

N.J.A.C. 8:39

**STANDARDS FOR LICENSURE OF
LONG-TERM CARE FACILITIES**

Effective Date: February 15, 2007
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N.J.A.C. 8:43E

**GENERAL LICENSURE PROCEDURES AND
ENFORCEMENT OF LICENSURE REGULATIONS**

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**New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
Office of Certificate of Need and Healthcare Facility Licensure
P.O. Box 358
Trenton, New Jersey 08625-0358
Telephone: (609) 292-5960
FAX: (609) 292-3780**

**To make a complaint about a
New Jersey licensed Long-Term Care Facility
call 1-800-792-9770 (toll-free hotline)**

Note: This is an unofficial version of the rules. The official rules can be found in the New Jersey Administrative Code, as published by LexisNexis at N.J.A.C. 8:39 and 8:43E.

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N.J.A.C. 8:39

STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES

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N.J.A.C. 8:39

STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES

SUBCHAPTER 1. GENERAL PROVISIONS

8:39-1.1 Scope and purpose

(a) This chapter contains rules and standards intended to assure the high quality of care delivered in long-term care facilities, commonly known as nursing homes, throughout New Jersey. Components of quality of care addressed by these rules and standards include access to care, continuity of care, comprehensiveness of care, coordination of services, humaneness of treatment, conservatism in intervention, safety of the environment, professionalism of caregivers, and participation in useful studies.

(b) These rules and standards apply to each licensed long-term care facility. They are intended for use in State surveys of the facilities and any ensuing enforcement actions. They are also designed to be useful to consumers and providers as a mechanism for privately assessing the quality of care provided in any long-term care facility.

8:39-1.2 Definitions

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

"Advance directive" means a written statement of a resident's instructions and directions for health care in the event of future decision-making incapacity, in accordance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., P.L. 1991, c.201. An advance directive may include a proxy directive, an instruction directive, or both.

"Advanced practice nurse" means a person certified by the New Jersey Board of Nursing in accordance with Section 8 or 9 of P.L. 1991, c.377; amended by P.L. 1999, c.85, s.6.

"Adverse drug reaction" means any unexpected, unintended, undesired or excessive response to a drug such that it:

1. Requires discontinuing the drug (therapeutic or diagnostic);
2. Requires changing the drug therapy;
3. Requires modifying the dose;
4. Negatively affects prognosis; or
5. Results in temporary or permanent harm or disability, or death.

"Available" means ready for immediate use (pertaining to equipment) or capable of being reached (pertaining to personnel), unless otherwise defined in these rules.

"Bed" or "licensed bed" means one of the total number of beds for which each licensed long-term care facility is approved for resident care by the Commissioner of the New Jersey State Department of Health and Senior Services.

"Cleaning" means the removal by scrubbing and washing, as with hot water, soap or detergent, or vacuuming, of infectious agents and of organic matter from surfaces on which and in which infectious agents may find conditions for surviving or multiplying.

"Commissioner" means the New Jersey State Commissioner of Health and Senior Services.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Conspicuously posted" means placed at a location within the facility accessible to and seen by residents and the public.

"Contamination" means the presence of an infectious or toxic agent in the air, on a body surface, or on or in clothes, bedding, instruments, dressings, or other inanimate articles or substances, including water, milk, and food.

"Controlled Dangerous Substances Acts" means the Controlled Substances Act of 1970 (Title II, Public Law 91-513) and the New Jersey Controlled Dangerous Substances Act of 1971, N.J.S.A. 24:21-1 et seq.

"Current" means up-to-date, extending to the present time.

"Defibrillator" means a medical device heart monitor and defibrillator that has received approval of its pre-market notification filed pursuant to 21 U.S.C. § 360(k) from the United States Food and Drug Administration, is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia, is capable of determining, without intervention by an operator, whether defibrillation should be performed, and upon determining that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to an individual's heart.

"Department" means the New Jersey State Department of Health and Senior Services.

"Dietitian" means a person who possesses a bachelor's degree from an accredited college or university with a major area of concentration in a nutrition-related field of study, and one year of full-time professional experience or graduate-level training in nutrition.

"Disinfection" means the killing of infectious agents outside the body, or organisms transmitting such agents, by chemical and/or physical means, directly applied.

"Documented" means written, signed, and dated. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.

"Drug administration" means a procedure in which a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such procedures. The complete procedure of administration includes:

1. Removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container);
2. Verifying it with the prescriber's orders;
3. Giving the individual dose to the resident;
4. Seeing that the resident takes it (if oral); and
5. Recording the required information, including the method of administration.

"Drug dispensing" means a procedure entailing the interpretation of the original or direct copy of the prescriber's order for a drug or a biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological to a resident or a service unit of the facility, in conformance with all applicable Federal, State, and local rules and regulations.

“Drug regimen review” means an individual resident record review conducted by the consultant pharmacist, including, but not limited to, laboratory tests, dietary requirements, physician’s or advanced practice nurse’s and nurse’s clinical notes, physician’s or advanced practice nurse’s orders and progress notes, in order to monitor for potentially significant adverse drug reactions, drug-to-drug and drug-food interactions, allergies, contraindications, rationality of therapy, drug use evaluation, and laboratory tests results.

"Epidemic" means the occurrence or outbreak in a facility of one or more cases of an illness in excess of normal expectancy for that illness, derived from a common or propagated source.

"Facility" means a facility or distinct part of a facility licensed by the New Jersey State Department of Health and Senior Services as a long-term care facility.

"Full-time" means relating to a time period established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"Guardian" means a person appointed by a court of competent jurisdiction to handle the affairs and protect the rights of any resident of the facility.

"Health care facility" means a facility so defined in N.J.S.A. 26:2H-1 et seq., and amendments thereto.

"Licensed nursing personnel" (licensed nurse) means registered professional nurses or practical (vocational) nurses licensed by the New Jersey State Board of Nursing.

"Medication error" means a discrepancy between what the prescriber ordered and what the resident receives. The error may or may not be seen by the (pharmacist) surveyor during an observation of a resident receiving medication. If a medication error is seen by the surveyor during a medication observation pass, it shall be included in determining the medication error rate.

“Medication error rate” is calculated by the following equation: (number of errors observed divided by the opportunities for errors) x 100.

"Monitor" means to observe, watch, or check.

“Pharmacist” means an individual so licensed by the New Jersey State Board of Pharmacy, pursuant to N.J.A.C. 13:39-3.

"Physician" means a person licensed to practice medicine by the New Jersey State Board of Medical Examiners, pursuant to N.J.S.A. 45:9-1 et seq.

"Reasonable hour" means any time between the hours of 8:00 A.M. and 8:00 P.M. daily.

"Resident" means a person who resides in the facility and is in need of 24-hour continuous nursing supervision.

"Self administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a resident to himself or herself. The complete procedure of self-administration includes:

1. Removing an individual dose from a previously dispensed (in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39), labeled container (including a unit dose container);
2. Verifying it with the directions on the label; and
3. Taking orally, injecting, inserting, or topically or otherwise administering the medication.

"Shift" means a time period defined as a full working day by the facility in its policy manual.

"Signature" means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D., D.O.) of a person, legibly written with his or her own hand. A controlled electronic signature system may be used.

"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity. "Direct supervision" means supervision on the premises within view of the supervisor.

"Unit-of-use" means a system in which drugs are delivered to the resident areas either in single unit packaging, bingo or punch cards, blister or strip packs, or other system where each drug is physically separate.

SUBCHAPTER 2. LICENSURE PROCEDURE

8:39-2.1 Certificate of Need

(a) According to the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for and receipt of a certificate of need issued by the Commissioner, in accordance with N.J.A.C. 8:33. Facilities exempt from certificate of need pursuant to law shall follow licensing procedures identified in N.J.A.C. 8:39-2.2 below.

(b) Application forms for a certificate of need and instructions for completion may be obtained from:

Office of Certificate of Need and Healthcare Facility Licensure
Division of Healthcare Facilities Evaluation and Licensing
New Jersey State Department of Health and Senior Services
P.O. Box 358
Trenton, NJ 08625-0358

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the certificate of need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:39-2.2 Application for licensure

(a) Following acquisition of a certificate of need, or a determination that a certificate of need is not required, any person, organization, or corporation desiring to operate a facility shall make application to the Commissioner for a license on Appendix E, incorporated herein by reference which include information regarding facility ownership, corporate officers and stockholders, and approval forms from local building, fire, health and zoning departments. Such forms may be obtained from:

Office of Certificate of Need and Healthcare Facility Licensure
Division of Healthcare Facilities Evaluation and Licensing
New Jersey State Department of Health and Senior Services
P.O. Box 358
Trenton, NJ 08625-0358

(b) The Department shall charge the following non-refundable fees:

Annual licensure fee (new and renewal)	\$1,500 plus \$15 per bed
Add-a-bed	\$1,500 plus \$15 per additional bed
Hemodialysis provided by the LTC facility	\$1,125
Hemodialysis provided by a separate provider	\$750.00
Relocation of a facility (within the same county)	\$375.00
Transfer of ownership (includes initial licensure fee)	\$2,500 plus \$15 per bed
Reduction in services or beds	\$250.00

Neither the maximum annual licensure fee nor the fee for transfer of ownership for any single facility shall exceed \$4,000.

(c) Any person, organization, or corporation considering application for license to operate a facility shall make an appointment for a preliminary conference at the Department with the Long-Term Care Licensing and Certification Program.

(d) For all projects that are exempt from the certificate of need requirement, the Department shall evaluate the track record of the applicant in accordance with N.J.A.C. 8:33-4.10(e).

(e) Any applicant denied a license to operate a facility shall have the right to a hearing in accordance with N.J.A.C. 8:33-4.10(e)4.

8:39-2.3 Newly constructed, expanded, or renovated facilities

Any construction, expansion, or renovation of a facility shall be completed in accordance with N.J.A.C. 8:39-31, Mandatory Physical Environment.

8:39-2.4 Surveys and license

(a) A license shall be issued to the operator of a facility when all of the following conditions are met:

1. A completed licensure application and the appropriate fee have been submitted;
2. An office conference for review of the conditions for licensure and operation has taken place between the Long-Term Care Licensing and Certification Program and representatives of the facility;
3. The applicant has submitted the following documents to the Long-Term Care Licensing and Certification Program: a copy of the certificate of occupancy, and written approvals from the Health Care Plan Review Unit of the New Jersey Department of Community Affairs and the local health authority;

4. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system; and

5. Survey(s) by representatives of the Department indicate that the facility meets the mandatory standards set forth in this chapter.

(b) No facility shall begin to operate without prior approval from the Long-Term Care Licensing and Certification Program of the Department.

(c) The facility shall accept no more than that number of residents for which it is approved and/or licensed.

(d) Survey visits shall be made to a facility at any time by authorized staff of the Department. Such visits shall include, but shall not be limited to, the review of all facility documents and resident records and conferences with residents.

(e) The license shall be granted for a period of one year, unless suspended or revoked, and shall be renewable annually on the original licensure date, or within 30 days thereafter, in accordance with the following:

1. The facility shall receive a request for renewal fee as provided in N.J.A.C. 8:39-2.2(b), along with an application for a healthcare facility license renewal, Appendix F, incorporated herein by reference, 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee and the renewal application is received by the Department; and

2. The license shall not be renewed if local regulations, or any other requirements, which substantially affect the provision of services as required by this chapter, are not met.

