CHAPTER 33-03-10.1
HOME HEALTH AGENCIES

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33-03-10.1-01. Definitions.

The following definitions, in addition to the definitions in North Dakota Century Code section 23-17.3-01, apply to this chapter:

1. "Agency" means home health agency.

2. "Branch" means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located close enough to share administration, supervision, and services.

3. "Clinical note" means a notation of a contact with a patient that is written and dated by a member of the health care team and that describes signs and symptoms, treatment and drugs administered and the patient's reaction, and any changes in physical or emotional condition.

4. "Companion services" includes staying or traveling with a patient and may include provision of guided maneuvering or nonweight bearing assistance.

5. "Department" means the state department of health.

6. "Governing body" means the individual or group in whom the ultimate authority and legal responsibility is vested for the conduct of the agency.

7. "Homemaker services" include preparing meals, shopping, assistance with bill paying, housework, laundry, transportation, communication, and mobility outside the patient's residence.

8. "Parent" means the agency office that develops and maintains administrative control of the branch offices.

9. "Progress notes" means a written notation, dated and signed by a member of the health care team, which summarizes facts about care furnished and the patient's response during a given period of time.

10. "Supervised practical training" means training in a laboratory or other setting in which the home health aide trainee demonstrates tasks on an individual under the direct supervision of a registered or licensed practical nurse.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-01, 23-17.3-08

33-03-10.1-02. Conflict with federal requirements.

If any part of this chapter is found to conflict with federal requirements, the more stringent shall apply. Such a finding or determination shall be made by the department and shall not affect the remainder of this chapter.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-08

33-03-10.1-03. Application, issuance, and renewal of license.

An entity meeting the definition of home health agency in North Dakota Century Code section 23-17.3-01 must obtain a license from the department to operate in North Dakota. A person or entity may not establish or operate an agency or use the terms home health agency or home health services without first having obtained a license.

1. Any person or entity who desires to maintain and operate an agency shall apply to the department for a license in the form prescribed and shall obtain an initial license before accepting patients for care or treatment.

   a. The department shall not approve an application for initial license unless:

      (1) The application and all required attachments and statements submitted by the applicant meet the requirements of this chapter. A description of all services provided and the geographic areas to be served by agency staff must be included.

      (2) The department has conducted an inspection or investigation of the agency to determine compliance with this chapter.

      (3) The department has completed an investigation into the fitness of the applicant and determined the applicant to be fit based on the following:

         (a) Evidence provided by the applicant which identifies that financial resources and sources of revenue for the applicant's agency appear adequate to provide the staff and services sufficient to comply with North Dakota Century Code chapter 23-17.3 and this chapter;

         (b) The applicant has furnished the department with a signed and notarized statement describing and dating every proceeding, within five years of the date of application, in which the applicant was involved which resulted in a limitation, suspension, revocation, or refusal to grant or renew an agency license or a medicare or medicaid decertification action; and

         (c) The applicant shall furnish a signed and notarized statement to the department describing every criminal proceeding within five years of the date of the application in which the licensee or any of its shareholders owning interest of five percent or more officers, directors, partners, or other controlling or

managing persons, has been convicted or nolo contendere plea accepted, of a criminal offense related to the operation or ownership of an agency.

b. The initial license is valid for a period not to exceed one year and expires on December thirty-first of the year issued.

2. The department shall issue a renewal license when an agency is in compliance with the provisions of these licensing requirements, as determined by periodic unannounced onsite surveys conducted by the department and other information submitted by the agency upon the request of the department. Renewal licenses shall expire on December thirty-first of each year. The application for renewal must be received by the department with sufficient time to process prior to the beginning of the licensure period.

3. In the case of an agency or operators of a preexisting agency which has had its license suspended or revoked or denied, the applicant shall submit with the request for relicensure sufficient justification to indicate the reasons for the suspension, revocation, or denial no longer exist, reasonable assurance that they will not recur, and evidence that all licensure requirements are met.

