Office of the Secretary of State and available from the Department of Insurance, ~~2910 N. 44th St., Phoenix, AZ 85018~~ 100 N. 15th Ave., Suite 102, Phoenix, AZ 85007-2624 and the National Association of Insurance Commissioners, Publications Department, ~~2301 McGee St., Suite 800, Kansas City, MO 64108, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197~~, modified as follows:

Section 1 A is modified to read: "No domestic stock insurer that has any class of equity securities held of record by 100 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation.

- B. Domestic stock insurance companies shall comply with this Section as required under A.R.S. § 20-143(B).

NOTICES OF EXEMPT RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Exempt Rulemaking.

It is not uncommon for an agency to be exempt from all steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act (APA) or Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10.

An agency's exemption is either written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters; or a court has

determined that an agency, board or commission is exempt from the rulemaking process.

The Office makes a distinction between certain exemptions as provided in these laws, on a case by case basis, as determined by an agency. Other rule exemption types are published elsewhere in the *Register*.

Notices of Exempt Rulemaking as published here were made with no special conditions or restrictions; no public input; no public hearing; and no filing of a Proposed Exempt Rulemaking.

NOTICE OF EXEMPT RULEMAKING TITLE 9. HEALTH SERVICES CHAPTER 10. DEPARTMENT OF HEALTH SERVICES HEALTH CARE INSTITUTIONS: LICENSING

[R19-86]

PREAMBLE

<u>1. Article, Part or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
R9-10-101	Amend
R9-10-102	Amend
R9-10-106	Amend
Article 5	Re-number
Article 5	New Article
R9-10-501	Re-number
R9-10-501	New Section
R9-10-502	Re-number
R9-10-502	New Section
R9-10-503	Re-number
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R9-10-524	New Section
R9-10-525	New Section
Article 21	New Article
R9-10-2101	Renumber
R9-10-2102	Renumber
R9-10-2102	Amend
R9-10-2103	Renumber
R9-10-2104	Renumber
R9-10-2105	Renumber
R9-10-2106	Renumber
R9-10-2107	Renumber
R9-10-2108	Renumber
R9-10-2109	Renumber
R9-10-2110	Renumber
R9-10-2111	Renumber
R9-10-2111	Amend
R9-10-2112	Renumber
R9-10-2113	Renumber
R9-10-2114	Renumber
R9-10-2115	Renumber
R9-10-2116	Renumber
R9-10-2117	Renumber
R9-10-2118	Renumber

2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific) and the statute or session law authorizing the exemption:

Authorizing statutes: A.R.S. §§ 36-132(A)(1) and (A)(17), and 36-136(G)
 Implementing statutes: A.R.S. §§ 36-405 through 36-407, 36-425.05
 Statute or session law authorizing the exemption: Laws 2019, Ch. 133, § 11

3. The effective date of the rule and the agency’s reason it selected the effective date:

April 25, 2019
 This is the date that SB 1211 is effective as Laws 2019, Ch. 133.

4. A list of all notices published in the Register as specified in R9-1-409(A) that pertain to the record of the exempt rulemaking:

None

5. The agency’s contact person who can answer questions about the rulemaking:

Name: Colby Bower, Assistant Director
 Address: Department of Health Services
 Public Health Licensing Services
 150 N. 18th Ave., Suite 510
 Phoenix, AZ 85007
 Telephone: (602) 542-6383
 Fax: (602) 364-4808
 E-mail: Colby.Bower@azdhs.gov
 or
 Name: Robert Lane, Chief
 Address: Department of Health Services
 Office of Administrative Counsel and Rules
 150 N. 18th Ave., Suite 200
 Phoenix, AZ 85007
 Telephone: (602) 542-1020
 Fax: (602) 364-1150
 E-mail: Robert.Lane@azdhs.gov

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

Arizona Revised Statutes (A.R.S.) §§ 36-132(A)(17) and 36-405 authorize the Department to license and regulate health care institutions. A.R.S. § 36-405 further authorizes the Department to classify and sub-classify health care institutions. The Department has implemented A.R.S. §§ 36-132(A)(17) and 36-405 in Arizona Administrative Code (A.A.C.) Title 9, Chapter 10. Intermediate care



facilities are a class of health care institutions that primarily provide health and rehabilitative services to individuals with developmental disabilities. These facilities are certified by the federal Centers for Medicare and Medicaid Services (CMS), but, until Laws 2019, Ch. 133 was enacted, were not required to be licensed by the Department. A.R.S. § 36-591(E), as amended by Laws 2019, Ch. 133, now requires intermediate care facilities to be licensed under A.R.S. Title 36, Chapter 4. Laws 2019, Ch. 133, § 11 also exempts the Department from rulemaking requirements in A.R.S. Title 41, Chapter 6 until April 24, 2020. After receiving an exception from the rulemaking moratorium established by Executive Order 2019-01, the Department is revising the rules in 9 A.A.C. 10, to add requirements for the licensing of intermediate care facilities. To enable the new rules to be found more easily, the Department is putting the new rules for intermediate care facilities into 9 A.A.C. 10, Article 5, immediately after the Article governing the licensing of nursing care institutions, and moving requirements for the licensing of recovery care centers, currently in Article 5, into a new Article 21. These rules conform to format and style requirements of the Office of the Secretary of State.

- 7. **A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**
None
- 8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable
- 9. **The summary of the economic, small business, and consumer impact, if applicable:**
Not applicable
- 10. **A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and final rulemaking package, (if applicable):**
Not applicable
- 11. **An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:**
Not applicable
- 12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**
 - a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
A health care institution license is specific to the licensee, class or subclass of health care institution, facility location, and scope of services provided. As such, a general permit is not applicable and is not used.
 - b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of the federal law:**
Not applicable
 - c. **Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**
Not applicable
- 13. **A list of any incorporated by reference material and its location in the rules:**
None
- 14. **Whether this rule previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:**
The rule was not previously made, amended, repealed, or renumbered as an emergency rule.
- 15. **The full text of the rules follows:**

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

ARTICLE 1. GENERAL

- Section
- R9-10-101. Definitions
 - R9-10-102. Health Care Institution Classes and Subclasses; Requirements
 - R9-10-106. Fees

ARTICLE 5. RECOVERY CARE CENTERS INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

- Section
- R9-10-501. Definitions
 - R9-10-502. Supplemental Application Requirements
 - R9-10-503. Administration
 - R9-10-504. Quality Management



<u>R9-10-505.</u>	<u>Contracted Services</u>
<u>R9-10-506.</u>	<u>Personnel</u>
<u>R9-10-507.</u>	<u>Admission</u>
<u>R9-10-508.</u>	<u>Transfer; Discharge</u>
<u>R9-10-509.</u>	<u>Transport</u>
<u>R9-10-510.</u>	<u>Transportation; Resident Outings</u>
<u>R9-10-511.</u>	<u>Resident Rights</u>
<u>R9-10-512.</u>	<u>Medical Records</u>
<u>R9-10-513.</u>	<u>Rehabilitation Services and Habilitation Services</u>
<u>R9-10-514.</u>	<u>Individual Program Plan</u>
<u>R9-10-515.</u>	<u>Seclusion; Restraint</u>
<u>R9-10-516.</u>	<u>Physical Health Services</u>
<u>R9-10-517.</u>	<u>Behavioral Care</u>
<u>R9-10-518.</u>	<u>Clinical Laboratory Services</u>
<u>R9-10-519.</u>	<u>Respiratory Care Services</u>
<u>R9-10-520.</u>	<u>Medication Services</u>
<u>R9-10-521.</u>	<u>Infection Control</u>
<u>R9-10-522.</u>	<u>Food Services</u>
<u>R9-10-523.</u>	<u>Emergency and Safety Standards</u>
<u>R9-10-524.</u>	<u>Environmental Standards</u>
<u>R9-10-525.</u>	<u>Physical Plant Standards</u>

ARTICLE 21. RECOVERY CARE CENTERS

Section

R9-10-501.	R9-10-2101.	Definitions
R9-10-502.	R9-10-2102.	Administration
R9-10-503.	R9-10-2103.	Quality Management
R9-10-504.	R9-10-2104.	Contracted Services
R9-10-505.	R9-10-2105.	Personnel
R9-10-506.	R9-10-2106.	Medical Staff
R9-10-507.	R9-10-2107.	Admission
R9-10-508.	R9-10-2108.	Discharge
R9-10-509.	R9-10-2109.	Transfer
R9-10-510.	R9-10-2110.	Patient Rights
R9-10-511.	R9-10-2111.	Medical Records
R9-10-512.	R9-10-2112.	Nursing Services
R9-10-513.	R9-10-2113.	Medication Services
R9-10-514.	R9-10-2114.	Ancillary Services
R9-10-515.	R9-10-2115.	Food Services
R9-10-516.	R9-10-2116.	Emergency and Safety Standards
R9-10-517.	R9-10-2117.	Environmental Standards
R9-10-518.	R9-10-2118.	Physical Plant Standards

ARTICLE 1. GENERAL

R9-10-101. Definitions

In addition to the definitions in A.R.S. § 36-401(A), 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. "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.