(f) The license shall be conspicuously posted in the facility.

(g) The license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate or if its ownership changes.

(h) Any facility which was closed or substantially ceased operation of any of its beds, facilities, services, or equipment for any consecutive two-year period shall be required to obtain a certificate of need in accordance with N.J.A.C. 8:33-3.2 et seq., before renewing its license to operate such beds, facilities, services, or equipment.

8:39-2.5 Surrender of license

The facility shall directly notify the Department, each resident, the resident's physician or advanced practice nurse, and any guarantors of payment concerned at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of licensure. In such cases, the license shall be returned to the Long-Term Care Licensing and Certification Program of the Department within seven calendar days from voluntary surrender, order of revocation, expiration, or suspension of license, whichever is applicable.

8:39-2.6 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the standards in this chapter, waive sections of this chapter if, in his or her opinion, such waiver would not endanger the life, safety, or health of the facility's residents or the public.

(b) A facility seeking a waiver of the standards in this chapter shall apply in writing to the Director of the Long-Term Care Licensing and Certification Program of the Department.

(c) A written application for waiver shall include at least the following:

1. The nature of the waiver requested;
2. The specific standards for which a waiver is requested;
3. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility or any individual upon full compliance;
4. An alternative proposal which would ensure resident safety; and
5. Documentation to support the application for waiver.

(d) The Department reserves the right to request additional information before processing an application for waiver.

(e) The Department shall issue to the facility written confirmation of either a grant or denial of any waiver request.

8:39-2.7 Action against licensee

Violations of this subchapter may result in action by the Department in accordance with N.J.A.C. 8:43E.

8:39-2.8 Special long-term care services

In accordance with N.J.A.C. 8:33H-1.7, the Department recognizes the following two special long-term care services, both of which require a certificate of need: behavior management and ventilator care. Long-term care beds that are approved for these special services shall be designated separately on the facility's license.

8:39-2.9 Chronic hemodialysis services

(a) If a facility provides hemodialysis services to its own long-term care residents only, the following conditions shall be met:

1. The facility shall be authorized to provide the service by the Long-Term Care Licensing and Certification Program of the Department subsequent to the submission and review of the information contained in this subchapter. The application shall describe how the standards in (a)2 through 4 below will be met. The facility shall comply with ambulatory care requirements for a chronic dialysis provider, in accordance with N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved. Waivers from the nine station minimum requirement at N.J.A.C. 8:43A-24.2 shall be considered on an individual basis;

2. A consultant nephrologist who is Board Certified or Board eligible shall be designated and available to provide medical direction for the hemodialysis service;

3. The facility shall identify the space where hemodialysis services will be provided:

i. Identified space shall be in compliance with the requirements at N.J.A.C. 8:43A-24, Licensure Standards for Ambulatory Care;

ii. If bedside hemodialysis services are offered, they shall be provided only in private rooms; and

4. Hemodialysis shall be listed as a "service" on the facility's license.

(b) If the facility or other separately licensed dialysis provider provides outpatient dialysis services on-site to persons who are not residents of the facility, the following conditions shall be met:

1. The facility shall file a licensing application in order to be authorized to provide the service. The facility shall comply with ambulatory care regulations for chronic dialysis services, in accordance with N.J.A.C. 8:43A, particularly N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved;

2. Outpatient records shall be kept separately from inpatient records; and

3. The hemodialysis program shall not utilize any space required by the long-term care program, such as passageways, corridors, or treatment room, and shall not require the commingling of hemodialysis patients with facility residents.

(c) Hemodialysis services may be provided to residents of the long-term care facility by separately licensed dialysis providers under the following circumstances:

1. The dialysis provider shall file a licensing application in order to be authorized to provide the service. The facility shall comply with ambulatory care requirements for chronic dialysis services, in accordance with N.J.A.C. 8:43A, particularly N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved;

2. The provider shall demonstrate the ability to serve nine patients Statewide within six months of licensing approval;

3. The provider shall have a New Jersey office or execute a jurisdictional agreement with the Department;

4. The provider shall describe all staffing, and how staffing will be provided at multiple sites, if applicable;

5. A copy of the contract between the dialysis provider and the long-term care facility shall be included with the licensing application. The contract shall clearly state the roles and responsibilities of both the dialysis provider and the long-term care facility. Any change in dialysis provider shall require prior authorization and submission of a separate licensure application by the dialysis provider;

6. The Department shall charge a fee for licensure of the dialysis service as an ambulatory care facility in accordance with N.J.A.C. 8:43A-2.2(b). Each site of service provision shall be considered a satellite. The Department shall charge a biennial inspection fee in accordance with N.J.A.C. 8:43A-2.2(m);

7. Hemodialysis shall be listed as a "service" on the facility's license; and

8. Both the provider and the long-term care facility shall inform the Department in writing 30 days prior to any planned service interruption and shall include a plan for the continuing care of any dialysis patients.

(d) Any long-term care facility which proposes to offer hemodialysis services through a separately licensed dialysis provider shall also comply with the following requirements:

1. The facility shall request written authorization from the Long-Term Care Licensing and Certification Program to contract with a licensed outside provider prior to implementing the service. A copy of the contract between the dialysis provider and the long-term care facility shall be included with the licensing application. The contract shall clearly state the roles and responsibilities of both the dialysis provider and the long-term care facility. Any change in dialysis provider shall require prior authorization and submission of a separate licensure application by the new dialysis provider; and

2. The facility shall identify the space in which the service will be provided, including documentation that the space meets the requirements of N.J.A.C. 8:43A-24. Any renovations or construction shall receive prior approval from the Department. Space required by the long-term care facility programs shall not be used.

8:39-2.10 Peritoneal dialysis

(a) If a long-term care facility offers peritoneal renal dialysis services to its own residents only, the following conditions shall be met:

1. A licensing application shall not be required;

2. The facility shall forward to the Department an attestation that the information listed below is available at the facility for review. Following receipt of this attestation, authorization to provide the service may be granted:

i. Policies and procedures for service provision, which shall include the following:

(1) Staff qualifications and training;

(2) Admission criteria;

(3) Transfer agreement with a certified ESRD hospital facility;

(4) Quality assurance mechanisms and criteria;

- (5) Infection prevention and control, including bag disposal;
- (6) Emergency situations;
- (7) Dietary requirements; and
- (8) How and where any necessary laboratory work will be completed.

3. A consultant nephrologist shall be designated and available to provide medical direction for the service; and

4. Peritoneal dialysis shall be listed as a "service" on the facility's license.

(b) Separately licensed dialysis providers may offer peritoneal dialysis services in a long-term care facility under the following circumstances:

1. All requirements in (a) above shall be met;
2. The dialysis provider shall be licensed as specified at N.J.A.C. 8:39-2.9(c);

3. A copy of the contract agreement for service provision between the dialysis provider and the long-term care facility shall be reviewed and approved by the Long-Term Care Licensing and Certification Program of the Department prior to the authorization of the long-term care facility to provide the service through a separately licensed agency. The agreement shall clearly state the roles and responsibilities of both parties; and

4. Both the long-term care facility and the dialysis agency shall notify the Department in writing 30 days prior to any planned service interruption and shall include a plan for the continuing care of any dialysis patients.

8:39-2.11 Add-a-bed

(a) Pursuant to N.J.S.A. 26:2H-7.2, a facility may request approval from the Department to increase total licensed beds by no more than 10 beds or 10 percent of its licensed bed capacity, whichever is less, without certificate of need approval. No more than one such request for approval shall be submitted every five years.

(b) The Department shall charge a nonrefundable fee of \$1,500 plus \$15.00 per additional bed for the filing of an application to add beds to increase a facility's total licensed capacity. Applicants shall contact the Office of Certificate of Need and Healthcare Facility Licensure at (609) 633-9042 to obtain Add-a-bed application forms. The completed forms, along with scaled floor plans and the appropriate fee, must be forwarded to the Department at the following address:

Office of Certificate of Need and Healthcare Facility Licensure
Division of Healthcare Facilities Evaluation and Licensing
New Jersey State Department of Health and Senior Services
P.O. Box 358
Trenton, NJ 08625-0358

(c) The Department shall deny an Add-a-bed application if any of the following conditions exist:

1. The facility's track record is unsatisfactory, in accordance with N.J.A.C. 8:33-4.10 and N.J.A.C. 8:43E-5.1;

2. The applicant fails to demonstrate that the facility has sufficient space to implement the new licensed bed capacity in a manner meeting Federal construction standards contained in the 1996-97 edition of "Guidelines For Design and Construction of Hospital and Health Care Facilities" (American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Department of Health and Human Services. The American Institute of Architects Press: Washington, DC), incorporated herein by reference as amended and supplemented;

3. The applicant fails to demonstrate that the facility has provided sufficient nurse staffing hours, in accordance with this chapter, to meet the needs of the current resident census;

4. The addition of beds will result in a unit size in excess of 64 beds;

5. The addition of beds will result in a violation of State licensure or Federal certification requirements; or

6. The proposed additional beds will result in a room occupancy that exceeds two residents per room.

8:39-2.12 Transfer of ownership

(a) In accordance with N.J.A.C. 8:33-3.3(a)4, the transfer of ownership of a long-term care facility shall not require a certificate of need except when the proposed owner does not satisfy the Department's track record review.

(b) Prior to transferring ownership of a facility, the prospective new owner shall submit an application to the Long-Term Care Licensing and Certification Program. The application shall include the following items:

1. The transfer of ownership fee of \$2,500 plus \$15 per bed, in accordance with N.J.A.C. 8:39-2.2 (b);

2. A cover letter stating the applicant's intent to purchase the facility, and identification of the facility by name, address, county, and number and type of licensed beds;

3. A description of the proposed transaction, including:

i. Identification of the current owners of the facility;

ii. Identification of 100% of the proposed new owners, including the names and addresses of all principals (i.e., individuals and/or entities with a 10% or more interest); and,

iii. If applicable, a copy of an organizational chart, including parent corporations and wholly owned subsidiaries;

4. A copy of the agreement of sale and, if applicable, a copy of any lease and/or management agreements; and

5. Disclosure of any licensed health care facilities owned, operated, or managed by the proposed owner or any of the principals, in New Jersey or any other state. If facilities are owned, operated, or managed in other states, letters from the regulatory agencies in each respective state, verifying that the facilities have operated in substantial compliance during the last 12 month period and have had no enforcement actions imposed during that period of time, shall be included in the application.

(c) Approval of a transfer of ownership is contingent upon a review of the applicant's track record, in accordance with N.J.A.C. 8:33-4.10 and N.J.A.C. 8:43E-5.1.

(d) Approval of a transfer of ownership is contingent upon payment of all outstanding Medicaid audit claims and State penalties issued by the Department against the current owner, or written verification by the applicant that the applicant will assume responsibility for payment of such audit findings and State penalties.

(e) When a transfer of ownership application has been reviewed and deemed acceptable, an approval letter from the Long-Term Care Licensing and Certification Program shall be sent to the applicant along with licensure application forms.

