

FINANCIAL IMPACT STATEMENT

DEPARTMENT	Department of Health
DIVISION	Health Facilities Services
PERSON COMPLETING THIS STATEMENT	Renee Mallory
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SHORT TITLE OF THIS RULE Rules and Regulations for Home Health Agencies

1. **Does this proposed, amended, or repealed Rule or Regulation have a financial impact?** No. It increases the time between surveys for well-functioning home health agencies.
2. **Please estimate the cost of compliance to regulated entities & others outside the department. Identify any financial impact on municipalities or counties.** None
3. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibitive, please explain.**
4. **If the purpose of this Rule or Regulation is to implement a federal Rule or Regulation, please give the incremental cost for implementing the Regulation.**
None

<u>2000-200 Fiscal Year</u>	<u>200 – 200 Fiscal Year</u>
General Revenue _____	General Revenue _____
Federal Funds _____	Federal Funds _____
Cash Funds _____	Cash Funds _____
Special Revenue _____	Special Revenue _____
Other _____	Other _____
Total _____	Total _____

5. **What is the total estimated cost by fiscal year to any entity or individual subject to the proposed, amended, or repealed Rule or Regulation?** None

<u>200 - 200 Fiscal Year</u>	<u>200 - 200 Fiscal Year</u>

6. **What is the total estimated cost by fiscal year to the agency to implement this Regulation?** None. Inspection surveys are already performed by the Division. The rule change diminishes the administrative burden on well-functioning agencies (those which have had no significant deficiencies, complaints or changes in management at or since the last survey).

<u>200 – 200 Fiscal Year</u>	<u>200 - 200 Fiscal Year</u>

7. **Does the Proposed Rule impose a cost on state or local school districts? No If yes, then file a fiscal impact statement.**

References: Act 884 of 1995, Ark. Code Ann. § 10-3-309
 Act 1104 of 1995, Ark. Code Ann. § 25-15-204
 Act 221 of 1977, Ark. Code Ann. § 19-1-302

**RULES AND REGULATIONS FOR
HOME HEALTH AGENCIES IN ARKANSAS
ARKANSAS DEPARTMENT OF HEALTH 2001
(Pursuant to Act 956 of 1987)**

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RULES AND REGULATIONS FOR
HOME HEALTH AGENCIES IN ARKANSAS
ARKANSAS DEPARTMENT OF HEALTH 2001
(Pursuant to Act 956 of 1987)

I

PREFACE

These rules and regulations have been prepared for the purpose of establishing a criterion for minimum standards for the licensure of Home Health Agencies in Arkansas that is consistent with current trends in patient care practices. By necessity they are of a regulatory nature but are considered to be practical minimal design and operational standards for these facilities. These standards are not static and are subject to periodic revisions in the future as new knowledge and changes in patient care trends become apparent. However, it is expected that facilities will exceed these minimum requirements and that they will not be dependent upon future revisions in these standards as a necessary prerequisite for improved services. Each Home Health Agency has a strong moral responsibility for providing optimum patient care and treatment for the patients it serves.

RULES AND REGULATIONS FOR HOME HEALTH AGENCIES IN ARKANSAS

AUTHORITY

The following Rules and Regulations for Home Health Agencies in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Act 956 of 1987.

III PURPOSE

In accordance with Act 956 of 1987, rules, regulations and minimum standards for home health programs operating in the State of Arkansas are hereby established. These rules will ensure high quality professional care for patients in their home by providing for the safe, appropriate care of all admitted to a home health program regardless of setting and shall apply to both new and existing agencies.

IV DEFINITIONS

The following word and terms, when used in these sections, shall have the stated meanings, unless the context clearly indicates otherwise:

1. **Administrator**-A person who is an agency employee and is a physician, registered nurse, or an individual with at least one year of supervisory or administrative experience in home health care or in related health provider programs.
2. **Assistance with Medication**-Ancillary aid needed by a patient to self-administer medication, such as reminding a patient to take a medication at the prescribed time, opening and closing a medication container, and returning a medication to the proper storage area. Such ancillary aid shall not include administration of any medication by injection, inhalation, or any other means, calculation of a patient's medication dosage, or altering the form of the medication by crushing, dissolving, or any other method.
3. **Branch Office**-A location or site from which a home health agency provides services within a portion of the total geographic area served by the primary agency. The branch office is part of the primary agency and is located sufficiently close (within a 50 mile radius) to share administrative supervision and services in a manner that renders it unnecessary to obtain a separate license as a home health agency. A branch office shall have at least one registered nurse assigned to that office on a full time basis.

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4. **Certified Agency**-A home health agency which holds a letter of approval signed by an official of the Department of Health and Human Services. The agency must be currently in compliance with the Conditions of Participation in the Social Security Act, Title XVIII.
5. **Clinical Note**-A dated, written or electronic and signed notation by agency personnel of a contact with a patient including a description of signs and symptoms, treatment and/or medication given, the patient's response, other health services provided, and any changes in physical and/or emotional condition.
6. **Clinical Record**-An accurate account of services provided for each patient and maintained by the agency in accordance with accepted medical standards.
7. **Contractor**-An entity or individual providing services for the agency who does not meet the definition of employee.
8. **Coordinating**-Bringing needed services into a common action, movement or condition of the health of the patient.
9. **Department**-The Arkansas Department of Health, Division of Health Facility Services.
10. **Director**-The Director of the Division of Health Facility Services-Arkansas Department of Health.
11. **Discharge Summary**-A recapitulation of all services provided by the home health agency before discharge of a patient.
12. **Division**-The Division of Health Facility Services of the Arkansas Department of Health.
13. **Employee**-Any individual for whom the agency is required to issue a form W-2.
14. **Geographic Area**-The land area, for which the agency shall be licensed, consisting of not more than a 50 mile radius surrounding the home health agency's primary or subunit location.
15. **Health**-The condition of being sound in body, mind and spirit, especially freedom from physical disease or pain.