7. “Administrative completeness review time-frame” has the same meaning as in A.R.S. § 41-1072.
8. “Administrative office” means a location used by personnel for recordkeeping and record retention but not for providing medical services, nursing services, or health-related services.
9. “Admission” 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.
10. “Adult” has the same meaning as in A.R.S. § 1-215.
11. “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.
12. “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.
13. “Ancillary services” means services other than medical services, nursing services, or health-related services provided to a patient.
14. “Anesthesiologist” means a physician granted clinical privileges to administer anesthesia.
15. “Applicant” means a governing authority requesting:
 - a. Approval of a health care institution’s architectural plans and specifications, or
 - b. A health care institution license.
16. “Application packet” means the information, documents, and fees required by the Department for the:
 - a. Approval of a health care institution’s modification or construction, or
 - b. Licensing of a health care institution.
17. “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.
18. “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.
19. “Attending physician” means a physician designated by a patient to participate in or coordinate the medical services provided to the patient.
20. “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.
21. “Authorized service” means specific medical services, nursing 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.
22. “Available” means:
 - a. For an individual, the ability to be contacted and to provide an immediate response by any means possible;
 - b. For equipment and supplies, physically retrievable at a health care institution; and
 - c. For a document, retrievable by a health care institution or accessible according to the applicable time-frames in this Chapter.
23. “Behavioral care”:
 - a. 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:
 - i. 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:
 - (1) Direction provided by a behavioral health professional, and
 - (2) Medication ordered by a medical practitioner or behavioral health professional; or
 - ii. 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
 - b. Does not include court-ordered behavioral health services.
24. “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.
25. “Behavioral health inpatient facility” means a health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
 - a. Have a limited or reduced ability to meet the individual’s basic physical needs;
 - b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
 - c. Be a danger to self;
 - d. Be a danger to others;
 - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
 - f. Be gravely disabled.
26. “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.



27. “Behavioral health observation/stabilization services” means crisis services provided, in an outpatient setting, to an individual whose behavior or condition indicates that the individual:
 - a. Requires nursing services,
 - b. May require medical services, and
 - c. May be a danger to others or a danger to self.
28. “Behavioral health paraprofessional” means an individual who is not a behavioral health professional who provides, under supervision by a behavioral health professional, the following services to a patient to address the patient's behavioral health issue:
 - a. 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
 - b. Health-related services.
29. “Behavioral health professional” means:
 - a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
 - i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or
 - ii. 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;
 - b. A psychiatrist as defined in A.R.S. § 36-501;
 - c. A psychologist as defined in A.R.S. § 32-2061;
 - d. A physician;
 - e. A behavior analyst as defined in A.R.S. § 32-2091;
 - f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
 - g. A registered nurse.
30. “Behavioral health residential facility” means a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
 - a. Limits the individual's ability to be independent, or
 - b. Causes the individual to require treatment to maintain or enhance independence.
31. “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.
32. “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.
33. “Behavioral health staff” means a:
 - a. Behavioral health paraprofessional,
 - b. Behavioral health technician, or
 - c. Personnel member in a nursing care institution or assisted living facility who provides behavioral care.
34. “Behavioral health technician” means an individual who is not a behavioral health professional who provides, with clinical oversight by a behavioral health professional, the following services to a patient to address the patient's behavioral health issue:
 - a. 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
 - b. Health-related services.
35. “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.
36. “Biohazardous medical waste” has the same meaning as in A.A.C. R18-13-1401.
37. “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.
38. “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.
39. “Certification” means, in this Article, a written statement that an item or a system complies with the applicable requirements incorporated by reference in A.A.C. R9-1-412.
40. “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.
41. “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.
42. “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.
43. “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.
44. “Clinical oversight” means:
 - a. Monitoring the behavioral health services provided by a behavioral health technician to ensure that the behavioral health technician is providing the behavioral health services according to the health care institution's policies and procedures,



- b. Providing on-going review of a behavioral health technician's skills and knowledge related to the provision of behavioral health services,
 - c. Providing guidance to improve a behavioral health technician's skills and knowledge related to the provision of behavioral health services, and
 - d. Recommending training for a behavior health technician to improve the behavioral health technician's skills and knowledge related to the provision of behavioral health services.
45. "Clinical privileges" means authorization to a medical staff member to provide medical services granted by a governing authority or according to medical staff bylaws.
46. "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.
47. "Common area" means licensed space in an assisted living facility or an intermediate care facility for individuals with intellectual disabilities that is:
- a. Not a resident's bedroom or a residential unit.
 - b. Not restricted to use by employees or volunteers of the assisted living facility or intermediate care facility for individuals with intellectual disabilities, and
 - c. Available for use by visitors and other individuals on the premises.
- ~~47-48.~~ "Communicable disease" has the same meaning as in A.R.S. § 36-661.
- ~~48-49.~~ "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.
- ~~49-50.~~ "Consultation" means an evaluation of a patient requested by a medical staff member or personnel member.
- ~~50-51.~~ "Contracted services" means medical services, nursing 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.
- ~~51-52.~~ "Contractor" has the same meaning as in A.R.S. § 32-1101.
- ~~52-53.~~ "Controlled substance" has the same meaning as in A.R.S. § 36-2501.
- ~~53-54.~~ "Counseling" has the same meaning as "practice of professional counseling" in A.R.S. § 32-3251.
- ~~54-55.~~ "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.
- ~~55-56.~~ "Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.
- ~~56-57.~~ "Court-ordered pre-petition screening" has the same meaning as in A.R.S. § 36-501.
- ~~57-58.~~ "Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.
- ~~58-59.~~ "Crisis services" means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.
- ~~59-60.~~ "Current" means up-to-date, extending to the present time.
- ~~60-61.~~ "Daily living skills" means activities necessary for an individual to live independently and include meal preparation, laundry, housecleaning, home maintenance, money management, and appropriate social interactions.
- ~~61-62.~~ "Danger to others" has the same meaning as in A.R.S. § 36-501.
- ~~62-63.~~ "Danger to self" has the same meaning as in A.R.S. § 36-501.
- ~~63-64.~~ "Detoxification services" means behavioral health services and medical services provided to an individual to:
- a. Reduce or eliminate the individual's dependence on alcohol or other drugs, or
 - b. Provide treatment for the individual's signs or symptoms of withdrawal from alcohol or other drugs.
- ~~64-65.~~ "Diagnostic procedure" means a method or process performed to determine whether an individual has a medical condition or behavioral health issue.
- ~~65-66.~~ "Dialysis" means the process of removing dissolved substances from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane.
- ~~66-67.~~ "Dialysis services" means medical services, nursing services, and health-related services provided to a patient receiving dialysis.
- ~~67-68.~~ "Dialysis station" means a designated treatment area approved by the Department for use by a patient receiving dialysis or dialysis services.
- ~~68-69.~~ "Dialyzer" means an apparatus containing semi-permeable membranes used as a filter to remove wastes and excess fluid from a patient's blood.
- ~~69-70.~~ "Disaster" means an unexpected occurrence that adversely affects a health care institution's ability to provide services.
- ~~70-71.~~ "Discharge" means a documented termination of services to a patient by a health care institution.
- ~~71-72.~~ "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.
- ~~72-73.~~ "Discharge planning" means a process of establishing goals and objectives for a patient in preparation for the patient's discharge.
- ~~73-74.~~ "Discharge summary" means a documented brief review of services provided to a patient, current patient status, and reasons for the patient's discharge.
- ~~74-75.~~ "Disinfect" means to clean in order to prevent the growth of or to destroy disease-causing microorganisms.