(f) Within five (5) days after the transaction has been completed, the applicant shall submit the following documents to the Long-Term Care Licensing and Certification Program:

1. Completed licensure application forms;
2. A notarized letter stating the date on which the transaction occurred;
and
3. A copy of a certificate of continuing occupancy from the local township, or a letter from the township verifying a policy of not issuing any such document for changes of ownership.

(g) For Medicaid certification, the new owner shall contact the Long-Term Care Licensing and Certification Program at (609) 633-9042.

(h) For Medicare certification, the new owner shall contact the Assistant Director of Long-Term Care Assessment and Survey at (609) 633-8981.

SUBCHAPTER 3.
COMPLIANCE WITH MANDATORY RULES AND ADVISORY STANDARDS

8:39-3.1 Mandatory rules

(a) Mandatory rules contain minimum and essential requirements of care provided by a facility.

(b) Failure to comply with any mandatory rules contained in this chapter shall constitute a deficiency for which the Department may take any or all of the enforcement actions set forth in N.J.A.C. 8:43E.

8:39-3.2 Advisory standards

(a) Advisory standards contain benchmarks of excellence or superior attainment in providing care of high quality.

(b) Facilities are strongly encouraged to use advisory standards in striving to provide the highest quality of care possible.

(c) Failure to comply with any or all advisory standards shall not constitute a deficiency or result directly or indirectly in any enforcement action by the Department.

(d) Compliance with advisory standards shall not be used as an indication of whether the facility is in compliance with mandatory rules or whether a facility should be made subject to a penalty or other action to protect residents.

8:39-3.3 Reporting compliance with advisory standards

(a) Compliance with advisory standards shall be calculated in accordance with the following:

1. The Department shall verify that at least 90 percent of no more than 30 advisory standards randomly selected from the total number of advisory standards which the facility claims to have met are in fact met; and

2. If the compliance rate determined at (a)1 above is 90 percent or greater, then, for any advisory subchapter in which the facility has claimed to meet 65 percent or more of the standards in the subchapter, recognition for meeting the entire subchapter shall be given.

(b) If a facility applies for a certificate of need, compliance with six or more of the following advisory subchapters at the time of the most recent survey of the facility shall be taken into consideration: access to care (N.J.A.C. 8:39-6), resident assessment and care plans (N.J.A.C. 8:39-12), pharmacy (N.J.A.C. 8:39-30), infection control and sanitation (N.J.A.C. 8:39-20), resident activities (N.J.A.C. 8:39-8), dietary services (N.J.A.C. 8:39-18), medical services (N.J.A.C. 8:39-24), nurse staffing (N.J.A.C. 8:39-26), physical environment (N.J.A.C. 8:39-32), and quality assessment and/or quality improvement (N.J.A.C. 8:39-34).

(c) If a facility can demonstrate that it has a system in place to meet the requirement, even though it is not applicable at the time of the survey, the surveyors may deem that, in their judgment, the standard is met.

**SUBCHAPTER 4.
MANDATORY RESIDENT RIGHTS**

8:39-4.1 Resident rights

(a) Each resident shall be entitled to the following rights:

1. To retain the services of a physician or advanced practice nurse the resident chooses, at the resident's own expense or through a health care plan;
2. To have a physician or advanced practice nurse explain to the resident, in language that the resident understands, his or her complete medical condition, the recommended treatment, and the expected results of the treatment, except when the physician deems it medically inadvisable to give such information to the resident and records the reason for such decision in the resident's medical record; and provides an explanation to his or her next of kin or guardian;
3. To participate, to the fullest extent that the resident is able, in planning his or her own medical treatment and care;
4. To refuse medication and treatment after the resident has been informed, in language that the resident understands, of the possible consequences of this decision. The resident may also refuse to participate in experimental research, including the investigations of new drugs and medical devices. The resident shall be included in experimental research only when he or she gives informed, written consent to such participation;
5. To be free from physical and mental abuse and/or neglect;
6. To be free from chemical and physical restraints, unless they are authorized by a physician or advanced practice nurse for a limited period of time to protect the resident or others from injury. Under no circumstances shall the resident be confined in a locked room or restrained for punishment, for the convenience of the nursing home staff, or with the use of excessive drug dosages;
7. To manage his or her own finances or to have that responsibility delegated to a family member, an assigned guardian, the nursing home administrator, or some other individual with power of attorney. The resident's authorization must be in writing, and must be witnessed in writing;

8. To receive a written statement or admission agreement describing the services provided by the nursing home and the related charges. Such statement or admission agreement must be in compliance with all applicable State and Federal laws. This statement or agreement must also include the nursing home's policies for payment of fees, deposits, and refunds. The resident shall receive this statement or agreement prior to or at the time of admission, and afterward whenever there are any changes;

9. To receive a quarterly written account of all resident's funds and itemized property that are deposited with the facility for the resident's use and safekeeping and of all financial transactions with the resident, next of kin, or guardian. This record shall also show the amount of property in the account at the beginning and end of the accounting period, as well as a list of all deposits and withdrawals, substantiated by receipts given to the resident or his or her guardian;

10. To have daily access during specified hours to the money and property that the resident has deposited with the nursing home. The resident also may delegate, in writing, this right of access to his or her representative;

11. To live in safe, decent, and clean conditions in a nursing home that does not admit more residents than it can safely accommodate while providing adequate nursing care;

12. To be treated with courtesy, consideration, and respect for the resident's dignity and individuality;

13. To receive notice of an intended transfer from one room to another within the facility or a change in roommate, including a right to an informal hearing with the administrator prior to the transfer as well as a written statement of the reasons for such transfer. The nursing home shall not move the resident to a different bed or room in the facility if the relocation is arbitrary and capricious. A transfer would not be considered arbitrary and capricious if a facility can document a clinical necessity for relocating the resident, such as a need for isolation or to address behavior management problems, or there is a hardship to an applicant for admission through a delay caused by inefficient distribution of beds by gender;

14. To wear his or her own clothes, unless this would be unsafe or impractical. All clothes provided by the nursing home shall fit in a way that is not demeaning to the resident;

15. To keep and use his or her personal property, unless this would be unsafe, impractical, or an infringement on the rights of other residents. The nursing home shall take precautions to ensure that the resident's personal possessions are secure from theft, loss, and misplacement;

16. To have physical privacy. The resident shall be allowed, for example, to maintain the privacy of his or her body during medical treatment and personal hygiene activities, such as bathing and using the toilet, unless the resident needs assistance for his or her own safety;

17. To have reasonable opportunities for private and intimate physical and social interaction with other people, including arrangements for privacy when the resident's spouse visits. If the resident and his or her spouse are both residents of the same nursing home, they shall be given the opportunity to share a room, unless this is medically inadvisable, as documented in their records by a physician or advanced practice nurse;

18. To confidential treatment of information about the resident. Information in the resident's records shall not be released to anyone outside the nursing home without the resident's approval, unless the resident transfers to another health care facility, or unless the release of the information is required by law, a third-party payment contract, or the New Jersey State Department of Health and Senior Services;

19. To receive and send mail in unopened envelopes, unless the resident requests otherwise. The resident also has a right to request and receive assistance in reading and writing correspondence unless it is medically contraindicated, and documented in the record by a physician or advanced practice nurse;

20. To have unaccompanied access to a telephone at a reasonable hour to conduct private conversations, and, if technically feasible, to have a private telephone in his or her living quarters at the resident's own expense;

21. To stay out of bed as long as the resident desires and to be awakened for routine daily care no more than two hours before breakfast is served, unless a physician recommends otherwise and specifies the reasons in the resident's medical record;

22. To receive assistance in awakening, getting dressed, and participating in the facility's activities, unless a physician or advanced practice nurse specifies reasons in the resident's medical record;

23. To meet with any visitors of the resident's choice between 8:00 A.M. and 8:00 P.M. daily. If the resident is critically ill, he or she may receive visits at any time from next of kin or a guardian, unless a physician or advanced practice nurse documents that this would be harmful to the resident's health;

24. To take part in nursing home activities, and to meet with and participate in the activities of any social, religious, and community groups, as long as these activities do not disrupt the lives of other residents;

25. To leave the nursing home during the day with the approval of a physician or advanced practice nurse and with the resident's whereabouts noted on a sign-out record. Arrangements may also be made with the nursing home for an absence overnight or longer;

26. To refuse to perform services for the nursing home;

27. To request visits at any time by representatives of the religion of the resident's choice and, upon the resident's request, to attend outside religious services at his or her own expense. No religious beliefs or practices shall be imposed on any resident;

28. To participate in meals, recreation, and social activities without being subjected to discrimination based on age, race, religion, sex, nationality, or disability. The resident's participation may be restricted or prohibited only upon the written recommendation of his or her physician or advanced practice nurse;

29. To organize and participate in a Resident Council that presents residents' concerns to the administrator of the facility. A resident's family has the right to meet in the facility with the families of other residents in the facility;

30. To discharge himself or herself from the nursing home by presenting a release signed by the resident. If the resident is an adjudicated mental incompetent, the release must be signed by his or her next of kin or guardian;

31. To be transferred or discharged only for one or more of the following reasons, with the reason for the transfer or discharge recorded in the resident's medical record:

i. In an emergency, with notification of the resident's physician or advanced practice nurse and next of kin or guardian;

ii. For medical reasons or to protect the resident's welfare or the welfare of others;

iii. To comply with clearly expressed and documented resident choice, or in conformance with the New Jersey Advance Directives for Health Care Act, as specified in N.J.A.C. 8:39-9.6(d); or

iv. For nonpayment of fees, in situations not prohibited by law.

32. To receive written notice at least 30 days in advance when the nursing home requests the resident's transfer or discharge, except in an emergency. Written notice shall include the name, address, and telephone number of the New Jersey Office of the Ombudsman for the Institutionalized Elderly, and shall also be provided to the resident's next of kin or guardian 30 days in advance;

33. To be given a written statement of all resident rights as well as any additional regulations established by the nursing home involving resident rights and responsibilities. The nursing home shall require each resident or his or her guardian to sign a copy of this document. In addition, a copy shall be posted in a conspicuous, public place in the nursing home. Copies shall also be given to the resident's next of kin and distributed to staff members. The nursing home is responsible for developing and implementing policies to protect resident rights;

34. To retain and exercise all the constitutional, civil, and legal rights to which the resident is entitled by law. The nursing home shall encourage and help each resident to exercise these rights; and

35. To voice complaints without being threatened or punished. Each resident is entitled to complain and present his or her grievances to the nursing home administrator and staff, to government agencies, and to anyone else without fear of interference, discharge, or reprisal. The nursing home shall provide each resident and his or her next of kin or guardian with the names, addresses, and telephone numbers of the government agencies to which a resident can complain and ask questions, including the Department and the Office of the Ombudsman for the Institutionalized Elderly. These names, addresses, and telephone numbers shall also be posted in a conspicuous place near every public telephone and on all public bulletin boards in the nursing home.

(b) Each resident, resident's next of kin, and resident's guardian shall be informed of the resident rights enumerated in this subchapter, and each shall be explained to him or her. None of these rights shall be abridged or violated by the facility or any of its staff.

**SUBCHAPTER 5.
MANDATORY ACCESS TO CARE**

8:39-5.1 Mandatory policies and procedures for access to care

(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.

(b) There shall be no discrimination against any resident or group of residents based on method of payment.