4. The department shall require an applicant or licensee to disclose the name, address, and official position of all persons who have a five percent or more ownership interest in the agency.

5. The department may issue a provisional license, valid for a specific period of time not to exceed ninety days. A provisional license may be issued when the department has determined there are one or more serious deficiencies or a pattern of repeat deficiencies related to compliance with these licensing requirements.

   a. A provisional license may be renewed at the discretion of the department, provided the licensee demonstrates to the department that it has made progress towards compliance and can effect compliance within the next ninety days. A provisional license may be renewed one time.

   b. When an agency operating under a provisional license notifies the department that it has corrected its deficiencies, the department will ascertain correction. Upon finding compliance, the department shall issue a renewal license.

6. When a subdivision of an agency, for example, the home care department of a hospital, applies for a license, the subdivision rather than the parent organization must be licensed as an agency and maintain records in such a way that subdivision activities and expenditures attributable to services provided are identifiable. The parent organization may determine who signs the agreement and other documents and receive and disburse funds.

7. If one or more branch offices are operated under the same management, the branch offices will be licensed under the parent agency's license.

8. Each license is valid only in the hands of the entity to whom it is issued and is not subject to sale, assignment, or other transfer, voluntary or involuntary, nor is a license valid for any agency other than those for which originally issued. The license must be displayed in a conspicuous place within the agency.

9. The agency shall notify the department in writing at least thirty days in advance of any of the following changes:

   a. Transfer or change of ownership.

b. Transfer of operating rights, including a lease of the agency where the lessor retains no control of the operation or management of the agency.

c. Change in the name of the agency.

d. A service is added or deleted.

e. A change in the geographic area served.

10. The agency shall notify the department in writing within thirty days of a change in administrative staff as identified on the annual licensure application or the nurse executive.

11. Upon discontinuance of the operation or transfer of ownership of an agency, the license must be returned to the department.

12. Existing agencies subject to this chapter which are already in operation on January 1, 1998, will be given a reasonable time, not to exceed May 1, 1998, within which to comply with the rules, regulations, and standards provided for herein.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-02, 23-17.3-08
Law Implemented: NDCC 23-17.3-02, 23-17.3-04, 23-17.3-05, 23-17.3-08

33-03-10.1-04. Inspection by the department.

The department may evaluate an agency's compliance with this chapter at any time through:

1. An announced or unannounced onsite review, including inspection and examination of all agency records and documents required by this chapter, interview with agency staff, and home visits with the patient's permission; or

2. A request for submission of written documentation verifying compliance.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-04, 23-17.3-08, 23-17.3-09

33-03-10.1-05. Plan of correction.

1. An agency shall submit to the department a plan of correction addressing the areas of noncompliance with the licensure requirements of this chapter.

2. A plan of correction must include:

   a. How the corrective action will be accomplished for those patients found to have been affected by the deficient practice;

   b. How the agency will identify other patients or services in the agency having the potential to be affected by the same deficient practice;

   c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and

   d. How the agency will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

3. A plan of correction is required within ten calendar days of the receipt of the deficiency statement and is subject to acceptance, acceptance with revisions, or rejection by the

department. Failure to submit an acceptable plan of correction may result in a directed plan of correction.

4. Corrections must be completed within sixty days of the survey completion date, unless an alternative schedule of correction has been specified by the department.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-04, 23-17.3-08

33-03-10.1-06. Enforcement.