- ~~75-76.~~“Documentation” or “documented” means information in written, photographic, electronic, or other permanent form.
- ~~76-77.~~“Drill” means a response to a planned, simulated event.
- ~~77-78.~~“Drug” has the same meaning as in A.R.S. § 32-1901.
- ~~78-79.~~“Electronic” has the same meaning as in A.R.S. § 44-7002.
- ~~79-80.~~“Electronic signature” has the same meaning as in A.R.S. § 44-7002.
- ~~80-81.~~“Emergency” means an immediate threat to the life or health of a patient.
- ~~81-82.~~“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.
- ~~82-83.~~“End-of-life” means that a patient has a documented life expectancy of six months or less.
- ~~83-84.~~“Environmental services” means activities such as housekeeping, laundry, facility maintenance, or equipment maintenance.
- ~~84-85.~~“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 A.A.C. R9-1-412.
- ~~85-86.~~“Exploitation” has the same meaning as in A.R.S. § 46-451.
- ~~86-87.~~“Factory-built building” has the same meaning as in A.R.S. § 41-2142.
- ~~87-88.~~“Family” or “family member” means an individual’s spouse, sibling, child, parent, grandparent, or another individual designated by the individual.
- ~~88-89.~~“Food services” means the storage, preparation, serving, and cleaning up of food intended for consumption in a health care institution.
90. “Full-time” means 40 hours or more every consecutive seven calendar days.
- ~~89-91.~~“Garbage” has the same meaning as in A.A.C. R18-13-302.
- ~~90-92.~~“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.
- ~~91-93.~~“General hospital” means a subclass of hospital that provides surgical services and emergency services.
- ~~92-94.~~“Gravely disabled” has the same meaning as in A.R.S. § 36-501.
- ~~93-95.~~“Hazard” or “hazardous” means a condition or situation where a patient or other individual may suffer physical injury.
- ~~94-96.~~“Health care directive” has the same meaning as in A.R.S. § 36-3201.
- ~~95-97.~~“Hemodialysis” means the process for removing wastes and excess fluids from a patient’s blood by passing the blood through a dialyzer.
- ~~96-98.~~“Home health agency” has the same meaning as in A.R.S. § 36-151.
- ~~97-99.~~“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.
- ~~98-100.~~“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.
- ~~99-101.~~“Home health services” has the same meaning as in A.R.S. § 36-151.
- ~~100-102.~~“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.
- ~~101-103.~~“Hospital” means a class of health care institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient.
- ~~102-104.~~“Immediate” means without delay.
- ~~103-105.~~“Incident” means an unexpected occurrence that harms or has the potential to harm a patient, while the patient is:
- On the premises of a health care institution, or
 - 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.
- ~~104-106.~~“Infection control” means to identify, prevent, monitor, and minimize infections.
- ~~105-107.~~“Informed consent” means:
- Advising a patient of a proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic drug, or diagnostic procedure; and associated risks and possible complications; and
 - Obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the patient or the patient’s representative.
- ~~106-108.~~“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.
109. “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.
- ~~110.~~ “Intermediate care facility for individuals with intellectual disabilities” or “ICF/IID” has the same meaning as in A.R.S. § 36-551.
- ~~107-111.~~“Interval note” means documentation updating a patient’s:
- Medical condition after a medical history and physical examination is performed, or
 - Behavioral health issue after an assessment is performed.
- ~~108-112.~~“Isolation” means the separation, during the communicable period, of infected individuals from others, to limit the transmission of infectious agents.
- ~~109-113.~~“Leased facility” means a facility occupied or used during a set time period in exchange for compensation.
- ~~110-114.~~“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.
- ~~111-115.~~ “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.
- ~~112-116.~~ “Licensee” means an owner approved by the Department to operate a health care institution.
- ~~113-117.~~ “Manage” means to implement policies and procedures established by a governing authority, an administrator, or an individual providing direction to a personnel member.
- ~~114-118.~~ “Medical condition” means the state of a patient’s physical or mental health, including the patient’s illness, injury, or disease.
- ~~115-119.~~ “Medical director” means a physician who is responsible for the coordination of medical services provided to patients in a health care institution.
- ~~116-120.~~ “Medical history” means an account of a patient’s health, including past and present illnesses, diseases, or medical conditions.
- ~~117-121.~~ “Medical practitioner” means a physician, physician assistant, or registered nurse practitioner.
- ~~118-122.~~ “Medical record” has the same meaning as “medical records” in A.R.S. § 12-2291.
- ~~119-123.~~ “Medical staff” means physicians and other individuals licensed pursuant to A.R.S. Title 32 who have clinical privileges at a health care institution.
- ~~120-124.~~ “Medical staff by-laws” 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.
- ~~121-125.~~ “Medical staff member” means an individual who is part of the medical staff of a health care institution.
- ~~122-126.~~ “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 medication as defined in A.R.S. § 32-1901.
- ~~123-127.~~ “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.
- ~~124-128.~~ “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.
- ~~125-129.~~ “Mental disorder” means the same as in A.R.S. § 36-501.
- ~~126-130.~~ “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, 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.
- ~~127-131.~~ “Monitor” or “monitoring” means to check systematically on a specific condition or situation.
- ~~128-132.~~ “Neglect” has the same meaning:
- a. For an individual less than 18 years of age, as in A.R.S. § 8-201; and
 - b. For an individual 18 years of age or older, as in A.R.S. § 46-451.
- ~~129-133.~~ “Nephrologist” means a physician who is board eligible or board certified in nephrology by a professional credentialing board.
- ~~130-134.~~ “Nurse” has the same meaning as “registered nurse” or “practical nurse” as defined in A.R.S. § 32-1601.
- ~~131-135.~~ “Nursing personnel” means individuals authorized according to A.R.S. § Title 32, Chapter 15 to provide nursing services.
- ~~132-136.~~ “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.
- ~~133-137.~~ “Occupational therapist” has the same meaning as in A.R.S. § 32-3401.
- ~~134-138.~~ “Occupational therapist assistant” has the same meaning as in A.R.S. § 32-3401.
- ~~135-139.~~ “Ombudsman” means a resident advocate who performs the duties described in A.R.S. § 46-452.02.
- ~~136-140.~~ “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.
- ~~137-141.~~ “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.
- ~~138-142.~~ “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.
- ~~139-143.~~ “Opioid treatment” means providing medical services, nursing services, health-related services, and ancillary services to a patient receiving an opioid agonist treatment medication for opiate addiction.
- ~~140-144.~~ “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 opiate addiction.



- ~~141-145.~~ “Order” means instructions to provide
- Physical health services to a patient from a medical practitioner or as otherwise provided by law; or
 - Behavioral health services to a patient from a behavioral health professional.
- ~~142-146.~~ “Orientation” means the initial instruction and information provided to an individual before the individual starts work or volunteer services in a health care institution.
- ~~143-147.~~ “Outing” means a social or recreational activity that:
- Occurs away from the premises,
 - Is not part of a behavioral health inpatient facility’s or behavioral health residential facility’s daily routine, and
 - Lasts longer than four hours.
- ~~144-148.~~ “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.
- ~~145-149.~~ “Outpatient treatment center” means a class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients.
- ~~146-150.~~ “Overall time-frame” means the same as in A.R.S. § 41-1072.
- ~~147-151.~~ “Owner” means a person who appoints, elects, or designates a health care institution’s governing authority.
- ~~148-152.~~ “Pain management clinic” has the same meaning as in A.R.S. § 36-448.01.
- ~~149-153.~~ “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.
- ~~150-154.~~ “Participant’s representative” means the same as “patient’s representative” for a participant.
- ~~151-155.~~ “Patient” means an individual receiving physical health services or behavioral health services from a health care institution.
- ~~152-156.~~ “Patient 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.
- ~~153-157.~~ “Patient’s representative” means:
- A patient’s legal guardian;
 - If a patient is less than 18 years of age and not an emancipated minor, the patient’s parent;
 - 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
 - A surrogate as defined in A.R.S. § 36-3201.
- ~~154-158.~~ “Person” means the same as in A.R.S. § 1-215 and includes a governmental agency.
- ~~155-159.~~ “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.
- ~~156-160.~~ “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.
- ~~157-161.~~ “Pharmacist” has the same meaning as in A.R.S. § 32-1901.
- ~~158-162.~~ “Physical examination” means to observe, test, or inspect an individual’s body to evaluate health or determine cause of illness, injury, or disease.
- ~~159-163.~~ “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.
- ~~160-164.~~ “Physical therapist” has the same meaning as in A.R.S. § 32-2001.
- ~~161-165.~~ “Physical therapist assistant” has the same meaning as in A.R.S. § 32-2001.
- ~~162-166.~~ “Physician assistant” has the same meaning as in A.R.S. § 32-2501.
- ~~167.~~ “Placement evaluation” means the same as in A.R.S. § 36-551.
- ~~163-168.~~ “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 patient.
- ~~164-169.~~ “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.
- ~~165-170.~~ “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.
- ~~166-171.~~ “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.
- ~~167-172.~~ “PRN” means *pro re nata* or given as needed.
- ~~168-173.~~ “Project” means specific construction or modification of a facility stated on an architectural plans and specifications approval application.
- ~~169-174.~~ “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.
- ~~170-175.~~ “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.
- ~~171-176.~~ “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.



- ~~172-177.~~ “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.
- ~~173-178.~~ “Recovery care center” has the same meaning as in A.R.S. § 36-448.51.
- ~~174-179.~~ “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.
- ~~175-180.~~ “Registered dietitian” means an individual approved to work as a dietitian by the American Dietetic Association’s Commission on Dietetic Registration.
- ~~176-181.~~ “Registered nurse” has the same meaning as in A.R.S. § 32-1601.
- ~~177-182.~~ “Registered nurse practitioner” has the same meaning as A.R.S. § 32-1601.
- ~~178-183.~~ “Regular basis” means at recurring, fixed, or uniform intervals.
- ~~184.~~ “Rehabilitation services” means medical services provided to a patient to restore or to optimize functional capability.
- ~~179-185.~~ “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.
- ~~180-186.~~ “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.
- ~~181-187.~~ “Resident’s representative” means the same as “patient’s representative” for a resident.
- ~~182-188.~~ “Respiratory care services” has the same meaning as “practice of respiratory care” as defined in A.R.S. § 32-3501.
- ~~183-189.~~ “Respiratory therapist” has the same meaning as in A.R.S. § 32-3501.
- ~~184-190.~~ “Respite services” means respite care services provided to an individual who is receiving behavioral health services.
- ~~185-191.~~ “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.
- ~~186-192.~~ “Risk” means potential for an adverse outcome.
- ~~187-193.~~ “Room” means space contained by a floor, a ceiling, and walls extending from the floor to the ceiling that has at least one door.
- ~~188-194.~~ “Rural general hospital” means a subclass of hospital having 50 or fewer inpatient beds and located more than 20 surface miles from a general hospital or another rural general hospital that requests to be and is licensed as a rural general hospital rather than a general hospital.
- ~~189-195.~~ “Satellite facility” has the same meaning as in A.R.S. § 36-422.
- ~~190-196.~~ “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.
- ~~191-197.~~ “Seclusion” means the involuntary solitary confinement of a patient in a room or an area where the patient is prevented from leaving.
- ~~192-198.~~ “Sedative-hypnotic medication” means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anti-convulsant, and muscle-relaxing properties.
- ~~193-199.~~ “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.
- ~~194-200.~~ “Sexual abuse” means the same as in A.R.S. § 13-1404(A).
- ~~195-201.~~ “Sexual assault” means the same as in A.R.S. § 13-1406(A).
- ~~196-202.~~ “Shift” means the beginning and ending time of a continuous work period established by a health care institution’s policies and procedures.
- ~~197-203.~~ “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.
- ~~198-204.~~ “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.
- ~~199-205.~~ “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.
- ~~200-206.~~ “Speech-language pathologist” means an individual licensed according A.R.S. Title 35, Chapter 17, Article 4 to engage in the practice of speech-language pathology, as defined in A.R.S. § 36-1901.
- ~~201-207.~~ “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.
- ~~202-208.~~ “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.
- ~~203-209.~~ “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.
- ~~204-210.~~ “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.
- ~~205-211.~~ “Substantial” when used in connection with a modification means:
- A change in a health care institution’s licensed capacity, licensed occupancy, or the number of dialysis stations;
 - An addition or deletion of an authorized service;