(c) The facility shall meet all currently applicable conditions attached to any certificate of need that has been granted to it.

(d) If a facility has reason to believe, based on a resident's behavior, that the resident poses a danger to himself or herself or others, and that the facility is not capable of providing proper care to the resident, then an evaluation should be performed and documented in accordance with Guidelines for Inappropriate Behavior and Resident to Resident Abuse in Appendix B, incorporated herein by reference.

(e) The facility shall make available to indigent individuals at least five percent of its beds or, if the facility is licensed for 100 or more beds, at least 10 percent of its beds. For purposes of this section, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care.

8:39-5.2 Admissions

(a) The facility shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the facility are to be added to the top of the list as soon as the hospital notifies the facility of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-threatening situations or life-care community admissions.

1. The facility shall meet the following requirements:

i. The facility shall maintain only one waiting list; this list shall reflect a roster updated on a regular basis, of all individuals who have applied for admission to the facility;

ii. The waiting list shall reflect in chronological order the full name and address of the individual applying by the date the written application for admission is made;

iii. Facilities that participate in the Medicaid program shall utilize the waiting list to admit individuals on a first-come, first-serve basis in the order in which they apply until the provider's Medicaid occupancy level equals the Statewide occupancy level, or the Medicaid occupancy level set forth in the provider's Certificate of Need, whichever is higher; and

iv. A file shall be maintained containing full documentation to support any valid reason why the individual whose name appears first on the waiting list is not admitted to the facility.

2. Any Medicaid participating facility whose Medicaid occupancy level is less than the Statewide occupancy level shall not deny admission to a Medicaid eligible individual who has been authorized for nursing facility services by the Long-Term Care Field Office, when a bed becomes available in accord with the waiting list.

i. Under the provisions of N.J.S.A 10:5-12.2, a facility with a residential unit or a life-care community may give its own residents priority when a bed becomes available.

(b) The facility shall not deny admission to any applicant for admission ("applicant for admission" means an individual who has made a formal application) based on diagnosis or health care needs if the applicant's health care needs can be reasonably accommodated without reducing the quality of care provided to other residents, and are commensurate with the services provided by the facility.

(c) Whenever the facility denies admission to an applicant for admission, the facility, within 14 days of the denial, shall provide written notice of the denial and the reasons therefore, to the applicant or person applying on the applicant's behalf. A record of each completed application, including the disposition and stated reason if admission is denied, shall be kept for one year.

8:39-5.3 Transfers

(a) Policies for transfer shall include method of transportation, procedures for security of the resident and all personal belongings or other items that accompany or immediately follow a transferred resident, a transfer form that is consistent with "Patient Information Transfer Form" in Appendix C, incorporated herein by reference, copies of relevant medical records, including assessments (MDS; PASRR) and advance directives if applicable.

(b) The facility shall arrange for transfer of residents to other health care facilities, and to health care services provided outside the nursing home, and in accordance with the physician's or advanced practice nurse's orders.

(c) All transfers shall be in accordance with N.J.A.C. 8:39-4.1.

8:39-5.4 Discharges

(a) No resident shall be discharged between 5:00 P.M. and 8:00 A.M., except in an emergency or with the consent of the resident and family or responsible person.

(b) Discharge plans, for those residents considered to be likely candidates for discharge into the community or a less intensive care setting, shall be developed by the interdisciplinary team prior to discharge and shall reflect communication with the resident and/or the resident's family.

(c) All discharges shall be in accordance with N.J.A.C. 8:39-4.1 and 39.

**SUBCHAPTER 6.
ADVISORY ACCESS TO CARE**

8:39-6.1 Advisory admission policies and procedures

(a) The waiting list of the facility incorporates a system to contact applicants or families at least quarterly, or according to an alternate schedule approved by the Department, to advise them concerning the status of the application and to inquire of the applicant's interest in remaining on the waiting list.

(b) Before admission, the resident's physician, the facility's social worker, the facility's admissions officer (if different from the social worker), and a registered professional nurse discuss the appropriateness of the placement.

(c) The facility makes available to indigent individuals at least 10 percent of its beds or, if the facility is licensed for 100 or more beds, at least 15 percent of its beds. For purposes of this subsection, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care.

(d) The facility provides a copy of admissions policies and criteria to all applicants for admission.

**SUBCHAPTER 7.
MANDATORY RESIDENT ACTIVITIES**

8:39-7.1 Mandatory administrative organization for resident activities

(a) The director of resident activities shall supervise all resident activity staff and coordinate all resident activity programs.

(b) The director of resident activities shall hold at least one of the following four qualifications:

1. A baccalaureate degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, therapeutic recreation, art, art education, psychology, sociology, or occupational therapy; or

2. A high school diploma and three years of experience in resident activities in a health care facility and satisfactory completion of an activities education program approved by the Department, after a review of the specific curriculum, consisting of 90 hours of training, and incorporating the following elements:

- i. Overview of the activity profession;
- ii. Human development: the late adult years;
- iii. Standards of practice: practitioner behavior;
- iv. Activity care planning for quality of life; and
- v. Methods of service delivery in the activity profession; or

3. Served as director of resident activities on June 20, 1988, and has continuously served as activities director since that time; or

4. Holds current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, P.O. Box 62589, Virginia Beach, Virginia 23466-2589) or the National Council for Therapeutic Recreation Certification (National Council for Therapeutic Recreation, Inc., P.O. Box 479, Thiells, NY 10984-0479).

(c) Activities directors who are employed in that capacity as of August 20, 2001, and who have completed an activities education course which was previously approved by the Department, will not be required to complete the course described at (b)2 above.

8:39-7.2 Mandatory staffing amounts and availability for activities

An average of 45 minutes of resident activities staff time per resident per week shall be devoted to resident activities, which requires at least one full-time equivalent staff member for every 53 residents.

8:39-7.3 Mandatory resident activity services

(a) Resident activities staff shall arrange a diversity of programs to maintain residents' sense of usefulness and self-respect. Included shall be activities in each of the following categories:

1. Social (for example, parties, club meetings, picnics, and other special events);
2. Physical (for example, exercise, sports, dancing, and swimming);
3. Creative (for example, crafts, poetry, drama, music therapy, art therapy, and gardening);
4. Educational and cultural (for example, discussion groups, guest speaker programs, concerts and other forms of live entertainment, and international meals);
5. Spiritual, such as religious services;
6. Awareness, including cognitive and sensory individual and group stimulation for confused and disoriented residents; and
7. Community-integrating (for example, visits by community volunteers, visits by nursery school classes, exchange visits with other health care facilities, participation in senior citizen organization meetings or support group sessions, and participation in adopt-a-grandparent programs).

(b) If the facility requires an exception from any of the categories of activities listed at (a)1 through 7 above, reasons for the exception, such as impracticability or lack of appropriateness or interest on the part of residents, shall be documented and written documentation of the reasons for the exception shall be provided to the Department upon request.

(c) Resident activity programs shall take place in individual, small group, and large group settings.

(d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement.

(e) Residents may participate in the activities program regardless of their financial status, with the exception of special events for which there is a charge for all residents.

(f) At least weekly, a listing of all scheduled activities shall be posted in a conspicuous place in the facility.

(g) Resident activities programs shall be developed and modified on the basis of input from residents, as well as staff, family, and others.

8:39-7.4 Mandatory space and environment for resident activities

Each facility shall have an activities room that is equipped with arts and crafts supplies, games, and reading materials.

**SUBCHAPTER 8.
ADVISORY RESIDENT ACTIVITIES**

8:39-8.1 Advisory policies and procedures for resident activities

There is a formal, continuous mechanism for activity planning, implementation and evaluation.

8:39-8.2 Advisory staff qualifications for resident activities

The director of resident activities possesses a baccalaureate degree from an accredited college or university with a major area of concentration in therapeutic recreation or creative arts therapy or holds current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, P.O. Box 62589, Virginia Beach, Virginia 23466-2589) or National Council for Therapeutic Recreation Certification (National Council for Therapeutic Recreation, Inc., P.O. Box 479, Thiells, NY 10984-0479).

8:39-8.3 Advisory staffing amounts and availability for resident activities

(a) At least 55 minutes of resident activities staff time per resident per week is devoted to resident activities. (This is an average. It is equal to one full-time equivalent staff member for every 44 residents.)

(b) The facility maintains an active volunteer program that includes scheduled visits to the facility on at least a weekly basis.

8:39-8.4 Advisory resident services for resident activities

(a) Resident activity programs are conducted during at least four evenings per week.

(b) Field trips are accessible for all residents who choose to participate, unless their participation would not be clinically feasible.

(c) Regularly scheduled outdoor recreation is provided.

(d) There is a pet therapy program for interested residents, with safeguards to prevent interference in the lives of other residents, and the program complies with policies and procedures developed by the facility (See Appendix A for example).

(e) The facility has an organized program for visits to residents by school or pre-school children throughout the year.

**SUBCHAPTER 9.
MANDATORY ADMINISTRATION**

8:39-9.1 Ownership

(a) The facility shall inform the Department of the ownership and management of the facility and its location, and proof of ownership shall be available at the facility.

1. In the case of group or corporate management of a facility, the facility shall specify:

- i. The name and address of the firm or corporation; and
- ii. The names and addresses of all stockholders who own 10% or greater of the voting shares; members of any limited liability corporation; partners; and directors of the firm or corporation.

2. Any proposed change in ownership shall be approved by the Department in accordance with N.J.A.C. 8:39-2.12.

(b) The facility shall not be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility.

8:39-9.2 Administrator

(a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator. The administrator shall be administratively responsible for all aspects of the facility.

1. In a facility with more than 240 beds, in addition to the licensed administrator, there shall be a full-time administrative supervisor who is assigned the evening shift and reports directly to the licensed administrator.

2. In a facility with 100 beds or more, the administrator shall serve full-time in an administrative capacity within the facility.

3. In facilities with fewer than 100 beds, a licensed administrator shall serve at least half-time within the facility.

4. Two facilities may share a common administrator, if such facilities are within a 20-mile radius and if the total number of beds for which both facilities are licensed is no more than 120.

(b) A facility shall not retain in any administrative, managerial, supervisory, or similar position, a nursing home administrator whose license is either suspended or revoked, pursuant to N.J.S.A. 26:2H-27 and 26:2H-28 and N.J.A.C. 8:34-1.1.

(c) When a vacancy exists in the position of administrator for 48 hours or more, the facility shall arrange for licensed administrative supervision on a consultant basis, which shall continue until a new licensed administrator shall be appointed, which shall be within 90 days of the appointment of the consultant.

8:39-9.3 Mandatory policies and procedures for staff

(a) There shall be written policies and procedures for personnel that are reviewed annually, revised as needed, and implemented. They shall include at least:

1. A written job description for each category of personnel in the facility and distribution of a copy to each newly hired employee;
2. Personnel policies in compliance with Federal and State requirements;
3. A system to ensure that written, job-relevant criteria are used in making evaluation, hiring, and promotion decisions;
4. A system to ensure that employees meet ongoing requirements for credentials; and
5. Written criteria for personnel actions that require disciplinary action.

(b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.)

(c) The facility shall ensure that all private duty nursing staff and contract personnel are monitored and those who do not meet the requirements at (b) above or facility policies and procedures are not permitted to perform services in the facility.