1. Agencies are subject to one or more enforcement actions, which may include suspension or revocation of a license or a denial to license for the following reasons:

   a. Noncompliance with the licensure requirements in this chapter has been identified which:

      (1) Presents imminent danger to patients;

      (2) Has a direct or immediate relationship to the health, safety, or security of the agency's patients;

      (3) If left uncorrected, has a potential for jeopardizing patient health or safety; or

      (4) Is a recurrence of the same or substantially same violation in a twenty-four-month period.

   b. Failure to correct any deficiency pursuant to a plan of correction or directed plan of correction, unless the department approves in writing an extension or modification of the plan of correction.

   c. Gross incompetence, negligence, or misconduct in operating the agency as determined through department investigation or through a court of law.

   d. Fraud, deceit, misrepresentation, or bribery in obtaining or attempting to obtain a license.

   e. Lending, borrowing, or using the license of another agency.

   f. Knowingly aiding or abetting in any way the improper granting of a license.

2. Conditions or practices that the department has determined to present imminent danger to patients receiving services from the agency must be abated or eliminated immediately or within a fixed period of time as specified by the department.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07

33-03-10.1-07. Order and notice of order.

1. Upon a determination that the circumstances make imposition of a sanction appropriate, the department shall issue a written order identifying the violations and the sanction imposed. A copy of the order must be sent by registered mail, return receipt requested, to the agency's owner, the agency's administrator, or head of the agency's governing body. The order must specify the terms or conditions under which the sanction will be terminated. The order must also advise the agency of the right to seek reconsideration.

2. When an agency has been subjected to a sanction, the department may notify, as appropriate, applicable professional licensing agencies, boards of registration or licensure, and federal, state, or county agencies of the circumstances and sanctions imposed.

3. When an agency has been subjected to a sanction, the department shall notify the county social service board of each county where the agency provides services. Each county social service board so notified shall post, in a prominent place within the office, the name and address of the agency and the sanction. The posting must remain in place for the entire period of any sanction other than closure or termination from the program and for the first ninety days of closure or termination.

4. When an agency has been subjected to a sanction, the agency shall place notices of the sanction, supplied by the department at all agency entrances and exits. The department may also require the agency to purchase space in the print media to achieve public dissemination of information concerning any sanction.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07, 23-17.3-08

33-03-10.1-08. Request for reconsideration.

1. Within ten days after receipt of the order, the agency may request reconsideration by the department. Within fifteen days after receipt of a request for reconsideration, the department shall grant or deny the request for reconsideration and may suspend the imposition of any sanction pending the decision on the reconsideration.

2. A request for reconsideration, in any event, must be denied unless it identifies, with specificity, each disputed violation and states the factual basis for its contention that the violation was erroneously determined. The correction of the factors that led to the determination of a violation may not be asserted as a basis for reconsideration.

3. If the department denies the request for reconsideration, the department shall notify the agency in writing of that decision. If the denial was for any reason other than a failure of the request to conform to the requirements of subsection 2, the notice must advise the agency of the right to appeal.

4. If the department determines to undertake the reconsideration, the decision on reconsideration must be rendered within forty days after the issuance of the order. The notice of the decision on reconsideration must advise the agency of the right to appeal.

5. If the agency fails to file a timely request for reconsideration which conforms to the requirements of subsection 2, the order is final in all respects, and no further administrative or judicial review is applicable.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07, 23-17.3-08

33-03-10.1-09. Appeals.

1. An agency dissatisfied with a decision on a timely request for reconsideration, which conforms to the requirements of subsection 2 of section 33-03-10.1-08, may appeal. An appeal may be perfected by mailing or delivering the information described in subdivisions a through d, to the department, state capitol, Bismarck, North Dakota, so that the mailed or delivered material arrives at the office of the division of health facilities on or before 5:00 p.m. on the thirty-first day after the date of the determination the department made with respect to a request for

reconsideration. An appeal under this section is perfected only if accompanied by written documents, including all of the following information:

a. A copy of the notice received from the department advising of the department's decision on the request for reconsideration;

b. A statement of each disputed violation and the reason or basis in fact for the dispute;

c. The authority in statute or rule upon which the appealing party relies for each disputed item; and

d. The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

2. Except as otherwise provided in this section, the appeal must be considered as provided in article 98-02.

3. The dispositive issue on appeal must be whether the violation occurred, not whether the violation has been corrected.

4. The hearing officer must make written findings of fact and conclusions of law, and must recommend a decision to the department. The recommended decision must set forth the reasons for the decision and the evidence upon which the decision is based.