- c. A change in the physical plant, including facilities or equipment, that costs more than \$300,000; or
 - d. 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 A.A.C. R9-1-412.
- ~~206-212.~~ “Substance abuse” means an individual’s misuse of alcohol or other drug or chemical that:
- a. Alters the individual’s behavior or mental functioning;
 - b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
 - c. Impairs, reduces, or destroys the individual’s social or economic functioning.
- ~~207-213.~~ “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.
- ~~208-214.~~ “Supportive services” has the same meaning as in A.R.S. § 36-151.
- ~~209-215.~~ “Substantive review time-frame” means the same as in A.R.S. § 41-1072.
- ~~210-216.~~ “Surgical procedure” means the excision or incision of a patient’s body for the:
- a. Correction of a deformity or defect,
 - b. Repair of an injury, or
 - c. Diagnosis, amelioration, or cure of disease.
- ~~211-217.~~ “Swimming pool” has the same meaning as “semipublic swimming pool” in A.A.C. R18-5-201.
- ~~212-218.~~ “System” means interrelated, interacting, or interdependent elements that form a whole.
- ~~213-219.~~ “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.
- ~~214-220.~~ “Tax ID number” means a numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
- ~~215-221.~~ “Telemedicine” has the same meaning as in A.R.S. § 36-3601.
- ~~216-222.~~ “Therapeutic diet” means foods or the manner in which food is to be prepared that are ordered for a patient.
- ~~217-223.~~ “Therapist” means an occupational therapist, a physical therapist, a respiratory therapist, or a speech-language pathologist.
- ~~218-224.~~ “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.
- ~~219-225.~~ “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.
- ~~220-226.~~ “Transport” means a licensed health care institution:
- a. Sending a patient to a receiving licensed health care institution for outpatient services with the intent of the patient returning to the sending licensed health care institution, or
 - b. Discharging a patient to return to a sending licensed health care institution after the patient received outpatient services from the receiving licensed health care institution.
- ~~221-227.~~ “Treatment” means a procedure or method to cure, improve, or palliate an individual’s medical condition or behavioral health issue.
- ~~222-228.~~ “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.
- ~~223-229.~~ “Unclassified health care institution” means a health care institution not classified or subclassified in statute or in rule.
- ~~224-230.~~ “Vascular access” means the point on a patient’s body where blood lines are connected for hemodialysis.
- ~~225-231.~~ “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.
- ~~226-232.~~ “Working day” means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state and federal holiday or a state-wide furlough day.

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

- A. A person may apply for a license as a health care institution class or subclass in A.R.S. Title 36, Chapter 4 or this Chapter, or one of the following classes or subclasses:
- 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.
 - ~~6-7.~~ Recovery care center,
 - ~~7-8.~~ Hospice inpatient facility,
 - ~~8-9.~~ Hospice service agency,
 - ~~9-10.~~ Behavioral health residential facility,
 - ~~10-11.~~ Assisted living center,
 - ~~11-12.~~ Assisted living home,
 - ~~12-13.~~ Adult foster care home,
 - ~~13-14.~~ Outpatient surgical center,
 - ~~14-15.~~ Outpatient treatment center,
 - ~~15-16.~~ Abortion clinic,
 - ~~16-17.~~ Adult day health care facility,
 - ~~17-18.~~ Home health agency,



~~18-19~~. Substance abuse transitional facility,
~~19-20~~. Behavioral health specialized transitional facility,
~~20-21~~. Counseling facility,
~~21-22~~. Adult behavioral health therapeutic home,
~~22-23~~. Behavioral health respite home,
~~23-24~~. Unclassified health care institution,
~~24-25~~. Pain management clinic.

- B. A person shall apply for a license for the class or subclass that authorizes the provision of the highest level of physical care services or behavioral health services the proposed health care institution plans to provide. The Department shall review the proposed health care institution's scope of services to determine whether the requested health care institution class or subclass is appropriate.
- C. 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.

R9-10-106. Fees

- A. An applicant who submits to the Department architectural plans and specifications for the construction or modification of a health care institution shall also submit an architectural drawing review fee as follows:
1. Fifty dollars for a project with a cost of \$100,000 or less;
 2. One hundred dollars for a project with a cost of more than \$100,000 but less than \$500,000; or
 3. One hundred fifty dollars for a project with a cost of \$500,000 or more.
- B. An applicant submitting an initial application or a renewal application for a health care institution license shall submit to the Department an application fee of \$50.
- C. Except as provided in subsection (D) or (E), an applicant submitting an initial application or a renewal application for a health care institution license shall submit to the Department a licensing fee as follows:
1. For an adult day health care facility, assisted living home, or assisted living center:
 - a. For a facility with no licensed capacity, \$280;
 - b. For a facility with a licensed capacity of one to 59 beds, \$280, plus the licensed capacity times \$70;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$560, plus the licensed capacity times \$70;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$840, plus the licensed capacity times \$70; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,400, plus the licensed capacity times \$70;
 2. For a behavioral health facility:
 - a. For a facility with no licensed capacity, \$375;
 - b. For a facility with a licensed capacity of one to 59 beds, \$375, plus the licensed capacity times \$94;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$750, plus the licensed capacity times \$94;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$1,125, plus the licensed capacity times \$94; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,875, plus the licensed capacity times \$94;
 3. For a behavioral health facility providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(2), the licensed occupancy times \$94;
 4. For a nursing care institution or an intermediate care facility for individuals with intellectual disabilities:
 - a. For a facility with a licensed capacity of one to 59 beds, \$290, plus the licensed capacity times \$73;
 - b. For a facility with a licensed capacity of 60 to 99 beds, \$580, plus the licensed capacity times \$73;
 - c. For a facility with a licensed capacity of 100 to 149 beds, \$870, plus the licensed capacity times \$73; or
 - d. For a facility with a licensed capacity of 150 beds or more, \$1,450, plus the licensed capacity times \$73;
 5. For a hospital, a home health agency, a hospice service agency, a hospice inpatient facility, an abortion clinic, a recovery care center, an outpatient surgical center, an outpatient treatment center that is not a behavioral health facility, or an unclassified health care institution:
 - a. For a facility with no licensed capacity, \$365;
 - b. For a facility with a licensed capacity of one to 59 beds, \$365, plus the licensed capacity times \$91;
 - c. For a facility with a licensed capacity of 60 to 99 beds, \$730, plus the licensed capacity times \$91;
 - d. For a facility with a licensed capacity of 100 to 149 beds, \$1,095, plus the licensed capacity times \$91; or
 - e. For a facility with a licensed capacity of 150 beds or more, \$1,825, plus the licensed capacity times \$91;
 6. For a hospital providing behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times \$91; and
 7. For an outpatient treatment center that is not a behavioral health facility and provides:
 - a. Dialysis services, in addition to the applicable fee in subsection (C)(5), the number of dialysis stations times \$91; and
 - b. Behavioral health observation/stabilization services, in addition to the applicable fee in subsection (C)(5), the licensed occupancy times \$91.
- D. In addition to the applicable fees in subsections (C)(5) and (C)(6), an applicant submitting an initial application or a renewal application for a single group hospital license shall submit to the Department an additional fee of \$365 for each of the hospital's satellite facilities and, if applicable, the fees required in subsection (C)(7).
- E. Subsections (C) and (D) do 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.
- F. All fees are nonrefundable except as provided in A.R.S. § 41-1077.



ARTICLE 5. ~~RECOVERY CARE CENTERS~~ INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

R9-10-501. Definitions

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. “Developmental disability” means the same as in A.R.S. § 36-551.
8. “Direct care” means medical services, nursing services, rehabilitation services, or habilitation services provided to a resident.
9. “Habilitation services” means activities provided to an individual to assist the individual with habilitation, as defined in A.R.S. § 36-551.
10. “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.
11. “Individual program plan” means the same as in A.R.S. § 36-551.
12. “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.
13. “Nursing care institution administrator” means an individual licensed according to A.R.S. Title 36, Chapter 4, Article 6.
14. “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.
15. “Qualified intellectual disabilities professional” means one of the following who has at least one year of experience working directly with individuals who have developmental disabilities:
 - 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;
 - f. A registered dietitian, as defined in A.R.S. § 36-416;
 - g. A licensed clinical social worker under A.R.S. § 32-3293; or
 - h. A nursing care institution administrator.
16. “Resident’s representative” has the same meaning as “responsible person” in A.R.S. § 36-551.

R9-10-502. Supplemental Application 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 to provide:
 - a. Active treatment to individuals under 18 years of age, including the licensed capacity requested;
 - b. Seclusion;
 - c. Clinical laboratory services;
 - d. Respiratory care services, or
 - e. Services to residents who have a 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:
1. The information required in subsection (A)(1), as applicable, and
 2. The documentation specified in subsection (A)(2).

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, 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;
 - 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 telemedicine, 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 a qualified intellectual disabilities professional to oversee rehabilitation 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. 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 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 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 (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:
 - 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).