(d) The facility shall develop and implement a grievance procedure for all staff. The procedure shall include, at least, a system for receiving grievances, a specified response time, assurance that grievances are referred appropriately for review, development of resolutions, and follow-up action.

(e) Each staff member shall wear clean clothes and shall use good personal hygiene.

8:39-9.4 Mandatory notification

(a) The administrator shall provide to the owner and/or governing body of the facility a copy of the licensing survey report and any additional survey-related data sent by the Department to the administrator of the facility.

(b) Results of the most recent licensure survey, Federal standard certification conducted by the Department and any plan of correction shall be available for inspection by any resident or visitor, in a readily accessible place, at all times. A notice announcing the availability of those results and all other surveys conducted in the past 12 months shall be conspicuously posted in diverse readily accessible areas of the facility.

(c) The facility shall make all policy and procedure manuals available to residents, families, and guardians during normal business hours or by prior arrangement.

(d) A facility shall notify the Department immediately in writing at such time as it becomes financially insolvent and upon the filing of a voluntary or involuntary petition for bankruptcy under Title 11 of the United States Code.

(e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following:

1. Interruption for three or more hours of physical plant services and/or other services essential to the health and safety of residents;

2. Termination of employment of the administrator or the director of nursing, and the name and qualifications of the proposed replacement;

3. All alleged or suspected crimes which endanger the life or safety of residents or employees, which are also reportable to the police department, and which result in an immediate on-site investigation by the police.

i. In addition, the State Office of the Ombudsman for the Institutionalized Elderly (1-877-582-6995) shall be immediately notified of any suspected or reported resident abuse, neglect, or exploitation of residents aged 60 or older, pursuant to P.L. 1983 c.43, N.J.S.A. 52:27G-7.1, and the Department shall be immediately notified for residents under the age of 60; and

4. All fires, disasters, deaths, and imminent dangers to a resident's life or health resulting from accidents or incidents in the facility.

(f) The facility shall notify the Department of the admission of any resident under 18 years of age.

8:39-9.5 Mandatory policies and procedures for residents' accounts

(a) The facility shall maintain a written record of all financial arrangements with each resident, next of kin who has entered into financial arrangements with the facility on behalf of the resident, and/or guardian. Copies of the record shall be accessible to the resident, next of kin who has entered into financial arrangements with the facility on behalf of the resident, or guardian during normal business hours or by prior arrangement.

(b) The facility shall provide the resident with 30 days prior written notice of charges, expenses, or other financial liabilities that are in addition to the agreed per diem rate. The resident's prior written approval for additional charges shall not be required in the event of a health emergency that requires the resident to receive immediate special services or supplies.

(c) Funds deposited with a facility for a particular resident's use and safekeeping shall be held in an account which is separate from any of the facility's operating accounts.

1. Funds in excess of \$50.00 shall be deposited in an interest bearing account(s) and all interest earned on resident's funds shall be credited to that account.

2. If a resident's personal funds do not exceed \$50.00, they shall be maintained in a separate interest bearing account, a non-interest bearing account, or a petty cash fund.

3. The facility shall assure the security of all personal funds of residents deposited with the facility, through purchase of a surety bond or an alternative that provides protection equivalent to a surety bond.

(d) All residents who have advanced a security deposit to a facility prior to or upon admission shall be entitled to receive interest earnings which accumulate on such funds or property.

1. The facility shall hold such funds or property in trust for the resident and they shall remain the property of the resident. All such funds shall be held in an interest-bearing account as established under the requirements of N.J.S.A. 30:13-1 *et seq.*

2. The facility may deduct an amount not to exceed one percent per annum of the amount so invested or deposited for costs of servicing and processing the accounts.

3. The facility, within 60 days of establishing an account, shall notify the resident, in writing, of the name of the bank or investment company holding the funds and the account number. The facility shall thereafter provide a quarterly statement to each resident it holds security funds in trust for, identifying the balance, interest earned, and any deductions for charges or expenses incurred in accordance with the terms of the contract or agreement of admission.

8:39-9.6 Mandatory policies and procedures for advance directives

(a) The facility shall develop and implement procedures to ensure that there is a routine inquiry made of each adult resident, upon admission to the facility and at other appropriate times, concerning the existence and location of an advance directive. If the resident is incapable of responding to this inquiry, the facility shall have procedures to request the information from the resident's family or in the absence of a family member, another individual with personal knowledge of the resident. The procedures shall assure that the resident or family's response to this inquiry is documented in the medical record. Such procedures shall also define the role of facility admissions, nursing, social service and other staff as well as the responsibilities of the attending physician or advanced practice nurse.

(b) The facility shall develop and implement procedures to promptly request and take reasonable steps to obtain a copy of currently executed advance directives from all residents. These shall be entered when received into the medical record of the resident.

(c) A resident shall be transferred to another health care facility only for a valid medical reason, in order to comply with other applicable laws or Department rules, to comply with clearly expressed and documented resident choice, or in conformance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 *et seq.*, in the instance of private, religiously affiliated health care institutions who establish policies defining circumstances in which it will decline to participate in the implementation of advance directives. Such institutions shall provide notice to residents or their families or health care representatives prior to or upon admission of their policies. A timely and respectful transfer of the individual to another institution which will implement the resident's advance directive shall be effected. The facility's inability to care for the resident shall be considered a valid medical reason. The sending facility

shall receive approval from a physician or advanced practice nurse and the receiving health care facility before transferring the resident.

(d) The facility shall, in consultation with the attending physician or advanced practice nurse, take all reasonable steps to effect the appropriate, respectful and timely transfer of residents with advance directives to the care of an alternative health care professional in those instances where a health care professional declines as a matter of professional conscience to participate in withholding or withdrawing life-sustaining treatment. In those instances where the health care professional is the resident's physician or advanced practice nurse, the facility shall take reasonable steps, in cooperation with the physician or advanced practice nurse, to effect the transfer of the resident to another physician's or advanced practice nurse's care in a responsible and timely manner. Such transfer shall assure that the resident's advance directive is implemented in accordance with their wishes within the facility, except in cases governed by (c) above.

(e) The facility shall have procedures to provide each adult resident upon admission, and where the resident is unable to respond, to the family or other representative of the resident, with a written statement of their rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive. Such statement shall be issued by the Commissioner. Appropriate written information and materials on advance directives and the institution's written policies and procedures concerning implementation of such rights shall also be provided. Such written information shall also be made available in any language which is spoken as a primary language, by more than 10 percent of the population served by the facility.

(f) The facility shall develop and implement procedures for referral of residents requesting assistance in executing an advance directive or additional information to either staff or community resource persons who can promptly advise and/or assist the resident.

(g) The facility shall develop and implement policies to address application of the facility's procedures for advance directives to residents who experience an urgent life-threatening situation.

(h) The facility shall develop and implement policies and procedures for the declaration of death of residents, in instances where applicable, in accordance with N.J.S.A. 26:6-1 et seq. and the New Jersey Declaration of Death Act, N.J.S.A. 26:6A-1 et seq. (P.L. 1991, c.90). Such policies shall also be in conformance with rules promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria (N.J.A.C. 13:35-6A), including the qualifications of physicians or advanced practice nurses authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used. The

policies and procedures shall also accommodate a resident's religious beliefs with respect to declaration of death.

(i) The facility shall establish procedures for considering disputes among the resident, health care representative and the attending physician concerning the resident's decision-making capacity or the appropriate interpretation and application of the terms of an advance directive to the resident's course of treatment. The procedures may include consultation with an institutional ethics committee, a regional ethics committee or another type of affiliated ethics committee, or with any individual or individuals who are qualified by their background and/or experience to offer clinical and ethical judgments.

(j) The facility shall establish a process for residents, families, and staff to discuss and address questions and concerns relating to advance directives and decisions to accept or refuse medical treatment.

(k) The facility shall provide periodic community education programs, individually or in coordination with other area facilities or organizations, that provide information to consumers regarding advance directives and their rights under New Jersey law to execute advance directives.

(l) At least one education or training program each year shall be held and documented for all administrative and resident care staff regarding the rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act (P.L. 1991, c.201) and the Federal Patient Self Determination Act (P.L. 101-508), and internal facility policies and procedures to implement these laws.

**SUBCHAPTER 10.
ADVISORY ADMINISTRATION**

8:39-10.1 Advisory policies and procedures for administration

(a) The administrator monitors trends in staff turnover.

(b) Each of at least five service directors participates in facility planning through preparation of annual budgets and annual reports, and participates in annual budget conferences among all service directors and the administrators.

8:39-10.2 Advisory staff qualifications

The administrator holds current professional certification from the American College of Health Care Administrators, or possesses a master's degree in health care administration or a related field.

8:39-10.3 Advisory staff education and training

(a) Personnel who provide direct resident care are offered an opportunity to attend at least one education program each year and receive fee reimbursement or compensatory time off. Records of continuing education programs attended are maintained.

(b) The facility conducts a tuition aid program directed toward the career development and upward mobility of staff, including both professional and ancillary personnel.

(c) The facility is a teaching nursing home, that is, the site of an internship, externship, or residency training program for health professionals, as part of the curriculum of an accredited or State-approved school or training program. The facility has sought input from the residents and/or the resident council concerning teaching programs.

(d) The facility maintains a library of textbooks and/or recent periodicals on long-term care, geriatric care, nursing, and other disciplines that is accessible to staff.

**SUBCHAPTER 11.
MANDATORY RESIDENT ASSESSMENT AND CARE PLANS**

8:39-11.1 Mandatory completion of resident assessment and coordination of care plans

A registered professional nurse (RN) shall assess the nursing needs of each resident, coordinate the written interdisciplinary care plan, sign and date the assessment to certify that it is complete, and ensure the timeliness of all services.

8:39-11.2 Mandatory policies and procedures for resident assessment and care plans

(a) A physician or advanced practice nurse shall provide orders for each resident's care beginning on the day of admission.

(b) Each physician or advanced practice nurse order shall be executed by the nursing, dietary, social work, activities, rehabilitation or pharmacy service, as appropriate in accordance with professional standards of practice.

(c) Each resident shall be examined by a physician or advanced practice nurse within five days before, or 48 hours after, admission.

(d) An initial assessment and care plan shall be developed on the day of admission and shall address all immediate needs, including, but not limited to, personal hygiene, dietary needs, medications, and ambulation.

(e) A comprehensive assessment shall be completed for each resident within 14 days of admission, utilizing the Standardized Resident Assessment Instrument (Minimum Data Set 2.0, or version current as of time of assessment, incorporated herein by reference).

1. The complete assessment and care plan shall be based on oral or written communication and assessments provided by nursing, dietary, resident activities, and social work staff; and when ordered by the physician or advanced practice nurse, assessments shall also be provided by other health professionals.

2. The care plan shall include measurable objectives with interventions based on the resident's care needs and means of achieving each goal.

3. Each facility shall have the equipment and software necessary to enter, store, and transmit each resident's Standardized Resident Assessment Instrument (MDS 2.0 or most current version) electronically to the Department and shall transmit such data to the Department. The facility shall use software which meets technical specifications for the MDS 2.0 (or the version current at the time of assessment) as required by the U.S. Health Care Financing

Administration at 42 CFR 483.20(b), and published in the Federal Register at 63 FR 2896.

i. Additional information is available from the MDS Automation Program, 609-984-8204 and at <http://www.hcfa.gov/medicaid/mds20/mds20.pdf>.