5. The department may accept, modify, or reject the recommended decision. If the department rejects the recommended decision, it may remand the matter to the office of administrative hearings with directions. The department, through its directions, may require the receipt of additional evidence, and the submission of amended findings of fact, conclusions of law, and recommended decision which reflect consideration of additional evidence. The department, through its directions, may require that the matter be referred to the same or a different hearing officer and the office of administrative hearings shall comply with that direction unless compliance is impossible.

6. An appeal may not suspend or delay the imposition of a remedy under this chapter.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-07, 23-17.3-08

33-03-10.1-10. Governing body.

The governing body is legally responsible for the quality of patient care services; for patient safety and security; for the conduct, operation, and obligations of the agency; and for ensuring compliance with all federal, state, and local laws. Contracts, arrangements, or other agreements may not limit the responsibility of the governing body in any way. The governing body shall:

1. Have bylaws or the equivalent, which shall be reviewed annually and be revised as needed. They must be made available to all members of the governing body. The bylaws or equivalent must specify the duties and responsibilities of the governing body.

2. Approve an overall plan and budget for the agency which includes an annual operating budget and capital expenditure plan.

3. Provide and maintain an office facility adequately equipped for efficient work and which provides a safe working environment in compliance with local ordinances and fire regulations.

4. Employ a qualified administrator who is designated in writing as administratively responsible and available for all aspects of agency operation including the employment of qualified staff, accuracy of public information, and implementation of the budget.

    a. A qualified administrator is:

        (1) A licensed physician, registered nurse, or college graduate with a bachelor's degree who has a minimum of three years of health care management; or

        (2) A person without a college degree may qualify by obtaining the equivalent of six years of supervisory experience in health care management.

    b. The administrator and nurse executive may be the same individual if the individual is dually qualified.

    c. The administrator must identify in writing an individual who is qualified and authorized to act in place of the administrator when the administrator is not available.

5. Organize agency services to ensure quality of patient care. An organizational chart, from the governing body to the patients, with a written description of the organization, authorities, responsibilities, accountabilities, and relationships must be maintained which must include:

    a. A description of each service offered;

    b. Policies and procedures pertaining to each service;

    c. Job descriptions for each discipline; and

    d. A description of the system for maintenance of patient records.

6. Ensure the development, implementation, review and revision of policies and procedures as changes in standards of practice occur. All policies and procedures must be reviewed at a minimum of every three years and must include the following:

    a. Operation and administration of the agency, including:

        (1) Provision of therapeutic and supportive services under the direction of a physician or registered nurse.

        (2) Acceptance of only patients for whom they can provide the needed services. Acceptance is based on medical, nursing, and social information provided by the patient's physician, the facility the patient is being discharged from, and the staff of the agency, as applicable.

        (3) Provision of services to patients consistent with the treatment plan established, signed, and regularly reviewed by the physician responsible for the patient's care. Supportive services may be provided, without a physician's order, consistent with the care plan established, signed, and regularly reviewed by the registered nurse when therapeutic services are not needed by the patient.

        (4) When therapeutic services are ordered, the total plan of care shall be reviewed by the patient's physician at such intervals as the patient's condition requires, but no less than once every two months. Verbal authorization to change the plan of treatment shall be reviewed and signed by the physician consistent with agency policy.

        (5) Availability of services to patients regardless of age, sex, religion, or ethnic background.

(6) Clinical records that are accurate, concise, and consistent with current medical records standards of practice must be maintained for each patient which cover the services the agency provides directly or through arrangement, and contain pertinent past and current medical, nursing, and social information including the plan of treatment and care.

(7) A means to ensure all records must be maintained in a confidential manner.