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.

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.

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;
- 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 and 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 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 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;
 - 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.

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 on 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 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 or provide another written statement by a physician, physician assistant, or registered nurse practitioner as specified in R9-10-113 if:
 - a. Fewer than 12 months have passed since the resident was screened for tuberculosis or since the date of the written statement, and
 - b. The documentation of freedom from infectious tuberculosis required in subsection (A)(9) accompanies the resident at the time of transfer.

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 for a transfer of a resident due to an emergency, an administrator shall ensure that:
 1. A qualified intellectual disabilities professional 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.
- C. Except in an emergency, a qualified intellectual disabilities professional 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 is developed by a qualified intellectual disabilities professional and authenticated by the resident’s attending physician or designee and includes:
 - a. The resident’s need for rehabilitation services or habilitation services at the time of transfer or discharge;
 - b. The resident’s need for medical services or nursing services;
 - c. The resident’s developmental, behavioral, social, and nutritional status;
 - d. The resident’s medical and psychosocial history;
 - e. The date of the discharge; and
 - f. The location of the resident after discharge.

R9-10-509. Transport

- A. Except as provided in subsection (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 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.

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
 - 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. 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 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;
 - 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.

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 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, 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 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 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 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.

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 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 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 an individual to be contacted under R9-10-503(I);



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 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. The discharge plan;
22. The discharge summary;
23. Transfer documentation;
24. If applicable:
 - a. A laboratory report;
 - b. A radiologic report;
 - c. A diagnostic report, and
 - d. A consultation report;
25. Documentation of freedom from infectious tuberculosis required in R9-10-507(10);
26. 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
27. If applicable, a copy of written notices, including follow-up instructions, provided to the resident or the resident's representative.

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.

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 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 or seclusion is included in subsection (A)(1)(d)(xxiv), 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;
- 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 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 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 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.

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.
 - 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 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 required in subsection (C)(9)(d);
 - d. The time of the assessment required in subsection (C)(9)(e);
 - e. The names of the medical practitioners and personnel members with direct resident contact while the resident was in the restraint or seclusion;
 - f. The times the resident was given the opportunity to eat or use the toilet according to subsection (C)(9)(f), and
 - g. 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.

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:
 - 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 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. A registered nurse is appointed as director of nursing who:
 - a. Works full-time at the ICF/IID, and
 - b. Is responsible for the direction of nursing services; 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 medical care plan;
4. At least one nurse is present on the ICF/IID's premises if a resident is on the premises;
5. Personnel members providing direct care to a resident with a medical care plan receive direction from a nurse;
6. At least once every three months, a nurse:
 - a. Assesses the health of a resident without a 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, initiates action, according to policies and procedures, to address the resident's needs;
7. 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;
8. 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 requires medical services, or
 - c. Has a significant change in condition; and
9. 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:
 - a. Treatment to address the identified issue, or
 - b. An assistive device to address an issue.

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.

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:
 - i. Within 24 hours after the test is complete with results if the test is performed at a laboratory on the ICF/IID's premises, or
 - ii. Within 24 hours after the test 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;
 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.

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.

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 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:



- 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.

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.

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 <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;
 - 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)(c);
 - d. The option to have a daily evening snack identified in subsection (B)(4)(c)(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;
- 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.

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:
 - 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 A.A.C. R9-1-412, 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 A.A.C. R9-1-412, and is in working order; and
 2. Sixteen or fewer residents, none of whom have a medical care plan:
 - 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 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.

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.

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 A.A.C. R9-1-412, that were in effect on the earlier of:
 - 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 architectural plans and specifications to the Department for approval 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 A.A.C. R9-1-412; 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 A.A.C. R9-1-412.
- 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 bed-spread, 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;
 - 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.

ARTICLE 21. RECOVERY CARE CENTERS

~~R9-10-501, 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.

~~R9-10-502, 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 ~~R9-10-503~~ 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 ~~R9-10-505(G)~~ 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
 - 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.

R9-10-503, 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.

R9-10-504, 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.

R9-10-505, 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:
 - 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 ~~R9-10-502(C)(1)(e)~~ 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.

~~R9-10-506, 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;
 - 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.

~~R9-10-507, 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.

~~R9-10-508, 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.

~~R9-10-509, 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.

~~R9-10-510, 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.

R9-10-511. 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 by 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.
- 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 ~~R9-10-507(B)(1)~~ 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.

R9-10-512, 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.

~~R9-10-513~~, 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
 - 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.

~~R9-10-514~~, 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.

~~R9-10-515~~, 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:
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.

~~R9-10-516~~, 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.

~~R9-10-517, 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



- 8. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable
- 9. **The summary of the economic, small business, and consumer impact, if applicable:**
Not applicable
- 10. **A description of any changes between the proposed rulemaking, including any supplemental proposed rulemaking, and the final rulemaking package (if applicable):**
Not applicable
- 11. **An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments, if applicable:**
AZPOST, on April 17, 2019, in an open meeting directed the Executive Director to pursue this exempt rulemaking pursuant to SB 1092. Additionally the legislative process is inherently a public process. The bill passed each chamber with a super-majority and was signed by the Governor.
- 12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules. When applicable, matters shall include, but not be limited to:**
 - a. **Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:**
Not applicable
 - b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**
Not applicable
 - c. **Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:**
No
- 13. **A list of any incorporated by reference material and its location in the rule:**
Not applicable
- 14. **Whether the rule was previously made, amended, repealed or renumbered as an emergency rule. If so, the agency shall state where the text changed between the emergency and the exempt rulemaking packages:**
Not applicable
- 15. **The full text of the rules follows:**

TITLE 13. PUBLIC SAFETY

CHAPTER 4. ARIZONA PEACE OFFICER STANDARDS AND TRAINING BOARD

ARTICLE 2. CORRECTIONAL OFFICERS

Section
R13-4-202. Uniform Minimum Standards

ARTICLE 2. CORRECTIONAL OFFICERS

R13-4-202. Uniform Minimum Standards

- A. To be admitted to the academy for training as a state correctional officer, an individual shall:
 - 1. Be a citizen of the United States or eligible to work in the United States;
 - 2. Be at least ~~24~~18 years of age by the date of graduation from the academy;
 - 3. Be a high school graduate or have successfully completed a General Education Development (G.E.D.) examination or equivalent as specified in R13-4-203(C)(3);
 - 4. Have a valid Arizona driver's license (Class 2 or higher) by the date of graduation from the academy;
 - 5. Undergo a complete background investigation that meets the standards of R13-4-203;
 - 6. Undergo a physical examination (within 12 months before appointment) as prescribed by the Director by a licensed physician designated by the Director;
 - 7. Not have been dishonorably discharged from the United States Armed Forces;
 - 8. Not have experimented with marijuana within the past 12 months;
 - 9. Not have experimented with a dangerous drug or narcotic within the past five years;
 - 10. Not have ever illegally used marijuana, or a dangerous drug or narcotic other than for experimentation;
 - 11. Not have a pattern of abuse of prescription medication; and
 - 12. Not have committed a felony or a misdemeanor of a nature that the Board determines has a reasonable relationship to the functions of the position, in accordance with A.R.S. § 13-904(E).
- B. If the Director wishes to appoint an individual whose conduct is grounds to deny certification under R13-4-109, the Director may petition the Board for a determination that the otherwise disqualifying conduct constitutes juvenile indiscretion by complying with R13-4-105(D).



- C. Code of Ethics. To enhance the quality of performance and the conduct and the behavior of correctional officers, an individual appointed to be a correctional officer shall commit to the following Code of Ethics and shall affirm the commitment by signing the Code:

“I shall maintain high standards of honesty, integrity, and impartiality, free from any personal considerations, favoritism, or partisan demands. I shall be courteous, considerate, and prompt when dealing with the public, realizing that I serve the public. I shall maintain mutual respect and professional cooperation in my relationships with other staff members.

I shall be firm, fair, and consistent in the performance of my duties. I shall treat others with dignity, respect, and compassion, and provide humane custody and care, void of all retribution, harassment, or abuse. I shall uphold the Constitutions of the United States and the state of Arizona, and all federal and state laws. Whether on or off duty, in uniform or not, I shall conduct myself in a manner that will not bring discredit or embarrassment to my agency or the state of Arizona.

I shall report without reservation any corrupt or unethical behavior that could affect either inmates, employees, or the integrity of my agency. I shall not use my official position for personal gain. I shall maintain confidentiality of information that has been entrusted to me and designated as such.

I shall not permit myself to be placed under any kind of personal obligation that could lead any person to expect official favors. I shall not accept or solicit from anyone, either directly or indirectly, anything of economic value such as a gift, gratuity, favor, entertainment, or loan, that is or may appear to be, designed to influence my official conduct. I will not discriminate against any inmate, employee, or any member of the public on the basis of race, gender, creed, or national origin. I will not sexually harass or condone sexual harassment of any person. I shall maintain the highest standards of personal hygiene, grooming, and neatness while on duty or otherwise representing the state of Arizona.”



NOTICES OF RULEMAKING DOCKET OPENING

This section of the Arizona Administrative Register contains Notices of Rulemaking Docket Opening.

A docket opening is the first part of the administrative rulemaking process. It is an "announcement" that the agency intends to work on its rules.

When an agency opens a rulemaking docket to consider rulemaking, the Administrative Procedure Act (APA) requires the publication of the Notice of Rulemaking Docket Opening.