(f) The complete care plan shall be established and implementation shall begin within 21 days, and shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.

(g) If a resident is discharged to a hospital and returns to the facility within 30 days of discharge, reassessment shall be conducted in those areas where the resident's needs have changed substantially. A complete reassessment shall be performed if the resident was discharged for more than 30 days.

(h) There shall be a scheduled comprehensive reassessment in each service involved in the initial assessment, plus other areas which the physician, advanced practice nurse, or interdisciplinary team indicates are necessary. Reassessments shall be performed according to time frames established in the previous care plan.

(i) A reassessment shall be performed in response to all substantial changes in the resident's condition, such as fractures, onset of debilitating chronic diseases, loss of a loved one, or recovery from depression.

(j) The facility shall have a written transfer agreement with one or more hospitals for emergency care and inpatient and outpatient services.

SUBCHAPTER 12.
ADVISORY RESIDENT ASSESSMENT AND CARE PLANS

8:39-12.1 Advisory policies and procedures for resident assessment and care plan

(a) The resident care plan is developed at a meeting held by an interdisciplinary team that includes professional and/or ancillary staff from each service providing care to the resident.

(b) The facility makes care planning meetings available at mutually agreeable times, including evenings and weekends, for the convenience of families and significant others.

8:39-12.2 Advisory resident services for off-site services

The facility provides and/or arranges for someone to accompany each resident to scheduled visits to off-site health care services.

**SUBCHAPTER 13.
MANDATORY COMMUNICATION**

8:39-13.1 Mandatory communication policies and procedures

(a) Each service shall maintain a current manual of policies and procedures for providing services.

(b) The administrative staff shall retain a written current manual of policies and procedures for the facility as a whole and for each individual service.

(c) The facility shall notify any family promptly of an emergency affecting the health or safety of a resident.

(d) The facility shall notify the attending physician or advanced practice nurse promptly of significant changes in the resident's medical condition.

8:39-13.2 Mandatory resident communication services

(a) Residents and their families shall be given the opportunity to participate in the development and implementation of the care plan, and their involvement shall be documented in the resident's medical record.

(b) Before or on the day of admission, residents and families shall be informed in writing about services provided by the facility, charges imposed for services at the facility, the availability of financial assistance, the rights and responsibilities of residents and families, and the role of each service on the health care team; and they shall be given a tour of resident care units in the facility.

(c) The facility shall listen to the views and act upon or respond to the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

8:39-13.3 Mandatory staff communication qualifications

(a) Staff shall always communicate with residents and families in a respectful way, and shall introduce and identify themselves to residents as required and necessary.

(b) The facility shall ensure that all staff, including staff members not fluent in English, are able to communicate effectively with residents and families.

8:39-13.4 Mandatory staff education and training for communication

(a) Each service shall conduct an orientation program for new employees of that service unless the orientation program is conducted by the administrator or a qualified designee.

1. For purposes of complying with this requirement, "new employees" shall be defined to include all permanent and temporary resident care personnel, nurses retained through an outside agency, and persons providing services by contract.

2. The orientation program shall begin on the first day of employment.

3. The orientation program for all staff shall include orientation to the facility and the service in which the individual will be employed, at least a partial tour of the facility, a review of policies and procedures, identification of individuals to be contacted under specified circumstances, and procedures to be followed in case of emergency.

(b) Each service shall provide education or training for all employees in the service at least four times per year and in response to resident care problems, implementation of new procedures, technological developments, changes in regulatory standards, and staff member suggestions. All staff members shall receive training at least two times per year about the facility's infection control procedures, including handwashing and personal hygiene requirements.

(c) At least one education training program each year shall be held for all employees on each of the following topics:

1. Procedures to follow in case of emergency;

2. Abuse, neglect, or misappropriation of resident property;

i. Abuse prevention strategies including, but not limited to, identifying, correcting, and intervening in situations where abuse, neglect, or misappropriation of resident property is likely to occur;

ii. Identifying events, such as suspicious bruising of residents or patterns and trends that may constitute abuse, neglect, or misappropriation of resident property;

iii. Protecting residents from harm during an investigation of abuse, neglect, or misappropriation of resident property;

iv. Identification of staff responsible for investigating and reporting results to the proper authorities;

v. Reporting substantiated incidents to the appropriate local/State/Federal agencies and taking all necessary corrective actions depending on the results of the investigation; and

vi. Reporting to the State nurse aide registry or licensing authorities any knowledge of any actions of any court of law which would indicate that an employee is unfit for service;

3. Resident rights;

4. Training in the specialized care of residents who are diagnosed by a physician as having Alzheimer's disease. The required training program shall be in conformance with the curriculum developed by the Department in accordance with N.J.S.A. 26:2M-7.2 (for certified nurse aides, licensed practical nurses, registered professional nurses and other healthcare professionals who provide direct care to residents within the facility);

i. Copies of the mandatory training program may be obtained from the Department by submitting a written request to:

Certification Program
Division of Long-Term Care Systems
New Jersey State Department of Health and Senior Services
PO Box 367
Trenton, NJ 08625-0367; and

5. Pharmacy (for all direct care staff).

**SUBCHAPTER 14.
ADVISORY COMMUNICATION**

8:39-14.1 Advisory resident services

(a) The facility has one or more wellness programs open to the public, such as programs to reduce or prevent smoking, alcohol and drug abuse, elder abuse, obesity, or hypertension.

(b) Periodic meetings are open to all staff, residents, and families to discuss any problems, encourage the resident to reach his or her potential, examine the goals and expectations of different individuals, describe how questions and complaints can be presented, and review the concept of interdisciplinary care.

(c) Provision is made for residents to retain membership, join, and/or participate in community activities. These should include organizations, community projects, holiday observances, or charitable events.

(d) A facility newsletter is provided to residents and families at least quarterly.

(e) Each staff member wears an easily readable name tag.

8:39-14.2 Advisory staff education and training for communication

(a) Periodic meetings are held with each service to discuss ways to improve care of all residents.

(b) Education and training of staff includes an accredited program in cardiopulmonary resuscitation (CPR) which offers staff an opportunity to be recertified on an annual basis.

(c) Each service establishes and implements education or training programs for members of other services on diverse topics.

(d) Education or training sessions are offered which address new concepts and directions in cultural and interpersonal concepts.

**SUBCHAPTER 15.
MANDATORY DENTAL SERVICES**

8:39-15.1 Mandatory resident dental services

(a) The facility shall provide or arrange emergency dental care to relieve pain and infection.

(b) The facility shall assist interested residents in making arrangements to receive dental examinations, routine prophylaxis, and care.

(c) The facility shall ensure that arrangements are made to transport residents for routine and emergency dental care.

(d) All resident dentures shall be labeled.

**SUBCHAPTER 16.
ADVISORY DENTAL SERVICES**

8:39-16.1 Advisory resident dental services

(a) The facility provides in-house dental services, including treatment and prophylactic care.

(b) The facility follows established protocols for providing all residents with regularly scheduled routine prophylactic dental services and treatments when indicated, delivered by a dentist or a dental hygienist, except for residents whose medical records contain an explanation of why such services would not benefit the resident.

SUBCHAPTER 17
MANDATORY DIETARY SERVICES

8:39-17.1 Mandatory structural organization for dietary services

(a) The facility shall designate a full-time food service director who, if not a dietitian, functions with scheduled consultation from a dietitian. The food service director shall be responsible for the direction, provision, and quality of dietary services.

(b) Menus shall be planned and scheduled by the food service director or the dietitian, and shall be approved by the dietitian at least 14 days in advance.

(c) The dietitian shall perform the dietary assessment and reassessment, which shall include examination of and communication with the resident if the resident's condition permits.

(d) Services that are provided by a food service company shall be covered by a written contract.

8:39-17.2 Mandatory policies and procedures for dietary services

(a) The facility shall make available a current dietary manual, which shall have been approved by the dietitian and the medical director. The facility shall serve diets that are consistent with the dietary manual.

(b) The facility shall post current menus with portion sizes in the food preparation area. The facility shall keep menus for 30 days with any changes accurately recorded.

(c) The facility shall designate responsibility for observation and documentation of meals refused or missed by a resident and of any resident who requires assistance with meals.

(d) A dietitian shall adhere to an established system of nutritional assessment, which shall include examination of and communication with the resident if the resident's condition permits.

(e) The facility shall routinely provide nondisposable dishes and cutlery at all meals except for special meal activities or individual resident needs.

(f) Meals shall be scheduled in such a way that no more than 14 hours elapse between a substantial evening meal and breakfast the next morning. The first meal shall not be served before 7:00 A.M. unless requested by the resident.

1. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if the following conditions are met:

- i. A resident group agrees to this meal span; and
- ii. A nourishing bedtime snack is served.

(g) All food service facilities shall operate with safe food handling practices in accordance with Chapter XII of the New Jersey Sanitary Code, N.J.A.C. 8:24.

8:39-17.3 Mandatory staffing amounts and availability for dietary services

(a) The dietitian shall spend an average of 15 minutes per resident each month providing dietary services in the facility, which requires one full-time equivalent dietitian for every 693 residents.

(b) Dietary service personnel shall be present for a period of at least 12 hours each day.

(c) For each meal, the facility shall assign staff to help residents who require assistance with eating.

8:39-17.4 Mandatory resident dietary services

(a) Each resident shall receive a diet which:

1. Corresponds to the physician's or advanced practice nurse's order, the dietitian's instructions, and resident's food preferences;
2. Is served in the proper consistency and at the proper temperature; and
3. Provides nutrients and calories based upon current recommended dietary allowances of the National Academy of Sciences, adjusted for the resident's age, sex, weight, physical activity, physiological function, and therapeutic needs.

(b) The facility shall provide between-meal and bedtime nourishment, and beverages shall be available at all times for each resident unless contraindicated by a physician, as documented in the resident's medical record.

(c) The facility shall offer substitute foods and beverages to all residents who refuse the food served at meal times. Such substitutes shall be of equivalent nutritional value and planned in advance in writing.

(d) No resident shall have to wait for assistance in eating for more than 15 minutes following delivery of a tray to the resident.

(e) The facility shall select foods and beverages, which include fresh and seasonal foods, and shall prepare menus with regard to the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal preference of residents.

**SUBCHAPTER 18.
ADVISORY DIETARY SERVICES**

8:39-18.1 Advisory structural organization for dietary services

A registered dietitian performs the resident dietary assessment and participates in the interdisciplinary plan of care.

8:39-18.2 Advisory staff qualifications for dietary services

The director of dietary services or the dietitian is registered by the Commission on Dietetic Registration of the American Dietetic Association (R.D.).

8:39-18.3 Advisory staffing amounts and availability for dietary services

The dietitian spends an average of 20 minutes per resident each month providing dietary services in the facility. (This is an average. It is equal to one full-time equivalent dietitian for every 520 residents.)

