CHAPTER 33-03-10.1
HOME HEALTH AGENCIES

SECTION 1. Subsection 5 of section 33-03-10.1-01 is amended as follows:

5. "Department" means the ~~state~~ department of health and human services.

History: Effective January 1, 1998; amended effective October 1, 2025.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-01, 23-17.3-08

SECTION 2. Subsection 6 of section 33-03-10.1-10 is amended as follows:

6. Ensure the development, implementation, review and revision of policies and procedures as changes in standards of practice occur. ~~All policies~~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.

History: Effective January 1, 1998; amended effective October 1, 2025.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

SECTION 3: Section 33-03-10.1-11 is amended as follows:

33-03-10.1-11. Quality ~~improvement~~assessment and ~~program evaluation~~performance improvement.

1. The agency shall develop, implement, and document an ongoing agencywide quality ~~improvement~~assessment 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~~assessment 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~~assessment program and ensure findings, conclusions, and recommendations are reported to the governing body.

2. The agency shall complete ~~an overall evaluation of its program~~a performance improvement project 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; amended effective October 1, 2025.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08

SECTION 4: Subsection 2 of section 33-03-10.1-14 is amended as follows:

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~~sixty 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.

History: Effective January 1, 1998; amended effective October 1, 2025.
General Authority: NDCC 23-01-04, 23-17.3-08
Law Implemented: NDCC 23-17.3-05, 23-17.3-08