(8) A means to report, investigate, and document action taken on grievances, including follow-through with the patient or the patient's family.

b. Personnel records that include the following documentation:

(1) Checking of state registries and licensure boards prior to employment for findings of inappropriate conduct, employment, disciplinary actions, and termination;

(2) Job descriptions;

(3) Orientation records;

(4) Training and education records;

(5) Disciplinary action records;

(6) Verification of current licensure or registration status, if applicable;

(7) Documentation of annual performance reviews; and

(8) Documentation of competency evaluation of home health aides, at a minimum, every two years.

c. Notification of each patient in writing of the patient's rights during the initial evaluation visit prior to the initiation of treatment. Patient rights, at a minimum, include the right to:

(1) Be given care without discrimination as to race, color, creed, sex, age, or national origin.

(2) Exercise the person's right as a patient of the agency. If the patient has been judged incompetent, the patient's family or guardian may exercise the patient's rights.

(3) Choose care providers and the right to communicate with those providers.

(4) Be fully informed of the patient's medical condition and to have access to the patient's medical record.

(5) Be informed, in advance, about the care to be furnished and any changes in the care to be furnished, the disciplines that will furnish the care, the frequency of visits proposed, any changes in the plan of care before the change is made, and of the patient's right to participate in planning the care and planning any changes in the care.

(6) Refuse care and to be informed of possible health consequences of this action.

(7) Be provided information regarding advanced directives prior to the initiation of treatment.

(8) Be informed of the need for transfer, referral, or discharge from the agency.

(9) Be treated with dignity, privacy, respect, and consideration as well as freedom from abuse, neglect, or misappropriation of the patient's property.

(10) Voice grievances regarding treatment or care that is, or fails to be, furnished or regarding lack of respect for property by anyone who is furnishing services on behalf of the agency and to not be subjected to discrimination or reprisal for doing so.

(11) Confidentiality regarding the patient's medical condition and medical records.

(12) Advise, before care is initiated, of the extent to which payment for agency services may be expected from Medicare, Medicaid, or other sources and the extent to which payment may be required from the patient. The patient must also be informed orally and in writing of any changes in payment sources no later than thirty calendar days after the agency becomes aware of the changes.

(13) Use of the toll-free hotline established by the department to receive complaints or questions about local agencies and the hours of operation of the hotline.

7. Ensure there is a written agreement or contract in place and signed by both parties when arranging for services from individuals not employed directly by the agency or from other agencies.

a. The written agreement or contract must at a minimum state the following:

(1) Patients may be accepted for care only by the agency;

(2) The specific service to be provided;

(3) The period of time the contract is in effect;

(4) The availability of the service;

(5) Financial arrangements;

(6) Verification that any individual providing service is appropriately licensed or registered as required by state statute or regulation;

(7) Provisions for supervision of contract personnel where applicable;

(8) Assurance that individuals providing services under contractual arrangements meet the same requirements as those specified for agency personnel;

(9) Provision for the documentation of services rendered in the patient's record;

(10) Provision for the sharing of assessment and plan of care data;

(11) The geographic area the contractor agrees to serve;

(12) Specify that only the contracting agency shall bill for services provided under the written agreements and collect the applicable payments pertaining to the contracted services; and

(13) Evaluation of the acceptability of the contracted services.

b. All contract services must be provided in accordance with the patient's plan of care.

c. The agency shall assure that all contract services are provided in accordance with the agreement. Agreements must be reviewed on an annual basis and updated as necessary.

d. The agency that is subcontracting its work must maintain or produce a complete home care record for each patient.

8. Ensure the agency obtains and maintains compliance with the applicable parts of the clinical laboratory improvement amendments of 1988, 42 CFR part 493, if the agency provides any laboratory testing service, regardless of the frequency or the complexity of the testing.

9. Meet with agency administrative staff to review the operation of the agency at a frequency sufficient to ensure safe and effective patient care.