8:39-18.4 Advisory resident dietary services

- (a) There are dietary observances for national and/or religious holidays.
- (b) Fresh fruits and vegetables are served in season on a daily basis.
- (c) The facility utilizes a dining room/area, other than day rooms, for residents with special needs.
- (d) Residents have access to a refrigerator or snack bar.
- (e) Residents are offered a selective menu consisting of at least three main entrees at each meal.
- (f) A menu committee composed of residents participates in meal planning.
- (g) The facility sponsors a guest meal program.

8:39-18.5 Supplies and equipment

The facility provides cloth table covers and cloth napkins at least once a day.

SUBCHAPTER 19.
MANDATORY INFECTION CONTROL AND SANITATION

8:39-19.1 Mandatory organization for infection control and sanitation

(a) The facility shall have an infection prevention and control program conducted by an infection control committee which shall include representatives from at least administrative, nursing, medical, dietary, housekeeping or environmental services, and pharmacy staffs. The infection control committee shall review all infection control policies and procedures, periodically review infection control surveillance data, and formulate recommendations to the administrator regarding infection control activities.

(b) Responsibility for the infection prevention and control program shall be assigned to an employee who is designated as the infection control coordinator, with education, training, completed course work, or experience in infection control or epidemiology; or services shall be provided by contract. If the services are provided by contract, the facility shall designate an on-site employee to implement, coordinate, and ensure compliance with infection control policies and procedures.

8:39-19.2 Mandatory employee health policies and procedures for infection control and sanitation

(a) Employees who have signs or symptoms of a communicable disease shall not be permitted to perform functions that expose residents to risk of transmission of the disease.

(b) If a communicable disease prevents the employee from working, a physician's or advanced practice nurse's statement approving the employee's return shall be required. Prior to the employee's return to work, the physician's or advanced practice nurse's statement shall be reviewed by the administrator or the administrator's designee. However, when an employee has been absent for no longer than three days, the employee's return to work may be approved by either the facility's director of nursing or the infection control committee, following assessment by a registered professional nurse.

(c) The facility shall develop and implement procedures for the care of employees who become ill while at work or who have a work-related accident.

8:39-19.3 Mandatory waste removal policies and procedures

(a) Regulated medical waste shall be collected, stored, handled, and disposed of in accordance with applicable Federal laws and regulations, and the facility shall comply with the provisions of N.J.S.A. 13:1E-48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules

promulgated pursuant to the aforementioned Act including, but not limited to, N.J.A.C. 7:26-3A.

(b) The infection control committee shall develop and implement written policies and procedures for collection, storage, handling, and disposal of all solid waste that is not regulated medical waste.

(c) All solid waste that is not regulated medical waste shall be disposed of in a sanitary landfill or other manner approved by the Department of Environmental Protection. Disposal shall be as frequent as necessary to avoid creating a nuisance.

8:39-19.4 Mandatory general policies and procedures for infection control and sanitation

(a) The facility shall develop, implement, comply with, and review, at least annually, written policies and procedures regarding infection prevention and control which are consistent with the most up-to-date Centers for Disease Control and Prevention publications, incorporated herein by reference, including, but not limited to, the following:

1. Guidelines for Handwashing and Hospital Environmental Control;
2. Guidelines for Isolation Precautions in Hospitals;
3. Prevention and Control of Tuberculosis in Facilities Providing Long-term Care to the Elderly;
4. Prevention of Nosocomial Pneumonia;
5. Prevention of Catheter Associated Urinary Tract Infections; and
6. Prevention of Intravascular Infections.

(b) Centers for Disease Control and Prevention publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161

or

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

(c) The facility shall comply with applicable current Occupational Safety and Health Administration (OSHA) requirements.

(d) The infection control coordinator shall provide continuous collection and analysis of data, including determination of nosocomial infections, epidemics, clusters of infections, infections due to unusual pathogens or multiple antibiotic resistant bacteria, and any occurrence of nosocomial infection that exceeds the usual baseline levels.

(e) The infection control coordinator shall make recommendations for corrective actions based on surveillance and data analysis.

(f) The facility shall have a system for investigating, evaluating, and reporting the occurrence of all reportable infections and diseases as specified in Chapter II of the State Sanitary Code (N.J.A.C. 8:57-1).

(g) The facility shall maintain listings of all residents and personnel who have reportable infections, diseases, or conditions.

(h) The facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused the vaccine, in accordance with N.J.A.C. 8:39-4.1(a)4. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year. Residents admitted after this date, during the flu season and up to February 1, shall, as medically appropriate, receive influenza vaccination prior to or on admission, unless refused by the resident.

(i) The facility shall document evidence of vaccination against pneumococcal disease for all residents who are 65 years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine in accordance with N.J.A.C. 8:39-4.1(a)4. The facility shall provide pneumococcal vaccination to residents who have not received this immunization, prior to or on admission unless the resident refuses offer of the vaccine.

(j) The facility shall implement a policy for tuberculosis screening of all residents which begins prior to admission and concludes within 30 days following admission. If the admission screening is conducted through chest X-ray within three months prior to admission, the resident shall receive a two-step Mantoux skin test within three months after admission.

(k) If used, all reusable respiratory therapy equipment and instruments that touch mucous membranes shall be disinfected or sterilized in accordance with the Centers for Disease Control and Prevention publication "Guidelines for Handwashing and Hospital Environmental Control," incorporated herein by reference, and with manufacturer's recommendations.

(l) Disinfection procedures for items that come in contact with bed pans, sinks, and toilets shall conform with established protocols for cleaning and disinfection, in accordance with the Centers for Disease Control publication "Guidelines for Handwashing and Hospital Environmental Control," and with manufacturer's recommendations. All resident care items shall be cleaned, disinfected, or sterilized, according to the use of the item.

(m) All residents shall be provided with an opportunity to wash their hands before each meal and shall be encouraged to do so. Staff shall wash their hands before each meal and before assisting residents in eating. Handwashing practices shall be monitored at least monthly by the infection control coordinator.

(n) Personnel shall wash their hands with soap and warm water for between 10 and 30 seconds or use other effective hand sanitation techniques immediately prior to contact with residents.

8:39-19.5 Mandatory staff qualifications; health history and examinations

(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.

(b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:

1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.

2. If the Mantoux test is significant (10 millimeters or more of induration), a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy.

3. Any employee with positive results shall be referred to the employee's personal physician or advanced practice nurse and if active tuberculosis is suspected or diagnosed shall be excluded from work until the physician or advanced practice nurse provides written approval to return.

(c) The facility shall have written policies and procedures requiring annual Mantoux tuberculin skin tests for all employees, except those exempted under (b) above.

(d) The facility shall assure that all current employees who have not received the two-step Mantoux test upon employment, except those exempted by (b) above, shall receive a test. The facility shall act on the results of tests of current employees in the same manner as prescribed in (b) above.

8:39-19.6 Mandatory space and environment for water supply

(a) The water supply used for drinking or culinary purposes shall be adequate in quantity, of a safe sanitary quality, and from a water system which shall be constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq., N.J.A.C. 7:10 and local laws, ordinances, and regulations. Copies of the Safe Drinking Water Act can be obtained from the Department of Environmental Protection, Bureau of Safe Drinking Water, P.O. Box 426, Trenton, New Jersey 08625-0426.

(b) There shall be no cross connections between city and well water supplies. When the facility uses well water for potable water every day, a double check valve shall be permitted if the facility has approval for such use from the water company and the New Jersey State Department of Environmental Protection.

(c) The facility shall post water quality test results in at least one conspicuous location in the facility, in accordance with N.J.S.A. 26:2H-12.14.

(d) Equipment requiring water drainage, such as ice machines and water fountains, shall be properly drained to a sanitary connection.

8:39-19.7 Mandatory space and environment for sanitation and waste management

(a) Solid waste shall be stored in clean, solidly constructed containers with tight-fitting lids for the storage of solid wastes.

(b) Storage areas for solid waste containers shall be kept clean. Waste shall be collected from all storage areas regularly to prevent nuisances such as odors, flies, or rodents.

(c) There shall be no back siphonage conditions present.

(d) All food service facilities shall be maintained in conformance with Chapter XII of the New Jersey State Sanitary Code, N.J.A.C. 8:24.

(e) If the facility has an incinerator, it shall operate with the necessary permits from the New Jersey Department of Environmental Protection and shall not create a nuisance to the facility or the community.

(f) Solid waste that is not regulated medical waste shall be stored within the containers provided for it outside the facility or in a separate room that is maintained in a clean and sanitary condition. Waste shall be collected from the storage room regularly to prevent nuisances such as odors, flies, or rodents, and so that the waste shall not overflow or accumulate beyond the capacity of the storage containers.

(g) Garbage compactors shall be located on an impervious pad that is graded to a drain. For new construction, the drain shall be connected to the sanitary sewage disposal system.

(h) Plastic bags shall be used for solid waste removal from resident care units and supporting departments. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal.

8:39-19.8 Mandatory supplies and equipment for infection control and sanitation

(a) The sewage disposal system shall be maintained in good repair and operated in compliance with State and local laws, ordinances, and regulations.

(b) Water piping carrying non-potable water shall be clearly labeled.

(c) Commercial sterile supplies shall be used in accordance with manufacturers' recommendations, and before expiration dates, and packages shall be inspected to ensure integrity.

(d) Bed pan washers shall be in good working order and properly maintained.

(e) Toilet tissue and proper waste receptacles shall be provided.

(f) Suitable hand cleanser and sanitary towels or approved hand-drying machines shall be provided.

(g) Equipment and supplies used for sterilization, disinfection, and decontamination purposes shall be maintained according to manufacturers' specifications.

**SUBCHAPTER 20.
ADVISORY INFECTION CONTROL AND SANITATION**

8:39-20.1 Advisory policies and procedures for infection control

(a) The facility routinely offers Hepatitis B vaccine to all employees, regardless of risk status or duties, without charge.

(b) Employees undergo periodic or annual health screening.

(c) The facility maintains records documenting contagious diseases contracted by employees during employment.

8:39-20.2 Advisory staff qualifications

(a) The infection control coordinator is certified in Infection Control (CIC) by the National Board of Infection Control, P.O. Box 14661, Lenexa, KS 66286-4661.

(b) The infection control coordinator is an active member of the National Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), 1275 K Street, NW, Suite 1000, Washington, DC 20005-4006.

(c) The infection control coordinator has completed an APIC Basic Training Course or has received at least 25 hours of training in infection control, and receives an additional six hours of training annually.

8:39-20.3 Advisory staff education and training for infection control

At least four education or training programs on infection control are held every year so that all staff members are fully informed about infection control requirements that apply to them.

**SUBCHAPTER 21.
MANDATORY LAUNDRY SERVICES**

8:39-21.1 Mandatory laundry policies and procedures

(a) Soiled laundry shall be stored in a ventilated area, separate from other supplies, and shall be stored, sorted, rinsed, and laundered only in areas specifically designated for those purposes.

(b) All soiled laundry from resident rooms and other service units shall be stored, transported, collected, and delivered in a covered laundry bag or cart. Laundry carts shall be in good repair, kept clean, and identified for use with either clean or soiled laundry.

(c) Soiled laundry contaminated with blood and/or body fluids shall be collected in an effectively closed leak proof bag of sufficient strength to safely contain such laundry from point of origin to point of processing.

(d) Clean laundry shall be protected from contamination during processing, storage, and transportation within the facility.