Under the APA effective January 1, 1995, agencies must submit a Notice of Rulemaking Docket Opening before beginning the formal rulemaking process. Many times an agency may file the Notice of Rulemaking Docket Opening with the Notice of Proposed Rulemaking.

The Office of the Secretary of State is the filing office and publisher of these notices. Questions about the interpretation of this information should be directed to the agency contact person listed in item #4 of this notice.

NOTICE OF RULEMAKING DOCKET OPENING
STATE RETIREMENT SYSTEM BOARD

[R19-88]

- 1. Title and its heading: 2, Administration
Chapter and its heading: 8, State Retirement System Board
Articles and their headings: 3, Long-term Disability; 8, Recovery of Overpayments
Section numbers: R2-8-301 through R2-8-304 and R2-8-807
2. The subject matter of the proposed rule: A.R.S. § 38-797.07(A)(7) requires the ASRS to stop paying LTD benefits...
3. A citation to all published notices relating to the proceeding: Notice of Proposed Rulemaking: 25 A.A.R. 1217, May 17, 2019
4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking: Name: Jessica A.R. Thomas, Rules Writer; Address: Arizona State Retirement System...
5. The time during which the agency will accept written comments and the time and place where oral comments may be made: The Board will accept comments during business hours...
6. A timetable for agency decisions or other action on the proceeding, if known: To be determined.

NOTICE OF RULEMAKING DOCKET OPENING
DEPARTMENT OF HEALTH SERVICES
OCCUPATIONAL LICENSING

[R19-89]

- 1. Title and its heading: 9, Health Services
Chapter and its heading: 16, Department of Health Services - Occupational Licensing
Article and its heading: 6, Radiation Technologists
Section numbers: R9-16-601 through R9-16-624
2. The subject matter of the proposed rules: Arizona Revised Statutes (A.R.S.) Title 9, Chapter 28, Article 2 provides for the certification of different classes of radiation technologists.



responsible for regulating radiation technologists. Moreover, the rules are inconsistent with statutory requirements and formatted in a way that is difficult to understand. All of these issues may cause confusion on the part of regulated persons, unnecessarily adding to their administrative burden, as described in a five-year-review report approved by the Governor’s Regulatory Review Council in December 2018. In addition, the rules do not comply with requirements in HB 2569 relating to reciprocity of professional licenses. After receiving an exception from the Governor’s rulemaking moratorium established by Executive Order 2019-01, the Department is revising the rules by expedited rulemaking to make changes described in the five-year-review report and to comply with HB 2569 to reduce the regulatory burden while achieving the same regulatory objective, comply with statutory requirements, and help eliminate confusion on the part of the public. The proposed amendments will conform to rulemaking format and style requirements of the Governor’s Regulatory Review Council and the Office of the Secretary of State. The Department may add, delete, or modify other Sections, as necessary.

3. A citation to all published notices relating to the proceeding:

None

4. The name and address of agency personnel with whom persons may communicate regarding the rules:

Name: Megan Whitby, Bureau Chief
 Address: Department of Health Services
 Public Health Licensing Services
 150 N. 18th Ave., Suite 400
 Phoenix, AZ 85007
 Telephone: (602) 364-3052
 Fax: (602) 364-2079
 E-mail: Megan.Whitby@azdhs.gov
 or
 Name: Robert Lane, Chief
 Address: Arizona Department of Health Services
 Office of Administrative Counsel and Rules
 150 N. 18th Ave., Suite 200
 Phoenix, AZ 85007
 Telephone: (602) 542-1020
 Fax: (602) 364-1150
 E-mail: Robert.Lane@azdhs.gov

5. The time during which the agency will accept written comments and the time and place where oral comments may be made:

To be announced in the Notice of Proposed Expedited Rulemaking

6. A timetable for agency decisions or other action on the proceeding, if known:

To be announced in the Notice of Proposed Expedited Rulemaking

**NOTICE OF RULEMAKING DOCKET OPENING
 DEPARTMENT OF HEALTH SERVICES
 EMERGENCY MEDICAL SERVICES**

[R19-90]

- 1. Title and its heading:** 9, Health Services
- Chapter and its heading:** 25, Department of Health Services - Emergency Medical Services
- Articles and their headings:** 7, Air Ambulance Service Licensing
 8, Air Ambulance Registration
- Section numbers:** R9-25-701, R9-25-703 through R9-25-711, R9-25-713 through R9-25-718, R9-25-801 through R9-25-807, and Table 8.1

2. The subject matter of the proposed expedited rules:
 Arizona Revised Statutes (A.R.S.) §§ 36-2202(A)(3) and (4) and 36-2209(A)(2) require the Arizona Department of Health Services (Department) to adopt standards and criteria pertaining to the quality of emergency care, rules necessary for the operation of emergency medical services, and rules for carrying out the purposes of A.R.S. Title 36, Chapter 21.1. The Department has adopted rules to implement these statutes in 9 A.A.C. 25. The rules in 9 A.A.C. 25, Article 7 and 8 establish requirements for licensing air ambulance services and for registration of air ambulances, respectively, to ensure the health and safety of patients being transported. In a five-year-review report approved by the Governor’s Regulatory Review Council on July 6, 2017, the Department identified several issues with the rules and proposed a rulemaking to address these issues. These issues include non-compliance with A.R.S. § 41-1080, unnecessary or duplicative requirements, unclear requirements, obsolete requirements, and poor organization of the rules. All of these issues may affect the effectiveness of the rules and, thus, threaten the health and safety of patients being transported. The Department also requested input from stakeholders to identify additional issues. After receiving an exception from the Governor’s rulemaking moratorium established by Executive Order 2019-01, the Department plans to revise the rules in 9 A.A.C. 25, Articles 7 and 8, to address these issues and other issues identified by stakeholders as part of the rulemaking process and to restructure the rules to improve clarity, remove duplication, and increase effectiveness. The proposed amendments will conform to rulemaking format and style requirements of the Governor’s Regulatory Review Council and the Office of the Secretary of



State.

3. A citation to all published notices relating to the proceeding:

None

4. The name and address of agency personnel with whom persons may communicate regarding the rules:

Name: Terry Mullins, Bureau Chief
Address: Arizona Department of Health Services
Bureau of Emergency Medical Services and Trauma System
150 N. 18th Ave., Suite 540
Phoenix, AZ 85007-3248

Telephone: (602) 364-3150

Fax: (602) 364-3568

E-mail: Terry.Mullins@azdhs.gov

or

Name: Robert Lane, Chief
Address: Arizona Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ 85007

Telephone: (602) 542-1020

Fax: (602) 364-1150

E-mail: Robert.Lane@azdhs.gov

5. The time during which the agency will accept written comments and the time and place where oral comments may be made:

To be announced in the Notice of Proposed Rulemaking

6. A timetable for agency decisions or other action on the proceeding, if known:

To be announced in the Notice of Proposed Rulemaking



NOTICES OF SUBSTANTIVE POLICY STATEMENT

The *Administrative Procedure Act* (APA) requires the publication of Notices of Substantive Policy Statement issued by agencies (A.R.S. § 41-1013(B)(9)).

Substantive policy statements are written expressions which inform the general public of an agency's current approach to rule or regulation practice.

Substantive policy statements are advisory only. A substantive policy statement does not include internal procedural documents that only affect an agency's

internal procedures and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the APA.

If you believe that a substantive policy statement does impose additional requirements or penalties on regulated parties, you may petition the agency under A.R.S. § 41-1033 for a review of the statement.

NOTICE OF SUBSTANTIVE POLICY STATEMENT BOARD OF TECHNICAL REGISTRATION

[M19-41]

1. **Title of the Substantive Policy Statement and the substantive policy statement number by which the substantive policy statement is referenced:**
Policy Number 19 - Multi-pane glazing assemblies as it relates to the Standards of Professional Practice for Arizona Home Inspectors provision 11.2 B.
2. **Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:**
April 24, 2019
3. **Summary of the contents of the substantive policy statement:**
Provision 11.2 B of the Standards of Professional Practice for Arizona Home Inspectors does not apply to the area between panes of glass in multi-pane glazing assemblies as it relates to the presence or absence of moisture or condensation. Exhaustive evaluation of the interior of multi-pane window assemblies is determined to be cosmetic and outside of the scope of a home inspection. Detection of problems related to the hermetic seal, interior coatings and gases that may or may not be present requires specific expertise. Additionally, the ability to determine the condition of the hermetic seal, interior coatings, and gases present within is highly dependent on climactic conditions, cleanliness of glazing, window screen and window covering obstructions.
4. **Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:**
A.A.C. R4-30-301.01(A)
5. **A statement as to whether the substantive policy statement is a new statement or a revision:**
This is a new policy statement.
6. **The agency contact person who can answer questions about the substantive policy statement:**
Name: Patrice Pritzl
Address: Board of Technical Registration
1110 W. Washington St.
Phoenix AZ 85007
Telephone: (602) 364-4955
Fax: (602) 364-4931
E-mail: Patrice.pritzl@azbtr.gov
Web site: <https://btr.az.gov>
7. **Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:**
Copies of Substantive Policy Statement number 18 are available from the Board of Technical Registration, located at 1110 W. Washington Street, Suite 240, Phoenix, AZ 85007 at no charge, and is available on our website at www.azbtr.gov.



GOVERNOR EXECUTIVE ORDER

Executive Order 2019-01 is being reproduced in each issue of the Administrative Register as a notice to the public regarding state agencies' rulemaking activities.

This order has been reproduced in its entirety as submitted.