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16. **Health Assessment**-A determination of a patient's physical and mental status performed by medical professionals.
17. **Home Health Agency**-Any person, partnership, association, corporation, or other organization, whether public or private, proprietary, or non-profit, that provides a home health service for pay or other consideration in a patient's residence.
18. **Home Health Aide/Personal Care Aide**-A person who provides personal care/personal services for a person in the home under the supervision of a registered nurse.
19. **Home Health Services**-The providing or coordinating of acute, restorative, rehabilitative, maintenance, preventive, or health promotion services through professional nursing or by other therapeutic services such as physical therapy, speech therapy, occupational therapy, medical social services, home health aide or personal services in a client's residence.
20. **Licensed Occupational Therapy Assistant**-A person who is currently licensed under the laws of Arkansas to use the title, Licensed Occupational Therapy Assistant.
21. **Licensed Physical Therapy Assistant**-A person who is currently licensed under the laws of Arkansas to use the title, Licensed Physical Therapy Assistant.
22. **Licensed Practical Nurse**-A person who is currently licensed under the laws of Arkansas to use the title, Licensed Practical Nurse.
23. **Maintenance**-To keep in an existing state.
24. **Medical Social Worker**-A person who is currently licensed under the laws of Arkansas as a social worker and who has a Master's Degree from a school accredited by the Council on Social Work Education and has one year of social work experience in a health care setting.
25. **Occupational Therapist**-A person who is currently licensed under the laws of Arkansas to use the title, Occupational Therapist Registered.
26. **Parent Agency**-The agency physically located within the state that develops and maintains administrative control of subunits and/or branches.

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27. **Patient Care Conference**-A documented conference among the home health agency staff or contractors providing care to a patient to evaluate patient care needs and the delivery of service.
28. **Personal Care**-Health related assistance in activities of daily living, hygiene and grooming for the sick or debilitated.
29. **Physical Therapist**-A person who is currently licensed under the laws of Arkansas to use the title, Registered Physical Therapist.
30. **Physician**-A person who is currently licensed under the Arkansas Medical Practices Act.
31. **Place of Business**-Any office of a home health agency that maintains home health service patient records or directs home health services. This shall include a suboffice, a branch office, or any other subsidiary location.
32. **Plan of Care**-A written plan which specifies scope, frequency and duration of services that is signed by a physician or podiatrist.
33. **Podiatric Medicine**-The diagnosis and medical, mechanical, and surgical treatment of ailments of the human foot.
34. **Podiatrist**-A person currently licensed by the Board of Podiatric Medicine to use the title, Podiatrist.
35. **Preventive**-To keep from happening or existing.
36. **Primary Agency**-The agency physically located within the state responsible for the service rendered to patients and for implementation of the plan of care.
37. **Psychiatric Nurse**-A registered nurse who is currently licensed under the laws of Arkansas and:
 - a. Has a Master's Degree in Psychiatric or Mental Health Nursing; or
 - b. Has a Baccalaureate Degree in Nursing with one year of experience in an active treatment unit in a psychiatric or mental health hospital or outpatient clinic; or mental health hospital or outpatient clinic; or

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- c. Has a Diploma or Associate Degree with two years experience in an active treatment unit in a psychiatric or mental hospital or outpatient clinic.

NOTE: Experience must have been within the last five years. If not, documentation must support psychiatric retraining or classes or CEUs to update psychiatric knowledge.

38. **Quality of Care**-Clinically competent care which meets professional standards, supported and directed in a planned pattern to achieve maximum dignity at the required level of comfort, preventive health measures and self management.
39. **Registered Nurse**-A person who is currently licensed under the laws of Arkansas to use the title, Registered Nurse.
40. **Rehabilitative**-To restore or bring to a condition of health or useful and constructive activity.
41. **Residence**-A place where a person resides, including a home, nursing home, residential care facility or convalescent home for the disabled or aged.
42. **Restorative**-Something that serves to restore to consciousness, vigor or health.
43. **Service Area**-The land area for which the agency shall be licensed, which shall be consistent with their Certification of Need (CON) or Permit of Approval (POA), if one is required, but in no case shall the service area consist of more than a 50 mile radius from the home health agency's primary or subunit location.
44. **Skilled Care Services**-Any service delivered by a health care professional requiring orders from a physician or podiatrist.
45. **Social Work Assistant**-A person who is currently licensed under the laws of Arkansas as a social worker.
46. **Speech-Language Pathologist**-A person who is currently licensed under the laws of Arkansas to use the title, Speech-Language Pathologist.

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47. **Subunit**-A semi-autonomous organization, which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision, and services on a daily basis with the parent agency and shall, therefore, independently meet the Conditions of Participation for home health agencies and/or shall independently meet the regulations and standards for licensure. A subunit may not have a branch office. The parent agency of the subunit shall be located and licensed within the state.
48. **Supervision**-Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity.

V

UNREGULATED AGENCY

- A. No person, partnership, association, corporation, or other organization, whether public or private, proprietary or nonprofit shall provide home health services in the State of Arkansas without a licensed fully operational physical location within the State. The authority is vested with the Director to determine if an agency is subject to regulation under the statute and is inherent in the responsibility to regulate agencies that are within the definitions of the Act.
- B. Personnel from the Department shall schedule an appointment with the person to determine whether the person is providing home health services. If the Director determines that a person is providing home health services, the person will be notified of the determination by certified mail and will be required to submit a claim for exemption in accordance with these rules within ten days of receipt of notice. If an agency does not prove an exemption, the entity must make arrangements for transfer of patients to an Arkansas licensed agency within 30 days.
- C. The Director shall notify the person by certified mail that the provision of home health service is unlawful without a home health service license. The Director may refer the case for injunctive relief to the Attorney General.

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VI EXEMPTIONS

- A. The Act exempts from its licensing requirements persons who hold other licenses or engage in certain limited activities. A person providing home health services, as defined in the Act, in addition to the limited activities for which an exemption would otherwise be available, shall obtain a license to provide the home health care services.