10. Keep minutes of all meetings including actions taken.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-11. Quality improvement and program evaluation.

1. The agency shall develop, implement, and document an ongoing agencywide quality improvement program to monitor, evaluate, and improve the quality of patient care, administrative, and support services, including all contracted services, and to ensure services are provided in compliance with professional standards of practice.

   a. The quality improvement program must include a written plan that identifies a mechanism to identify problems, recommend appropriate action, implement recommendations, and monitor results.

   b. Each quarter a sample of active and closed clinical records must be reviewed, by a group of appropriate professionals representing the home health services provided during the previous quarter, to determine whether established policies are followed in furnishing services directly or through contract. This review must be documented as a part of the quality improvement program.

   c. The clinical records for all patients must be reviewed each sixty-two-day period to determine adequacy of the plan of treatment and the appropriateness of continuance of care.

   d. The administrator shall maintain a record of the activities of the quality improvement program and ensure findings, conclusions, and recommendations are reported to the governing body.

2. The agency shall complete an overall evaluation of its program annually and documentation of the reviews must be maintained as a part of the administrative records. The evaluation must, at a minimum, include an overall policy review, administrative review, and a clinical record review.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-12. Education programs.

The agency shall design, implement, and document educational programs to orient new employees and keep all staff current on new and expanding programs, therapeutic services, techniques, equipment, and concepts of quality care.

1. The following topics must be covered with all staff annually:

   a. Prevention and control of infections, including universal precautions;

   b. Patient rights; and

   c. Safety and emergency procedures.

2. In addition to meeting the training and competency evaluation or competency evaluation requirements in section 33-03-10.1-18, individuals providing home health aide services must receive twelve hours of inservice education within a twelve-month period.

   a. This inservice education may occur while the aide is furnishing care to the patient.

   b. Inservice training must be supervised by a registered nurse with a minimum of two years' experience, one of which is in the provision of home health services.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-13. Medical services.

1. All therapeutic services delivered to the patient by the agency must be approved by the patient's physician, including frequency and duration of services.

2. All therapeutic services must be provided consistent with a written treatment plan established and periodically reviewed by the patient's physician and must include at least the following:

   a. Orders for home health services, including orders for:

      (1) Skilled nursing, home health aide services, or other therapeutic services;

      (2) Medical supplies and equipment;

      (3) Medications and treatments when applicable;

      (4) Special dietary or nutritional needs when applicable; and

      (5) Medical tests including laboratory tests and x-rays when applicable.

   b. Diagnosis and prognosis.

   c. Functional limitations.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-14. Nursing services.

1. Skilled nursing services must be provided under the direction of a nurse executive (director of nursing) who is a registered nurse licensed to practice in North Dakota, with at least one

year's full-time experience in providing direct patient care in a home health setting and three years' experience as a registered nurse. The nurse executive must have written administrative authority, responsibility, and accountability for the integration and coordination of nursing services consistent with the overall agency organization and plan for patient care. The nurse executive shall:

a. Be a full-time, salaried employee of the agency;

b. Supervise all patient care activities to assure compliance with current standards of accepted nursing and medical practice;

c. Develop, maintain, periodically review, and cause to implement philosophy, objectives, standards of practice, policies and procedures, and job descriptions for each level of nursing service personnel;

d. Ensure there are sufficient qualified nursing personnel to meet the nursing care needs of the patients in accordance with the plan of care;

e. Ensure there is a registered nurse available by telephone during operating hours and when home health services are being provided to receive referrals, orders, patient phone calls, and any other concerns that may arise; and

f. Identify an alternate registered nurse in writing to function as the nurse executive when the nurse executive is not available.

2. A registered nurse shall:

a. Make the initial evaluation visit, initiate the plan of care, regularly reevaluate the patients' nursing needs, and make necessary revisions to the plan of care.