EXECUTIVE ORDER 2019-01

Moratorium on Rulemaking to Promote Job Creation and Customer-Service-Oriented Agencies; Protecting Consumers Against Fraudulent Activities

[M19-04]

WHEREAS, government regulations should be as limited as possible; and

WHEREAS, burdensome regulations inhibit job growth and economic development; and

WHEREAS, protecting the public health, peace and safety of the residents of Arizona is a top priority of state government; and

WHEREAS, in 2015 the State of Arizona implemented a moratorium on all new regulatory rulemaking by State agencies through executive order and renewed the moratorium in 2016, 2017 and 2018; and

WHEREAS, the State of Arizona eliminated or repealed 422 needless regulations in 2018 and 676 in 2017 for a total of 1,098 needless regulations eliminated or repealed over two years; and

WHEREAS, estimates show these eliminations saved job creators more than \$31 million in operating costs in 2018 and \$48 million in 2017 for a total of over \$79 million in savings over two years; and

WHEREAS, approximately 283,300 private sector jobs have been added to Arizona since January 2015; and

WHEREAS, all government agencies of the State of Arizona should continue to promote customer-service-oriented principles for the people that it serves; and

WHEREAS, each State agency shall continue to conduct a critical and comprehensive review of its administrative rules and take action to reduce the regulatory burden, administrative delay and legal uncertainty associated with government regulation while protecting the health, peace and safety of residents; and

WHEREAS, each State agency should continue to evaluate its administrative rules using any available and reliable data and performance metrics; and

WHEREAS, Article 5, Section 4 of the Arizona Constitution and Title 41, Chapter 1, Article 1 of the Arizona Revised Statutes vests the executive power of the State of Arizona in the Governor.

NOW, THEREFORE, I, Douglas A. Ducey, by virtue of the authority vested in me by the Constitution and laws of the State of Arizona hereby declare the following:

- 1. A State agency subject to this Order shall not conduct any rulemaking, whether informal or formal, without the prior written approval of the Office of the Governor. In seeking approval, a State agency shall address one or more of the following as justifications for the rulemaking:
a. To fulfill an objective related to job creation, economic development or economic expansion in this State.
b. To reduce or ameliorate a regulatory burden while achieving the same regulatory objective.
c. To prevent a significant threat to the public health, peace, or safety.
d. To avoid violating a court order or federal law that would result in sanctions by a federal court for failure to conduct the rulemaking action.
e. To comply with a federal statutory or regulatory requirement if such compliance is related to a condition for the receipt of federal funds or participation in any federal program.
f. To comply with a state statutory requirement.
g. To fulfill an obligation related to fees or any other action necessary to implement the State budget that is certified by the Governor's Office of Strategic Planning and Budgeting.
h. To promulgate a rule or other item that is exempt from Title 41, Chapter 6, Arizona Revised Statutes, pursuant to section 41-1005, Arizona Revised Statutes.
i. To address matters pertaining to the control, mitigation, or eradication of waste, fraud or abuse within an agency or wasteful, fraudulent, or abusive activities perpetrated against an agency.
j. To eliminate rules which are antiquated, redundant or otherwise no longer necessary for the operation of state government.
2. A State agency subject to this Order shall not publicize any directives, policy statements, documents or forms on its website unless such are explicitly authorized by Arizona Revised Statutes or Arizona Administrative Code.
3. A State agency subject to this Order and which issues occupational or professional licenses shall review the agency's rules and practices related to receiving and acting on substantive complaints about unlicensed individuals who are allegedly holding them-



selves out as licensed professionals for financial gain and are knowingly or recklessly providing or attempting to provide regulated services which the State agency director believes could cause immediate and/or significant harm to either the financial or physical health of unknowing consumers within the state. Agencies shall identify and execute on opportunities to improve its complaint intake process, documentation, tracking, enforcement actions and coordination with proper law enforcement channels to ensure those allegedly trying to defraud unsuspecting consumers and putting them at risk for immediate and/or significant harm to their financial or physical health are stopped and effectively diverted by the State agency to the proper law-enforcement agency for review. A written plan on the agency's process shall be submitted to the Governor's Office no later than May 31, 2019.

4. For the purposes of this Order, the term "State agencies" includes, without limitation, all executive departments, agencies, offices, and all state boards and commissions, except for: (a) any State agency that is headed by a single elected State official; (b) the Corporation Commission; and (c) any board or commission established by ballot measure during or after the November 1998 general election. Those state agencies, boards and commissions excluded from this Order are strongly encouraged to voluntarily comply with this Order in the context of their own rulemaking processes.
5. This Order does not confer any legal rights upon any persons and shall not be used as a basis for legal challenges to rules, approvals, permits, licenses or other actions or to any inaction of a State agency. For the purposes of this Order, "person," "rule," and "rulemaking" have the same meanings prescribed in section 41-1001, Arizona Revised Statutes.

IN WITNESS THEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona.

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this ninth day of January in the Year Two Thousand and Nineteen and of the Independence of the United States of America the Two Hundred and Forty-Third.

ATTEST:

Katie Hobbs
SECRETARY OF STATE

REGISTER INDEXES

The *Register* is published by volume in a calendar year (See “General Information” in the front of each issue for more information).

Abbreviations for rulemaking activity in this Index include:

PROPOSED RULEMAKING

PN = Proposed new Section
PM = Proposed amended Section
PR = Proposed repealed Section
P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING

SPN = Supplemental proposed new Section
SPM = Supplemental proposed amended Section
SPR = Supplemental proposed repealed Section
SP# = Supplemental proposed renumbered Section

FINAL RULEMAKING

FN = Final new Section
FM = Final amended Section
FR = Final repealed Section
F# = Final renumbered Section

SUMMARY RULEMAKING**PROPOSED SUMMARY**

PSMN = Proposed Summary new Section
PSMM = Proposed Summary amended Section
PSMR = Proposed Summary repealed Section
PSM# = Proposed Summary renumbered Section

FINAL SUMMARY

FSMN = Final Summary new Section
FSMM = Final Summary amended Section
FSMR = Final Summary repealed Section
FSM# = Final Summary renumbered Section

EXPEDITED RULEMAKING**PROPOSED EXPEDITED**

PEN = Proposed Expedited new Section
PEM = Proposed Expedited amended Section
PER = Proposed Expedited repealed Section
PE# = Proposed Expedited renumbered Section

SUPPLEMENTAL EXPEDITED

SPEN = Supplemental Proposed Expedited new Section
SPEM = Supplemental Proposed Expedited amended Section
SPER = Supplemental Proposed Expedited repealed Section
SPE# = Supplemental Proposed Expedited renumbered Section

FINAL EXPEDITED

FEN = Final Expedited new Section
FEM = Final Expedited amended Section
FER = Final Expedited repealed Section
FE# = Final Expedited renumbered Section

EXEMPT RULEMAKING**EXEMPT**

XN = Exempt new Section
XM = Exempt amended Section
XR = Exempt repealed Section
X# = Exempt renumbered Section

EXEMPT PROPOSED

PXN = Proposed Exempt new Section
PXM = Proposed Exempt amended Section
PXR = Proposed Exempt repealed Section
PX# = Proposed Exempt renumbered Section

EXEMPT SUPPLEMENTAL PROPOSED

SPXN = Supplemental Proposed Exempt new Section
SPXR = Supplemental Proposed Exempt repealed Section
SPXM = Supplemental Proposed Exempt amended Section
SPX# = Supplemental Proposed Exempt renumbered Section

FINAL EXEMPT RULEMAKING

FXN = Final Exempt new Section
FXM = Final Exempt amended Section
FXR = Final Exempt repealed Section
FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING

EN = Emergency new Section
EM = Emergency amended Section
ER = Emergency repealed Section
E# = Emergency renumbered Section
EEXP = Emergency expired

RECODIFICATION OF RULES

RC = Recodified

REJECTION OF RULES

RJ = Rejected by the Attorney General

TERMINATION OF RULES

TN = Terminated proposed new Sections
TM = Terminated proposed amended Section
TR = Terminated proposed repealed Section
T# = Terminated proposed renumbered Section

RULE EXPIRATIONS

EXP = Rules have expired

See also “emergency expired” under emergency rulemaking

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RULES EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