The following persons are not required to be licensed under Section 2 of Act 956 of 1987:

1. A physician, dentist, registered nurse, or physical therapist who is currently licensed under the laws of Arkansas who provides home health services only to a patient as a part of his or her private office practice and the services are incidental to such office practice;
2. The following health care professionals providing home health service as a sole practitioner: a registered nurse, a licensed vocational nurse, a physical therapist, an occupational therapist, a speech therapist, a medical social worker, or any other health care professional as determined by the department;
3. A non-profit registry operated by a national or state professional association or society of licensed health care practitioners, or a subdivision thereof, that operates solely as a clearinghouse to put consumers in contact with licensed health care practitioners who will give care in a patient's residence and that neither maintains the official patient records nor directs patient services;
4. An individual whose permanent residence is in the patient's residence;
5. An employee of a person holding a license under this Act who provides home health services only as an employee of the licensed person and who receives no benefit for providing home health services other than wages from the employer;
6. A home, nursing home, convalescent home, or other institution for the disabled or aged that provides health services only to residents of the home or institution;
7. A person who provides one health service through a contract with a person licensed;
8. A durable medical equipment supply company;

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9. A pharmacy or wholesale medical supply company that furnishes those services to persons in their homes that relate to drugs and supplies;
 10. A hospital or other licensed health care facility serving only inpatient residents: and
 11. A visiting nurse service or home aide service constructed by and for the adherents of a religious denomination for the purpose of providing service for those who depend upon spiritual means through prayer alone for healing.
- B. When there is a question about the subject of regulation status of a person, and the person claims exemption under the Act, the Director shall ask the person to make a written claim to the Department, citing the subsection of the Act under which exemption is claimed and including any and all documentation supporting the exemption claim.
- C. The Director shall evaluate the information received and determine if the person is exempt. The Director shall notify the person in writing upon the completion of the evaluation.

VII APPLICATION FOR LICENSE

- A. Any person, partnership, association, corporation or other organization, whether public or private, proprietary or nonprofit who supplies individuals to provide any of the services listed below shall be considered an agency.
- B. Agencies shall be required to obtain a license if the following services are provided to an individual in their home or place of residence. These services include:
1. Skilled Nursing Services;
 2. Physical Therapy Services;
 3. Occupational Therapy Services;
 4. Speech-Language Pathology Services;
 5. Medical Social Work Services;
 6. Home Health Aide Services;
 7. Personal Care Aide Services;

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8. Extended Care Services.
- C. Prior to applying for a license an agency shall obtain a Permit of Approval (POA), if applicable. Each agency must serve the area which is consistent with their Certificate of Need (CON) or POA. Any agency not required to obtain a POA shall not routinely serve greater than a 50 mile radius. Under conditional emergency circumstances an agency may be allowed to provide extended care to an individual patient who resides beyond a 50 mile radius based on approval by Health Facility Services, Arkansas Department of Health. (See requirements for Extended Care Services.)
- D. Application for temporary license shall be on forms prescribed by the Department and shall be for a period not to exceed six months.
- E. Annual license applications shall be on forms prescribed by the Department and shall be effective on a calendar year basis with an expiration date of December 31.
- F. 1. Each agency shall receive either a Class A or Class B license. If the agency is certified to participate in the Title XVIII Medicare program, a Class A license shall be issued. A class A agency shall meet the Conditions of Participation as a home health agency under Title XVIII of the Social Security Act and the regulations adopted thereunder (42 Code of Federal Regulations 405.1201 et seq), which regulations are adopted by reference herein for all purposes. Copies of the regulation adopted by reference in this section are indexed and filed in the Division of Health Facility Services, Arkansas Department of Health, 5800 West Tenth, Suite 400, Little Rock, Arkansas 72204, and are available for public inspection during regular working hours.
2. If the agency is not certified to participate in the Medicare program but provides home health services as defined by Act 956 of 1987 a Class B license shall be issued.
3. Any agency holding a Class A License may obtain a Derivative Class B license from the Department, provided that the agency holding said Class A license meets the licensing standards set forth in Act 956 of 1987 and the Rules and Regulations herein for Class B licensure. A Class B license so issued to the holder of a Class A license shall not be severed from the underlying Class A license **nor** separately extended into geographic areas apart from the class A service area.

A separate POA from the holder of a Class A license shall not be required by the Health Department in order to issue a Derivative Class B license.

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4. Each Class A or Class B license shall designate whether an agency provides the following categories of service: intermittent skilled care, extended care and/or personal care only.
 5. When a category of service is added the agency shall notify the Division of Health Facility Services of the intent. The Division shall then request from the agency the appropriate information needed to determine if the agency meets the regulatory requirements for the category of service being requested. Once this determination is made the Division shall make the appropriate changes to the license.
 6. If a category of service is being discontinued, the agency shall notify the Division. Notification must include information on how the agency will ensure appropriate transfer of patients.
 7. Each agency that is licensed Class A or Class B shall meet the General Requirements section of these regulations. According to services provided, agencies shall also be required to meet other sections as follows:
 - a. Skilled Care - General Requirements (Section XI), Skilled Care Services (Section XII);
 - b. Extended Care - General Requirements (Section XI), Skilled Care Services (Section XII), Extended Care Services (Section XIII);
 - c. Personal Care - General Requirements (Section XI), Personal Care Services (Section XIV).
 8. No license shall be issued to operate a subunit or branch whose primary agency is not located within the State of Arkansas.
- G. No license shall be transferred from one entity to another. If a person, partnership, organization or corporation is considering acquisition of a licensed agency, in order to insure continuity of patient services, the entity shall submit a license application at least 60 days prior to the acquisition for each place of business.
- H. No license shall be transferred from one location to another without prior approval from the Division as provided in this subsection. If an agency is considering relocation, the agency shall complete and submit a form provided by the Division 30 days prior to the intended relocation.

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1. A relocation shall be approved by the Division if the new location is within the existing service area.
 2. All other relocations shall not be approved, and the licensee shall submit a new application for a license.
- I. The agency shall notify the Division of any of the following:
1. Addition or deletion of services provided;
 2. Request to change license classification;
 3. Request to withdraw home health designation;
 4. Notification of termination of provision of home health services;
 5. If a Class A agency, notification of changes in certified status;
 6. Any change in telephone number;
 7. Any name changes in the agency within five working days after the effective date of the name change; and
 8. Address change.