(1) If the patient receives skilled nursing services and home health aide services, the registered nurse must make supervisory visits no less frequently than every two weeks.

(2) If the patient is not receiving skilled nursing services, but is receiving home health aide, homemaker, or companion services, the registered nurse must make contact at least every sixty-two days to determine the appropriateness of the plan of care and the acceptability of the care provided.

b. Initiate preventive and rehabilitative nursing procedures, prepare clinical notes, coordinate therapeutic and supportive services, inform the physician and other personnel of changes in the patient's condition and needs, and counsel the patient and family regarding patient care needs.

c. Assign home health aides to specific patients dependent upon the needs of the patient and the skill of the home health aide.

d. Participate in inservice programs, supervise and teach other nursing personnel.

3. Licensed practical nurses shall furnish patient care services in accordance with agency policies, prepare clinical and progress notes, and assist the physician and registered nurse in performing specialized procedures and patient teaching.

4. If home health aide services are provided, either directly or by contract, the services must be provided by individuals who meet the training and competency or competency requirements specified in section 33-03-10.1-18 and meet registry requirements as specified by state statute. Individuals providing home health aide services shall:

a. Be supervised by a registered nurse; and

b. Provide patient care and services that home health aides are permitted to provide by state statute and rules which are consistent with the physician's orders, assigned by the registered nurse for a specific patient, contained in the patient's plan of care and written instructions from the registered nurse or other appropriate professionals, and agency policies and procedures.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-15. Patient plan of care.

A written plan of care must be developed for each patient which must include reference to at least the following:

1. All pertinent diagnoses;

2. Prognosis, including short-term and long-term objectives of care;

3. Types and frequency of services to be provided, including medication, diet, treatment procedures, equipment, and devices;

4. Functional limitations of the patient;

5. Activities permitted;

6. Safety measures required to protect the patient from injury; and

7. Sociopsychological needs of the patient.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-16. Clinical record services.

An agency shall maintain clinical records for each patient and provide relevant information from these clinical records to the personnel providing services in the patient's home.

1. The clinical record must contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results of treatment accurately. All clinical records must contain at least the following general categories of data:

   a. Identification data and consent forms;

   b. The name, address, and phone number of the patient's physician;

   c. The physician's signed order for therapeutic services and the approved plan of care, which must include, when appropriate to the services being provided:

      (1) Medical diagnosis;

      (2) Medication orders;

      (3) Dietary orders;

      (4) Treatment orders;

(5) Activity orders; and

(6) Safety orders.

d. Initial and periodic assessments and care plans by professionals providing services;

e. Signed and dated admission, observation, progress, clinical and supervisory notes, and other information necessary to document services are provided and not just offered;

f. Copies of summary reports sent to the physician;

g. Diagnostic and therapeutic orders signed by the physician;

h. Reports of treatment and clinical findings;

i. Transfer form, if applicable; and

j. Discharge summary.

2. All clinical information pertaining to the patient's care must be maintained in a centralized location by the parent or branch office.

3. Clinical records of services provided must be kept in ink, typed, or electronic data systems.

4. Entries into the clinical record for services rendered must be written within twenty-four hours and incorporated into the clinical record in a timeframe specified by agency policy.

5. Entries must be made by the person providing services, must contain a statement of facts personally observed, and must be signed and dated. Initials may be used in the clinical record if the full name has been identified in another location in the record.

6. Verbal orders from a physician must be signed and incorporated into the clinical record in a timeframe consistent with agency policy.

7. Clinical records must be safeguarded against loss or unauthorized use. Written policies and procedures must be in place regarding the use and removal of records and the conditions for release of information. The patient's or legal representative's written consent must be required for release of information not authorized by statute.