January		February		March		April		May		June	
Date Filed	Effective Date										
1/1	3/2	2/1	4/2	3/1	4/30	4/1	5/31	5/1	6/30	6/1	7/31
1/2	3/3	2/2	4/3	3/2	5/1	4/2	6/1	5/2	7/1	6/2	8/1
1/3	3/4	2/3	4/4	3/3	5/2	4/3	6/2	5/3	7/2	6/3	8/2
1/4	3/5	2/4	4/5	3/4	5/3	4/4	6/3	5/4	7/3	6/4	8/3
1/5	3/6	2/5	4/6	3/5	5/4	4/5	6/4	5/5	7/4	6/5	8/4
1/6	3/7	2/6	4/7	3/6	5/5	4/6	6/5	5/6	7/5	6/6	8/5
1/7	3/8	2/7	4/8	3/7	5/6	4/7	6/6	5/7	7/6	6/7	8/6
1/8	3/9	2/8	4/9	3/8	5/7	4/8	6/7	5/8	7/7	6/8	8/7
1/9	3/10	2/9	4/10	3/9	5/8	4/9	6/8	5/9	7/8	6/9	8/8
1/10	3/11	2/10	4/11	3/10	5/9	4/10	6/9	5/10	7/9	6/10	8/9
1/11	3/12	2/11	4/12	3/11	5/10	4/11	6/10	5/11	7/10	6/11	8/10
1/12	3/13	2/12	4/13	3/12	5/11	4/12	6/11	5/12	7/11	6/12	8/11
1/13	3/14	2/13	4/14	3/13	5/12	4/13	6/12	5/13	7/12	6/13	8/12
1/14	3/15	2/14	4/15	3/14	5/13	4/14	6/13	5/14	7/13	6/14	8/13
1/15	3/16	2/15	4/16	3/15	5/14	4/15	6/14	5/15	7/14	6/15	8/14
1/16	3/17	2/16	4/17	3/16	5/15	4/16	6/15	5/16	7/15	6/16	8/15
1/17	3/18	2/17	4/18	3/17	5/16	4/17	6/16	5/17	7/16	6/17	8/16
1/18	3/19	2/18	4/19	3/18	5/17	4/18	6/17	5/18	7/17	6/18	8/17
1/19	3/20	2/19	4/20	3/19	5/18	4/19	6/18	5/19	7/18	6/19	8/18
1/20	3/21	2/20	4/21	3/20	5/19	4/20	6/19	5/20	7/19	6/20	8/19
1/21	3/22	2/21	4/22	3/21	5/20	4/21	6/20	5/21	7/20	6/21	8/20
1/22	3/23	2/22	4/23	3/22	5/21	4/22	6/21	5/22	7/21	6/22	8/21
1/23	3/24	2/23	4/24	3/23	5/22	4/23	6/22	5/23	7/22	6/23	8/22
1/24	3/25	2/24	4/25	3/24	5/23	4/24	6/23	5/24	7/23	6/24	8/23
1/25	3/26	2/25	4/26	3/25	5/24	4/25	6/24	5/25	7/24	6/25	8/24
1/26	3/27	2/26	4/27	3/26	5/25	4/26	6/25	5/26	7/25	6/26	8/25
1/27	3/28	2/27	4/28	3/27	5/26	4/27	6/26	5/27	7/26	6/27	8/26
1/28	3/29	2/28	4/29	3/28	5/27	4/28	6/27	5/28	7/27	6/28	8/27
1/29	3/30			3/29	5/28	4/29	6/28	5/29	7/28	6/29	8/28
1/30	3/31			3/30	5/29	4/30	6/29	5/30	7/29	6/30	8/29
1/31	4/1			3/31	5/30			5/31	7/30		



July		August		September		October		November		December	
Date Filed	Effective Date										
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1	12/2	1/31
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2	12/3	2/1
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3	12/4	2/2
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4	12/5	2/3
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5	12/6	2/4
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6	12/7	2/5
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7	12/8	2/6
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8	12/9	2/7
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9	12/10	2/8
7/11	9/9	8/11	10/10	9/11	11/10	10/11	12/10	11/11	1/10	12/11	2/9
7/12	9/10	8/12	10/11	9/12	11/11	10/12	12/11	11/12	1/11	12/12	2/10
7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12	12/13	2/11
7/14	9/12	8/14	10/13	9/14	11/13	10/14	12/13	11/14	1/13	12/14	2/12
7/15	9/13	8/15	10/14	9/15	11/14	10/15	12/14	11/15	1/14	12/15	2/13
7/16	9/14	8/16	10/15	9/16	11/15	10/16	12/15	11/16	1/15	12/16	2/14
7/17	9/15	8/17	10/16	9/17	11/16	10/17	12/16	11/17	1/16	12/17	2/15
7/18	9/16	8/18	10/17	9/18	11/17	10/18	12/17	11/18	1/17	12/18	2/16
7/19	9/17	8/19	10/18	9/19	11/18	10/19	12/18	11/19	1/18	12/19	2/17
7/20	9/18	8/20	10/19	9/20	11/19	10/20	12/19	11/20	1/19	12/20	2/18
7/21	9/19	8/21	10/20	9/21	11/20	10/21	12/20	11/21	1/20	12/21	2/19
7/22	9/20	8/22	10/21	9/22	11/21	10/22	12/21	11/22	1/21	12/22	2/20
7/23	9/21	8/23	10/22	9/23	11/22	10/23	12/22	11/23	1/22	12/23	2/21
7/24	9/22	8/24	10/23	9/24	11/23	10/24	12/23	11/24	1/23	12/24	2/22
7/25	9/23	8/25	10/24	9/25	11/24	10/25	12/24	11/25	1/24	12/25	2/23
7/26	9/24	8/26	10/25	9/26	11/25	10/26	12/25	11/26	1/25	12/26	2/24
7/27	9/25	8/27	10/26	9/27	11/26	10/27	12/26	11/27	1/26	12/27	2/25
7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27	12/28	2/26
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28	12/29	2/27
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29	12/30	2/28
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1



REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the Register weekly. There is a three-week turnaround period between a deadline date and the publication date of the Register. The weekly deadline dates and issue dates are shown below. Council meetings and Register deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements following publication of the notice in the Register.

Deadline Date (paper only) Friday, 5:00 p.m.	Register Publication Date	Oral Proceeding may be scheduled on or after
November 9, 2018	November 30, 2018	December 31, 2018
November 16, 2018	December 7, 2018	January 7, 2019
November 23, 2018	December 14, 2018	January 14, 2019
November 30, 2018	December 21, 2018	January 22, 2019
December 7, 2018	December 28, 2018	January 28, 2019
December 14, 2018	January 4, 2019	February 4, 2019
December 21, 2018	January 11, 2019	February 11, 2019
December 28, 2018	January 18, 2019	February 19, 2019
January 4, 2019	January 25, 2019	February 25, 2019
January 11, 2019	February 1, 2019	March 4, 2019
January 18, 2019	February 8, 2019	March 11, 2019
January 25, 2019	February 15, 2019	March 18, 2019
February 1, 2019	February 22, 2019	March 25, 2019
February 8, 2019	March 1, 2019	April 1, 2019
February 15, 2019	March 8, 2019	April 8, 2019
February 22, 2019	March 15, 2019	April 15, 2019
March 1, 2019	March 22, 2019	April 22, 2019
March 8, 2019	March 29, 2019	April 29, 2019
March 15, 2019	April 5, 2019	May 6, 2019
March 22, 2019	April 12, 2019	May 13, 2019
March 29, 2019	April 19, 2019	May 20, 2019
April 5, 2019	April 26, 2019	May 28, 2019
April 12, 2019	May 3, 2019	June 3, 2019
April 19, 2019	May 10, 2019	June 10, 2019
April 26, 2019	May 17, 2019	June 17, 2019
May 3, 2019	May 24, 2019	June 24, 2019
May 10, 2019	May 31, 2019	July 1, 2019
May 17, 2019	June 7, 2019	July 8, 2019
May 24, 2019	June 14, 2019	July 15, 2019
May 31, 2019	June 21, 2019	July 22, 2019



GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year-Review Reports and any adopted rule submitted to the Governor's Regulatory Review Council. Council meetings and Register deadlines do not correlate. We publish these deadlines as a courtesy.

All rules and Five-Year Review Reports are due in the Council office by 5 p.m. of the deadline date. The Council's office is located at 100 N. 15th Ave., Suite 402, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit <http://grrc.az.gov>.

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES FOR 2019

[M19-05]

DEADLINE FOR PLACEMENT ON AGENDA*	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
<i>Tuesday</i> January 22, 2019	<i>Tuesday</i> February 19, 2019	<i>Tuesday</i> February 26, 2019	<i>Tuesday</i> March 5, 2019
<i>Tuesday</i> February 19, 2019	<i>Tuesday</i> March 19, 2019	<i>Tuesday</i> March 26, 2019	<i>Tuesday</i> April 2, 2019
<i>Tuesday</i> March 19, 2019	<i>Tuesday</i> April 23, 2019	<i>Tuesday</i> April 30, 2019	<i>Tuesday</i> May 7, 2019
<i>Tuesday</i> April 23, 2019	<i>Tuesday</i> May 21, 2019	Wednesday May 29, 2019	<i>Tuesday</i> June 4, 2019
<i>Tuesday</i> May 21, 2019	<i>Tuesday</i> June 18, 2019	<i>Tuesday</i> June 25, 2019	<i>Tuesday</i> July 2, 2019
<i>Tuesday</i> June 18, 2019	<i>Tuesday</i> July 23, 2019	<i>Tuesday</i> July 30, 2019	<i>Tuesday</i> August 6, 2019
<i>Tuesday</i> July 23, 2019	<i>Tuesday</i> August 20, 2019	<i>Tuesday</i> August 27, 2019	Wednesday September 4, 2019
<i>Tuesday</i> August 20, 2019	<i>Tuesday</i> September 17, 2019	<i>Tuesday</i> September 24, 2019	<i>Tuesday</i> October 1, 2019
<i>Tuesday</i> September 17, 2019	<i>Tuesday</i> October 22, 2019	<i>Tuesday</i> October 29, 2019	<i>Tuesday</i> November 5, 2019
<i>Tuesday</i> October 22, 2019	<i>Tuesday</i> November 19, 2019	<i>Tuesday</i> November 26, 2019	<i>Tuesday</i> December 3, 2019
<i>Tuesday</i> November 19, 2019	<i>Tuesday</i> December 24, 2019	<i>Tuesday</i> January 7, 2020	<i>Tuesday</i> January 14, 2020
<i>Tuesday</i> December 24, 2019	<i>Tuesday</i> January 21, 2020	<i>Tuesday</i> January 28, 2020	<i>Tuesday</i> February 4, 2020

* Materials must be submitted by 5 PM on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.