VIII INSPECTIONS

- A. An onsite inspection shall determine if standards for licensure are being met before the initial license is issued. If an agency wishes to add an additional service category to an already existing license, the Department may determine if specific standards are met by mail or by an onsite visit.
- B. Agencies applying for licensure will receive an initial inspection. Subsequent inspections will be conducted on one year, two year or three-year survey cycles.
1. One year inspection cycles include:
 - a. Agencies licensed less than two years;

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- b. Agencies having a substantiated complaint since the last inspection; or
 - c. Agencies found to have deficiencies relating to patient care during the last inspection;
2. Two year survey cycles include:
- a. Agencies found to have deficiencies on the last inspection but were not placed on the one year inspection cycle;
 - b. Agencies having more than two complaints during a six month period or three complaints during a twelve month period; or
 - c. Agencies that have had a change of ownership or a significant change in management staff.

All other agencies will be placed on three-year survey cycles.

- C. If the inspection is conducted in order to determine compliance with standards, the agency shall come into compliance within 60 days. An onsite follow-up visit or a follow-up by mail shall be conducted to determine if deficiencies have been corrected. If the agency fails to comply, the Director may propose to suspend or revoke the license in accordance with the section relating to License Denial, Suspension, or Revocation.

IX DENIAL, SUSPENSION, REVOCATION OF LICENSE

- A. The Division may deny issuing a license to an agency if the agency fails to comply with these rules.
- B. The Division may suspend the license of an agency for one or more of the following reasons:
- 1. Violation of the provisions of the statute or of any of the standards in these rules;
 - 2. Misstatement of a material fact on any documents required to be submitted to the Division or requirements to be maintained by the agency pursuant to these rules;
 - 3. Commission by the agency or its personnel of a false, misleading, or deceptive act or practice;
 - 4. Materially altering any license issued by the Department.

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- C. The Division may revoke the license of an agency for one or more of the following reasons;
1. A repeat violation within a 12 month period which resulted in a license suspension;
 2. An intentional or negligent act by the agency or its employees which materially affects the health and safety of a patient.
- D. If the Director of the Division of Health Facility Services of the Department proposes to deny, suspend, or revoke a license, the Director shall notify the agency of the reasons for the proposed action and offer the agency an opportunity for a hearing. The agency may request a hearing within 30 days after the date the agency receives notice. The request shall be in writing and submitted to the Director, Division of Health Facility Services, Arkansas Department of Health, 5800 West Tenth, Suite 400, Little Rock, Arkansas 72204. A hearing shall be conducted pursuant to the Administrative Procedures Act. If the agency does not request a hearing in writing after receiving notice of the proposed action, the agency is deemed to have waived the opportunity for a hearing and the proposed action shall be taken.
- G. The Division may suspend or revoke a license to be effective immediately when the health and safety of patients are threatened. The Division shall notify the agency of the emergency action and shall notify the agency of the date of a hearing, which shall be within seven days of the effective date of the suspension or revocation. The hearing shall be conducted pursuant to the Administrative Procedures Act.

X BRANCH OFFICES

- A. The agency shall notify the Department in writing in advance of the plan to establish a branch office. Included in the notification shall be a description of the services to be provided (must be the same as the parent agency), the geographic area to be served by the branch office and a description of exactly how supervision by the parent agency will occur. All branch offices shall be subject to approval by the Division. Once the agency receives approval by the Division to establish the requested branch office the agency shall notify the Division of the branch office address, telephone number, and the name of the registered nurse supervisor.
- B. Onsite supervision of the branch office shall be conducted by the parent/primary agency at least every two months. The supervisory visits shall be documented and include the date of the visit, the content of the consultation, the individuals in attendance, and the recommendations of the staff. In addition, branch supervision shall include clinical record review of the branch records, inclusion in the agency's quality assurance activities, meetings with the branch supervisor, and home visits.

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- C. A full-time registered nurse shall be assigned to the branch office and shall be available during all operating hours. This person shall be an employee of the agency.
- D. All admissions shall be coordinated through the parent/primary agency and a current roster of patients shall be maintained by the parent agency at all times.
- E. A branch office shall offer the same services as those offered by the parent/primary agency.

XI GENERAL REQUIREMENTS

A. Operational Policies

1. The agency shall have a written plan of operation including:
 - a. Organizational chart showing ownership and lines of authority down to the patient care level;
 - b. The services offered, including hours of operation and lines of delegation of responsibility down to the patient care level;
 - c. Criteria for patient acceptance, referral, transfer and termination;
 - d. Evidence of direct administrative and supervisory control and responsibility for all services including services provided by branch offices;
 - e. An annual operating budget approved by the governing body;
 - f. Written contingency plan in the event of dissolution of the agency.
2. Policies shall be developed and enforced by the agency and include the following:
 - a. Orientation of all personnel to the policies and objectives of the agency;
 - b. Participation by all personnel in appropriate employee development programs, including a specific policy on the number of inservice hours that will be required for registered nurses, licensed practical nurses and aides;
 - c. Periodic evaluation of employee performance;

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- d. Personnel policies;
 - e. Patient care policies;
 - f. Disciplinary actions and procedures;
 - g. Job description (statement of those functions which constitute job requirements) and job qualifications (specific education and training necessary to perform the job) for each position with the agency; and
 - h. Infection control policies including the prevention of the spread of infectious and communicable diseases from agency personnel to clients.
3. A personnel record shall be maintained for each employee. A personnel record shall include, but not be limited to, the following: job description; qualification; application for employment; verification of licensure, permits, references, job experience, and educational requirements as appropriate; performance evaluations and disciplinary actions; and letters of commendation. All information shall be kept current. In lieu of the job description and qualifications for employment, the personnel record may include a statement signed by the employee that the employee has read the job description and qualifications for the position accepted.
4. It shall be the responsibility of the administration to establish written policies concerning pre-employment physicals and employee health. The policies shall include but not be limited to:
- a. Each employee shall have an up-to-date health file;
 - b. At a minimum, each employee shall be tested or evaluated annually for tuberculosis in accordance with the applicable section of the Tuberculosis Manual of the Arkansas Department of Health;
 - c. Work restrictions shall be placed on home health personnel who are known to be affected with any disease in a communicable stage or to be a carrier of such disease, to be afflicted with boils, jaundice, infected wounds, diarrhea or acute respiratory infections. Such individuals shall not work in any area in any capacity in which there is the likelihood of transmitting disease to patients, agency personnel or other individuals within the home or a potential of contaminating food, food contact surfaces, supplies or any surface with pathogenic organisms;
 - d. Other test shall be performed as required by agency policy.