8. Clinical records must be maintained consistent with acceptable professional guidelines.

9. Retention of patient records must be as follows:

a. Patient records of discharged patients must be preserved for a period of ten years from the date of discharge. Records of deceased patients must be preserved seven years.

b. In the case of minors, records must be retained for the period of minority and ten years from the date of live discharge. Records of deceased patients who are minors must be preserved for the period of minority and seven years.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

33-03-10.1-17. Therapeutic services.

Any therapeutic service provided by the agency, either directly or by contract, must be provided by individuals qualified consistent with state law to provide the therapeutic service. Individuals providing therapeutic services shall:

1. Provide treatments in accordance with the scope of practice for their profession.

2. Assess the needs of the patient, prepare a plan of care based on the assessment, and provide services to the patient as specified in the plan of care, reassessing the patient's response to services provided and revising a plan of care as needed.

3. Prepare clinical and progress notes to be included in the clinical record.

4. Participate in and document all care planning, care conferences, and quality improvement activities.

5. Act as a consultant to other agency personnel.

6. Work with the family.

7. Teach and supervise other health personnel when appropriate.

History: Effective January 1, 1998.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-01, 23-17.3-05, 23-17.3-08

33-03-10.1-18. Home health aide training and competency evaluation.

Any individual employed by an agency to provide home health aide services directly or by contract must complete a nurse aide training and competency evaluation program or a competency evaluation program which meets the following:

1. The training program must total at least seventy-five clock hours, with at least sixteen of the seventy-five hours being devoted to classroom training prior to initiating the supervised practical training. At least sixteen hours of the total program hours must be devoted to supervised practical training.

   a. The training, including supervised practical training, of home health aides must be performed under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in the provision of home health care services. Other professionals may be used to provide instruction under the supervision of the qualified registered nurse.

   b. The training program must, at a minimum, include the following topics:

      (1) Communication skills;

      (2) Observation, reporting, and documentation of patient status and care or services furnished;

      (3) Reading and recording of temperature, pulse, and respiration;

      (4) Basic infection control procedures;

      (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;

      (6) Maintenance of a clean, safe, and healthy environment;

      (7) Recognizing emergencies and knowledge of emergency procedures;

      (8) The physical, emotional, and developmental needs of and ways to work with the patients served;

(9) Patient rights;

(10) Appropriate and safe techniques in personal hygiene and grooming which include:

(a) Bed bath;

(b) Sponge, tub, or shower bath;

(c) Shampoo, sink, tub, or bed;

(d) Oral hygiene; and

(e) Nail or skin care.

(11) Safe transfer techniques and ambulation;

(12) Normal range of motion and positioning;

(13) Adequate nutrition and fluid intake; and

(14) Any other tasks the agency may choose to have the home health aide perform.

c. The agency must maintain sufficient documentation to demonstrate that the requirements for the training of home health aides of this section are met.

d. Agencies that have had state or federal enforcement action, other than the citation of deficiencies, filed against them in the past two years are not eligible to operate a home health aide training program.

2. An individual may provide home health aide services on behalf of the agency only after that individual has successfully completed a competency evaluation that consists of the following:

a. The competency evaluation must be conducted by a registered nurse.

b. The competency evaluation must address each of the items listed in subdivision b of subsection 1.

(1) The items listed in paragraphs 3, 10, 11, and 12 of subdivision b of subsection 1 must be completed by observation of the aide's performance of the tasks with a patient or other live individual.

(2) All other items listed in subdivision b of subsection 1 can be evaluated through written or oral examination or observation of the aide with a patient.

c. A home health aide is not considered to have successfully passed a competency evaluation program if the aide has an unsatisfactory rating in more than one of the required areas.

(1) A home health aide cannot perform any task for which the aide is evaluated to perform unsatisfactorily unless under the direct supervision of a licensed nurse.

(2) The home health aide must receive training in the areas determined unsatisfactory and pass a subsequent evaluation satisfactorily prior to performing the task without supervision.

d. The agency must maintain documentation that the competency evaluation requirements of this section have been met by each home health aide.

History: Effective January 1, 1998.

General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08