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B. Governing Body

1. The governing body, or a committee designated by the governing body, of the agency shall establish a mechanism to:
 - a. Approve a quality assurance plan whereby problems are identified, monitored and corrected;
 - b. Adopt and periodically review written bylaws or an acceptable equivalent;
 - c. Approve written policies and procedures related to safe adequate services and operation of the agency with annual or more frequent review by administrative or supervisory personnel;
 - d. Appoint an administrator and approve a plan for an alternate in the absence of the administrator;
 - e. Oversee the management and fiscal affairs of the agency;
 - f. Approve a method of obtaining regular reports on participant satisfaction.
2. The governing board shall insure the agency has an administrator who is an employee of the agency or related institution to:
 - a. Organize and direct the agency's ongoing functions;
 - b. Maintain an ongoing liaison between the governing body and the personnel;
 - c. Employ qualified personnel and ensure appropriate ongoing education and supervision of personnel and volunteers;
 - d. Ensure the accuracy of public information materials and activities;
 - e. Implement a budgeting and accounting system; and
 - f. Ensure the presence of an alternate administrator to act in the administrator's absence.

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3. The governing board shall be responsible for ensuring the agency has a full-time supervising registered nurse to supervise clinical services. Full-time shall be according to established business hours of the agency. The administrator and supervising nurse may be the same individual.
4. If a licensed agency contracts with another entity for services, the governing body shall ensure that administration, patient management and supervision down to the patient care level are ultimately the responsibility of the licensed agency.

C. Services Provided by Contractors

An Arkansas licensed home health agency may contract to provide services in the licensed agency's service area provided that administration, patient management and supervision down to the patient care level are ultimately the responsibility of the licensed agency.

A written contract is required and must specify the following:

1. All referrals are through the primary agency and patients are accepted for care only by the primary agency;
2. The services to be provided;
3. The contracted entity conforms to all applicable agency policies, including personnel qualifications;
4. The primary agency is responsible for reviewing, approving and assuring the implementation of the plan of treatment;
5. The manner in which services will be controlled, coordinated and evaluated by the primary agency;
6. The procedures for submitting medical record documentation and scheduling of staff;
7. The procedure for how changes in the plan of treatment will be communicated between the two agencies; and
8. The procedures for determining charges and reimbursement.

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D. Quality Improvement

1. An agency shall adopt, implement and enforce a policy on a quality improvement program which provides for accountability and desired outcomes.
2. Those responsible for the quality improvement program shall:
 - a. Implement and report on activities and mechanisms for monitoring the quality of care;
 - b. Identify, and when possible, resolve problems; and
 - c. Make suggestions for improving care.
3. As part of the quality improvement program a clinical record review shall be conducted at least quarterly by appropriate professionals. A minimum of ten percent of both active and closed records shall be reviewed or a minimum of ten records per quarter if the case load is less than 99. The purpose of the clinical record review is to evaluate all services provided for consistency with professional practice standards for home health agencies and the agency's policies and procedures, compliance with the plan of care, the appropriateness, effectiveness and adequacy of the services offered, and evaluations of anticipated patient outcomes. Evaluations shall be based on specific record review criteria that are consistent with the agency's admission policies and other agency specific care policies and procedures.

E. Patient Rights

1. The agency shall provide each patient and family with a copy of the Bill of Rights affirming the patient's right to:
 - a. Be informed of the services offered by the agency and those being provided to the patient;
 - b. Participate in the development of the plan of care and to be informed of the dates and approximate time of service;
 - c. Receive an explanation of any responsibilities the participant may have in the care process;
 - d. Be informed of the name of agency and how to contact that agency during all hours of operation;

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- e. Be informed of the process for submitting and addressing complaints to the agency and be notified of the State Home Health Hotline number;
 - f. Be informed orally and in writing of any charges which insurance might not cover and for which the patient would be responsible;
 - g. Courteous and respectful treatment, privacy and freedom from abuse and discrimination;
 - h. Confidential management of participant records and information;
 - i. Access information in the participant's own record upon request; and
 - j. Receive prior notice and an explanation for the reasons of termination, referral, transfer, discontinuance of service or change in the plan of care.
2. The agency shall provide each patient and family with a written list of responsibilities affirming the patient's responsibility to:
 - a. Assist in developing and maintaining a safe environment;
 - b. Treat all agency staff with courtesy and respect;
 - c. Participate in the development and update of the plan of care;
 - d. Adhere to the plan of care or services as developed by the agency and to assist in the care as necessary.
- F. Advance Directives
1. The agency shall have written policies and procedures regarding advance directives.
 2. The agency shall inform and distribute written information to each patient on the initial evaluation visit concerning its policies on advance directives. Written information shall include notifying patients of their right to:
 - a. Make decisions about their medical care;
 - b. Accept or refuse medical or surgical treatment; and

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- c. Formulate, at the individual's option, an advance directive.
3. The agency shall document in the patient's medical record whether he or she has executed an advance directive.

G. Services Provided

All services shall be rendered and supervised by qualified personnel. An agency shall provide at least one of the following:

1. If nursing service is provided, a registered nurse shall be employed by the agency to supervise nursing care. A licensed practical nurse may only provide services under the supervision of a registered nurse. The administrator shall designate a registered nurse to serve as an alternate supervisor;
2. If physical therapy is provided, a registered physical therapist shall be employed by or under contract with the agency to provide services and/or supervision. A licensed physical therapy assistant may only provide services under the supervision of a registered physical therapist.
3. If occupational therapy service is provided, a licensed occupational therapist shall be employed by or under contract with the agency to provide services. A licensed occupational therapy assistant may only provide services under the supervision of a registered occupational therapist;
4. If speech-language pathology services are provided, a licensed speech-language pathologist shall be employed by or under contract with the agency to provide services and/or supervision;
5. If medical social work is provided, a licensed medical social worker shall be employed by or under contract with the agency. A social work assistant may only provide social services under the supervision of a licensed medical social worker;
6. If home health/personal care aide service is provided, a home health/personal care aide shall be employed by or under contract to provide home health aide services. The aide shall be supervised by a registered nurse at least every 62 days.

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H. Nursing Services

1. A registered nurse shall make the initial evaluation visit and initiate the plan of care and necessary revisions. The initial evaluation routinely must be performed within 72 hours of the initial referral or discharge from an inpatient facility.
2. A registered nurse shall regularly re-evaluate the patient's nursing needs. A visit to the patient's home by the registered nurse shall be conducted at least every 62 days and after each hospitalization.
3. The registered nurse and the licensed practical nurse shall prepare clinical notes and furnish services according to agency policy.
4. If a patient is under a psychiatric plan of care, a psychiatric nurse shall be available to make the initial evaluation visit, re-evaluate the patient's nursing needs at least every 30 days and complete clinical notes.

I. Physical Therapy Services

1. The registered physical therapist shall assist the physician in evaluating the level of function and help develop the plan of care (revising it as necessary). The initial evaluation shall be conducted within five working days of the referral or sooner if medical necessity dictates.
2. If a licensed physical therapy assistant is used, the registered physical therapist shall conduct a visit to the patient's home at least every 62 days to re-evaluate the patient's condition and supervise the licensed physical therapy assistant.
3. The registered physical therapist is responsible for discharge planning from physical therapy services and for communicating this plan to the patient.
4. The registered physical therapist and licensed physical therapy assistant shall prepare clinical notes and furnish services according to agency policy.

J. Occupational Therapy Services

1. The registered occupational therapist shall assist the physician in evaluating the level of function and help develop the plan of care (revising it as necessary). The initial evaluation shall be conducted within five working days of the referral or sooner if medical necessity dictates.

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2. If a licensed occupational therapy assistant is used, the registered occupational therapist shall conduct a visit to the patient's home at least every 62 days to re-evaluate the patient's condition and supervise the licensed occupational therapy assistant.
3. The registered occupational therapist is responsible for discharge planning from occupational therapy services and for communicating this plan to the patient.
4. The registered occupational therapist and the licensed occupational therapy assistant shall prepare clinical notes and furnish services according to agency policy.

K. Speech-Language Pathology Services

1. The licensed speech-language pathologist shall assist the physician in evaluating the level of function and help develop the plan of care (revising it as necessary). The initial evaluation visit shall occur within five working days of the referral or sooner if medical necessity dictates.
2. The licensed speech-language pathologist shall prepare clinical notes and furnish services according to agency policy.

L. Medical Social Services

1. The licensed medical social worker shall participate in evaluating the patient's need for services and in the development of the plan of care.
2. The licensed medical social worker shall supervise the social work assistant according to agency policy.
3. The licensed medical social worker and social work assistant shall prepare clinical notes and provide services according to agency policy.

M. Home Health Aide Services/Personal Care Aide Services

1. Each home health/personal care aide shall meet at least one of the following requirements:
 - a. Have at least one year of experience in an institutional setting (home health agency, hospital, hospice, or long-term care facility). This experience shall be verified by a previous employer;

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- b. Have a certificate issued by the State of Arkansas for working in long-term care facilities. A copy of this certificate shall be available for review;
- c. Have completed a 40 hour aide training course that meets the requirements set forth in these regulations.

NOTE: In lieu of the requirement for completion of the home health aide training course, a nursing student may qualify as a home health aide by submitting documentation from the Director of programs and/or the Dean of a School of Nursing that states that the nursing student has demonstrated competency in providing basic nursing care in accordance with the school's curriculum.

2. The agency is responsible for evaluating the competency of any aide who has not been employed as an aide in an institutional setting in the last 24 months. At a minimum, the aide shall be observed by a registered nurse performing the skills required to care for a patient including bathing, transferring, range of motion exercises, toileting, dressing, nail care and skin care. The registered nurse shall observe the aide performing these skills on a person. Any other tasks or duties for which the aide may be responsible may be evaluated by written test, oral test or observation. There shall be documentation by the agency to show evidence of this evaluation.
3. A registered nurse shall complete an aide assignment sheet for each patient receiving aide services. Each aide caring for the patient shall receive a copy of the assignment sheet and provide services as assigned. A copy of the assignment sheet shall be left in the patient's home.
4. Each aide assignment sheet shall be individualized and specific according to the patient's needs.
5. The registered nurse shall conduct a visit to the patient's place of residence at least every 62 days to supervise the aide and update the aide assignment sheet.
6. In no event shall a home health aide be assigned to receive or reduce to writing orders from a physician. A home health aide shall not perform any sterile procedure or any procedure requiring the application of medication requiring a prescription.
7. Upon a request by a patient and/or family member for assistance with medications, the registered nurse may assign a home health aide to assist with oral medications which are normally self-administered. Assistance shall be limited to reminding a patient to take a medication at a prescribed time, opening and closing a medication container and returning a medication to a proper storage area.

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8. Except as otherwise provided in these rules, duties of the home health aide may include:
 - a. Personal care: bathing, grooming, feeding, ambulation, exercise, oral hygiene, and skin care;
 - b. Assistance with medications ordinarily self-administered as assigned;
 - c. Household services essential to health care in the home;
 - d. Completion of records and reporting to appropriate supervisor;
 - e. Taking and charting vital signs;
 - f. Charting intake and output;
 - g. Extension of therapy services; and
 - h. Any duty consistent with the State Board of Nursing Regulations on Delegation of Duties may be assigned by a registered nurse to meet the individual needs of the patient.
9. If the training is provided by the agency, the training program for home health aides shall be conducted under the supervision of a registered nurse. The training program may contain other aspects of learning, but shall include the following:
 - a. A minimum of 40 hours of classroom and clinical instruction related particularly to the home health setting;
 - b. Written course objectives with expected outcomes and methods of evaluation; and
 - c. An assessment that the student knows how to read and write English and to carry out directions.
10. Course and clinical work content shall include, but not be limited to, bathing, ambulation and exercise, personal grooming, principles of nutrition and meal preparation, health conditions, developmental stages and mental status, household services essential to health care at home, assistance with medication, safety in the home, completion of appropriate records and reporting changes to appropriate supervisor.

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11. Aides shall receive a minimum of 12 hours of inservice training per 12 months. The inservices provided shall address areas that directly relate to the patient care aspects of the aide's job.

N. Records and Documentation

1. The home health agency shall maintain records which are orderly, intact, legibly written and available and retrievable either in the agency or by electronic means and suitable for photocopying or printing.
2. Records shall be stored in a manner which:
 - a. Prevents loss or manipulation of information;
 - b. Protects the record from damage; and
 - c. Prevents access by unauthorized persons.
3. Records shall be retained for a minimum of five years after discharge of the patient or two years after the age of majority.
4. Each record shall include:
 - a. Appropriate identifying information;
 - b. Initial assessment (performed by a registered nurse or therapist). If the agency is unable to perform the initial evaluation for physical therapy, occupational therapy or speech-language pathology in the required time frame, the reason for the delay shall be documented. If delays are due to the agency not having the staff to perform the initial evaluation and/or provide services, there shall be documentation to show the patient and the physician were notified of the delay and were given an estimated date when services would begin. The patient and physician shall also be informed of other agencies in the area available to provide the ordered services.
 - c. Plan of care (which shall include as applicable, medication, dietary, treatment, activities).
 - d. Clinical notes; and
 - e. Acknowledgment of receiving information regarding advance directives.

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5. The following shall be included, if applicable;
 - a. Physician and/or podiatrist order;
 - b. Records of supervisory visits;
 - c. Medication administration records;
 - d. Records of case conferences; and
 - e. Discharge summary.
 6. Clinical notes are to be written the day the service is rendered and incorporated into the record no less often than every 14 days.
 7. Provisions shall be made for the protection of records in the event an agency ceases operation.
- O. Discharge Planning
1. There shall be a specific plan for discharge in the clinical record and there must be ongoing discharge planning with the patient.

P. Complaints

Each agency shall keep a record of complaints received. Documentation shall be kept on each complaint regarding the name of the complainant, the relationship to the patient (if applicable), the nature of the complaint, and the action taken to resolve the complaint.

XII STANDARDS FOR SKILLED CARE SERVICES

In addition to meeting the General Requirements, agencies providing skilled care shall meet the following:

A. Acceptance of Patients

1. Agencies shall only accept patients for treatment on the basis of a reasonable expectation that the patient's needs can be met adequately by the agency in the patient's place of residence.

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2. If an agency receives a referral on a patient who requires home health services that are not available at the time of referral, the agency shall contact the referral source and/or the patient's physician to let them know the situation. The agency shall only admit the patient if no other agency licensed in the area has the service(s) available.

B. Care and Services

1. An initial assessment shall be completed in the patient's residence by an employee of the agency who has completed orientation/training in the initial assessment procedures of the agency and has demonstrated competency in the performance of these skills. The initial assessment shall be completed by a registered nurse or licensed therapist, as appropriate.
2. At the time of the admission, the plan of care shall be developed in conjunction with the patient and/or family and the appropriate health care professional.
3. The plan of care shall include potential services to be rendered; the frequency of visits and/or hours of service, assignment of health care providers and the estimated length of services. The plan of care shall be revised at least every 62 days. The plan of care shall be individualized according to each of the individual patient's needs.
4. The plan of care and each verbal order obtained shall be signed by the physician or podiatrist within 30 days of the of the order.
5. Case conferences shall be held at least every two months on each patient. The clinical record or minutes of these case conferences shall reflect input by the disciplines providing care to the patient.
6. For patients receiving extended care nursing services, a current medication administration record shall be maintained and incorporated into the clinical record. Notation shall be made in the clinical notes of medications not given and reason. Any untoward action shall be reported to the supervisor and documented.
7. The clinical record shall include documentation of medication allergies or sensitivities and medication interactions. There must be a medication profile, including the dose, frequency and route of administration for each prescription medication the patient is receiving.

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C. 24 Hour Availability

1. If an agency provides 24 hour availability, the agency shall have a registered nurse available after hours. When an agency provides extended care, the agency shall provide 24 hour coverage and availability. A licensed practical nurse may take initial call and perform services as ordered on the plan of care. Any services outside the plan of care must be approved by a registered nurse prior to the services being rendered.
2. If 24 hour availability is provided, the agency shall have a policy describing at least the following:
 - a. How patients will contact the agency after hours; and
 - b. How the agency will ensure the registered nurse on call has access to all current patient information.
3. If 24 hour availability is not offered by the agency, the agency shall be responsible for assuring each patient is aware of the steps to take in an emergency or unusual situation.

D. Controlled Drugs

1. Agencies shall have a written policy stating how controlled drugs will be monitored if agency staff transports the drugs from the pharmacy to the patient.
2. If controlled drugs are being administered by the agency, there shall be a policy regarding how the drugs will be administered and monitored.

XIII

STANDARDS FOR EXTENDED CARE SERVICES

Extended Care is defined as six or more hours of continuous home health services provided in a 24 hour period, by a licensed agency which provides both skilled nursing and other home health services. (Medicaid Personal Care is not included in the above definition.)

In addition to meeting the applicable standards for Class B license, all agencies providing extended care must meet the following:

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- A. Shall make available in writing the hours of service and provide a registered nurse supervisor or a registered nurse and supervisor for consultation and triage at least during those hours. The agency shall be responsible for assuring that each patient, or guardian if the patient is mentally incompetent, is aware of the steps to take in an emergency or unusual situation. The agency must have a contingency plan regarding how the case is managed if a scheduled employee is unable to staff the case;
- B. The patient's permanent medical record shall be available at the licensed agency location that has been approved by the Division to provide the services;
- C. A medical record must also be maintained in the home if a patient is receiving skilled extended care.
 - 1. The record must contain:
 - a. Current plan of treatment (physician's orders);
 - b. Medication profile;
 - c. Clinical notes;
 - d. Documentation of any medication administered by agency staff including the date, time, dosage and the manner of administration;
 - e. Any other information deemed necessary by the licensed agency.
 - 2. The information included in the home record must be filed in the permanent medical record at least every two weeks if it is not already included in the permanent record.
 - 3. If extended care aide service is the only service being provided, a home record is not required. Written instructions for the aide service must be maintained in the home and in the permanent record;
- D. For patients receiving skilled extended care, a visit must be made to the patient's home by a registered nurse, who is an employee of the licensed agency, no less frequently than every two weeks to supervise the services being provided. Patients requiring extended care services beyond three months and classified by the licensed agency as chronic/stabilized will require supervision once every month.

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For patients receiving extended care aide services only, the aide must be continually supervised and a visit must be made to the patient's home by a registered nurse at least every 30 days;

- E. The agency must have an orientation plan for the staff providing the care to the patients. Since extended care cases may involve highly technical services, this plan must reflect how the agency ensures that the individuals providing the extended care are qualified to provide these types of services;
- F. **Contracting for Extended Care Services**
An Arkansas licensed home health agency may contract with another entity to provide extended care in the licensed agency's service area provided that administration, patient management and supervision down to the patient care level is ultimately the responsibility of the licensed agency.

A written contract is required and must specify the following:

1. All referrals are through the primary agency and patients are accepted for care only by the primary agency;
2. The services to be provided;
3. The contracted entity conforms to all applicable agency policies, including personnel qualification;
4. The primary agency is responsible for reviewing, approving and assuring the implementation of the plan of treatment;
5. The manner in which services will be controlled, coordinated and evaluated by the primary agency;
6. The procedures for submitting medical record documentation and scheduling of staff;
7. The procedure for how changes in the plan of treatment will be communicated between the two agencies;

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G. Conditional Emergency Service

Notwithstanding the provisions of these Rules and Regulations, the Division of Health Facility Services shall be empowered to permit the provision of extended care to one or more individuals by any licensed extended care provider where such provider:

1. Certifies that the patient requires conditional emergency services which shall be defined as; a medically indicated skilled extended care case in which the patient requires specialized care of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, not available through licensed agencies in the area and which, if not provided, would result in the patient being institutionalized;
2. Furnishes such information on forms prescribed by the Department regarding the patients receiving conditional emergency services that would include but not be limited to:
 - a. Name of patient;
 - b. Address of the patient;
 - c. Diagnosis;
 - d. The type of specialized skilled extended care the patient requires and why the patient would require institutionalization if the care was not provided;
3. Furnishes information to the Department ensuring that all agencies whose extended care licensed area encompasses the location of the patient were contacted to determine if the required services could be provided. Such information should include the name of the agency contacted, the name of the person contacted, the date and time of the contact, and the reason given for not being able to provide the care. If the agency contacted does not respond with an answer within 24 hours of the initial contact the agency seeking to provide the services may proceed as required. The lack of response should be noted in the information furnished to the Department.

In each case the Division of Health Facility Services shall maintain a file or register concerning the Conditional Emergency Service and notify both the Health Services Agency and any licensed providers whose extended care geographical area includes the location of the service.

The approval will be for a period of 180 days. For each consecutive 180 day period thereafter, the agency will be required to submit documentation as required in G.

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If, at the end of each 180 day period services are available through an agency licensed for the area, the agency providing the service must notify the patient/caregiver of the availability of services through a licensed agency in the area and offer the opportunity to transfer.

The choice of transfer shall be the patient/caregiver's decision.

An agency operating outside their licensed service area must provide documentation to the Department at the beginning of each 180 day period that the patient was informed of any new agencies providing extended care services in the area and was given the choice of transferring. The information shall be submitted on forms prescribed by the Department.

An agency operating outside their licensed geographic area to provide extended care may provide all services required by the patient until such time the skilled extended care is discontinued or the patient is transferred to an agency licensed to provide extended care services in the area. The discharging agency will be responsible for referring the patient to an agency licensed to serve the area in which the patient resides if the patient requires further service.

XIV

STANDARDS FOR PERSONAL CARE SERVICES

- A. The registered nurse shall perform an initial evaluation visit within five days of a specific request for personal care aide services.
- B. If the agency cannot perform an initial evaluation visit within five days of a specific request for services, there shall be documentation regarding the reason, the anticipated date the evaluation will be conducted, and notification of the patient regarding when the evaluation will be performed.
- C. If the agency does not have services available at the time of the initial evaluation, the agency shall explain this to the patient. If the agency cannot staff the case within two weeks of the initial evaluation, the agency shall be responsible for contacting other agencies in the area to determine if services are available. If another agency can provide the services in a shorter length of time, the patient shall be informed and given the choice of changing agencies.
- D. If an aide misses a scheduled visit, there shall be documentation that the patient was contacted prior to the missed visit. Every attempt shall be made to send a substitute aide to provide the care.

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- E. For individuals receiving personal care services only, the agency is not required to have the plan of care signed by a physician, unless otherwise required by other agencies or laws. However, a plan of care shall be developed outlining the scope, frequency and duration of services.
- F. If care is ordered per hour, the aide shall document the time the aide arrived at the home and the time the aide departed.
- G. Each aide shall document each visit the tasks that were performed. If a task is not completed that is specifically ordered on the aide assignment sheet, there shall be a documented reason why. Patient care problems noted by the aide during the course of care shall be reported to the registered nurse.
- H. The registered nurse shall make a visit to each patient's home at least every 62 days to supervise aide services. A registered nurse shall be available for consultation during operating hours.

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CERTIFICATION

This will certify that the foregoing revisions to the Rules and Regulations for Home Health Agencies in Arkansas were adopted by the State Board of Health of Arkansas at a regular session of said Board held in Little Rock, Arkansas, on the 25th day of January, 2001.

Fay W. Boozman, M.D.
Secretary of Arkansas State Board of Health
Director, Arkansas Department of Health

Dated at Little Rock, Arkansas, this 5th day of February, 2001.

The forgoing Rules and Regulation, copy having been filed in my office, are hereby approved on this 12th day of February, 2001.

Mike Huckabee
Governor