(e) Soiled and clean laundry shall be kept separate.

(f) An established protocol, reviewed by the infection control committee, shall be followed to reduce the number of bacteria in the fabrics.

(g) Equipment surfaces that come into contact with laundry shall be sanitized.

(h) The facility shall develop and implement policies and procedures, reviewed by the infection control committee, to protect staff from contamination when handling soiled laundry.

(i) Sour testing to ensure neutralization of alkaline residues from built detergents shall be conducted, and fabric pH shall be maintained at 7.0 or below after souring.

(j) The facility shall develop and implement policies and procedures to ensure that residents' personal clothing is collected, processed and returned to the resident in a sanitary manner and in good condition.

(k) The facility shall have a system to identify each resident's clothing and a procedure to locate and/or minimize loss of clothing.

8:39-21.2 Mandatory space and environment for laundry facilities

If the facility has an on-premises laundry, it shall provide a receiving, holding, and sorting area with hand-washing facilities. The walls, floors, and ceilings of the area shall be clean and in good repair. The flow of ventilating air shall be from clean to soiled areas, and ventilation shall be adequate to prevent heat and odor build-up.

8:39-21.3 Mandatory supplies and equipment for laundry

(a) The facility shall have a supply of linen appropriate to the resident's needs that is clean, in good repair, and is at least three times the number of residents.

(b) The facility shall have a supply of blankets that is at least two times the number of residents.

8:39-21.4 Mandatory quality assurance for laundry

All facilities, including those that contract with a commercial laundry service, shall evaluate the service as part of the quality assurance program.

**SUBCHAPTER 22.
ADVISORY LAUNDRY SERVICES
(RESERVED)**

**SUBCHAPTER 23.
MANDATORY MEDICAL SERVICES**

8:39-23.1 Mandatory structural organization for medical services

(a) Each facility shall have a medical director who is currently licensed to practice medicine by the New Jersey State Board of Medical Examiners.

1. The medical director shall coordinate medical care and direct the administrative aspects of medical care in the facility.
2. The medical director shall approve all medical care policies and procedures. These policies and procedures shall be followed.
3. The medical director shall participate in the facility's quality assurance program through attendance at meetings, or interviews, and/or preparation or review of reports.
4. The medical director shall be an active participant on the facility's infection control committee, pharmacy and therapeutics committee, and a committee that is responsible for developing policies and procedures for resident care.
5. The medical director shall ensure that for each resident there is a designated primary and an alternate physician who can be contacted when necessary.
6. The medical director shall review all reports of incidents that have been documented in accordance with N.J.A.C. 8:39-9.4(e)4.
7. The medical director, or physicians designated by the medical director, shall respond quickly and effectively to medical emergencies that are not handled by another attending physician, including inpatient admissions.

(b) In facilities providing pediatric care services, the medical director/attending physician shall be board certified, or eligible to be board certified, by the American Board of Pediatrics or American Board of Family Practice.

(c) Facilities with fewer than 60 beds may develop an alternate system of medical direction, if the facility can document that medical staff perform the requirements at (a)1 through 4 above.

8:39-23.2 Mandatory medical services

(a) Each physician or advanced practice nurse order shall be properly entered into the resident's medical record.

(b) Each resident's attending physician or advanced practice nurse shall review the resident's medical record on a scheduled basis to ensure that care plans and medical orders are properly followed.

(c) The facility shall maintain a list of consultant physicians who are available for referrals made by the attending physician and shall make arrangements for referrals to psychological services.

(d) A physician or advanced practice nurse shall visit each resident at least every 30 days unless the medical record contains an explicit justification for not doing so. Following the initial visit, alternate 30-day visits may be delegated by a physician to a New Jersey licensed physician assistant, in accordance with facility policies.

8:39-23.3 Defibrillator

(a) The facility shall maintain at least one defibrillator available to trained staff in a central location.

(b) The facility shall have a written protocol on the use of the defibrillator. The protocol shall address:

1. The testing and maintenance of the defibrillator according to the manufacturer's operational guidelines; and
2. The training of staff in the use of the defibrillator.

(c) The facility shall arrange and pay for the training of a sufficient number of direct-care staff in cardio-pulmonary resuscitation and the proper use of the defibrillator to ensure that at least one direct-care staff member on every shift holds a current certification from the American Red Cross, American Heart Association or other training program recognized by the Department in cardio-pulmonary resuscitation and the use of the defibrillator.

(d) The facility shall notify the appropriate first aid, ambulance or rescue squad or other appropriate emergency medical services provider of the type of defibrillator acquired and its location.

**SUBCHAPTER 24.
ADVISORY MEDICAL SERVICES**

8:39-24.1 Advisory medical staff qualifications

The medical director is board-certified in a primary care specialty, such as family medicine, gerontology, or general internal medicine.

8:39-24.2 Advisory resident medical services

(a) The facility arranges for physician or advanced practice nurse visits in the facility on a scheduled appointment basis in an office provided for that purpose.

(b) The facility has a staff or consultant psychiatrist with admitting privileges to the inpatient psychiatric unit at a hospital.

**SUBCHAPTER 25.
MANDATORY NURSE STAFFING**

8:39-25.1 Mandatory policies and procedures for nurse staffing

(a) There shall be a full-time director of nursing or nursing administrator who is a registered professional nurse licensed in the State of New Jersey, who has at least two years of supervisory experience in providing care to long-term care residents, and who supervises all nursing personnel.

(b) During a temporary absence of the director of nursing, there shall be a registered professional nurse on duty who shall be designated in writing as an alternate to the director of nursing. The alternate shall be temporarily responsible for supervising all nursing personnel.

8:39-25.2 Mandatory nurse staffing amounts and availability

(a) The facility shall provide nursing services and licensed nursing and ancillary personnel at all times. In accordance with N.J.A.C. 13:37-6.2, the registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel.

(b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:

1. Total number of residents multiplied by 2.5 hours/day; plus
2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:

Wound care	0.75 hour/day
Nasogastric tube feedings and/or gastrostomy	1.00 hour/day
Oxygen therapy	0.75 hour/day
Tracheostomy	1.25 hours/day
Intravenous therapy	1.50 hours/day
Use of respirator	1.25 hours/day
Head trauma stimulation/advanced neuromuscular/orthopedic care	1.50 hours/day

(c) The following definitions shall be used for nursing services set forth in (b)2 above:

1. Wound care includes, but is not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites. In this category are Stage II pressure sores encompassing two or more distinct lesions on separate anatomical sites, and Stage III and Stage IV pressure sores.

i. Tube site and surrounding skin related to ostomy feeding is not to be counted as wound care unless there are complicating factors, such as: exudative, suppurative or ulcerative inflammation which require specific physician or advanced practice nurse prescribed intervention provided by the licensed nurse beyond routine cleansing and dressing.

ii. Stage III and Stage IV are defined as follows:

(1) Stage III. The wound extends through the epidermis and dermis into the subcutaneous fat and is a full thickness wound. There may be inflammation, necrotic tissue, infection and drainage and undermining sinus tract formation. The drainage can be serosanguinous or purulent. The area is painful.

(2) Stage IV. The pressure wound extends through the epidermis, dermis, and subcutaneous fat into fascia, muscle and/or bone. Eschar, undermining odor and profuse drainage may exist.

(3) Other wounds which may be categorized under wound care as defined in (c)1 above include:

(A) Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the individual is receiving antibiotic therapy;

(B) Wounds with a drain or T-tube;

(C) Wounds which require irrigation or instillation of a sterile cleansing or medicated solution and/or packing with sterile gauze;

(D) Recently debrided ulcers;

(E) Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when dressing is changed (for example, post radical neck surgery, cancer of the vulva);

(F) Open wounds, widespread skin disease or complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;

(G) Complicated post-operative wounds that exhibit signs of infection, allergic reactions or an underlying medical condition that affects healing.

2. Tube feedings, which include nasogastric tube and percutaneous feedings, provide the individual with more than 26% of his or her calories and at least 501 milliliters of hydration daily and are required to treat the individual's condition after all non-invasive avenues to improve the nutritional status have been exhausted with no improvement. The clinical record shall document the non-invasive measures provided and the individual's poor response. The record shall also indicate the medical condition for which the feedings are ordered. Included in this service is the routine care of the tube site and surrounding skin of the surgical gastrostomy.

i. Feeding tubes that are routinely clamped off and are no longer the primary source of dietary administration and nutritional support are covered under the basic 2.5 hours/day of nursing service and shall not be counted as an additional nursing service.

3. Oxygen therapy includes complex provision of oxygen/respiratory therapies due to the nature of the individual's condition, the type or multiplicity of procedures required and the need for therapies for which the individual is dependent upon administration by licensed staff, such as positive pressure breathing therapy, nasal BiPAP and aerosol therapy.

4. Tracheostomy includes new tracheostomy sites and complicated cases involving symptomatic infections and unstable respiratory functioning.

5. Intravenous therapy includes clinically indicated therapies ordered by the physician, such as central venous lines, Hickman/Broviac catheters, heparin locks, total parenteral nutrition, clysis, hyperalimentation and peritoneal dialysis. When clinically indicated, intravenous medications should be appropriately and safely administered within prevailing medical protocols. If intravenous therapy is for the purpose of hydration, the clinical record shall document any preventive measures and attempts to improve hydration orally, and the individual's inadequate response.

6. Respirator use includes care for individuals who are stable and no longer require acute or specialized respirator programs and who require mechanical ventilation to oxygenate their blood. Ongoing assessment, intervention, and evaluation by a registered professional nurse are needed. The individual's treatment plan should include protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician or advanced practice nurse.

7. Head trauma stimulation/advanced neuromuscular/orthopedic care:

i. Care of head trauma is directed toward individuals who are stable (have plateaued) and can no longer benefit from a rehabilitative unit or unit for specialized care of the injured head. Individuals shall have access to and periodic reviews by such specialists as a neurologist, neuropsychologist, psychiatrist and vocational rehabilitation specialist, in accordance with their

clinical needs. There shall also be contact with appropriate therapies, such as physical therapy, speech-language pathology services and occupational therapy. The distinguishing characteristic for add-on hours for head trauma is the necessity for ongoing assessment and evaluation by a registered professional nurse focusing on early identification of complications, and implementation of appropriate nursing interventions. Nursing protocols may be initiated which are specifically designed to meet individual needs of head injured individuals. The nurse may also supervise a coma stimulation program, when this need is identified by the interdisciplinary team.

ii. Advanced neuromuscular care needs shall be identified by the physician for individuals during an unstable episode or where there is advanced and progressive deterioration in which the individual requires observation for neurological complications, monitoring, and administration of medications or nursing interventions to stabilize the condition and prevent unnecessary regression.

iii. Advanced orthopedic care is the care of plastered body parts with a pre-existing peripheral vascular or circulatory condition requiring observations for complications and monitoring and administration of medication to control pain and/or infection. Such care also involves additional measures to maintain mobility; care of post-operative fracture and joint arthroplasty, during the immediate subacute post-operative period involving proper alignment; teaching and counseling and follow-up to therapeutic exercise and activity regimens. Individuals in this group shall be identified by the physician as needing advanced orthopedic care. If the requirement for advanced orthopedic care exceeds 30 days, clinical need must be demonstrated and clearly documented by the interdisciplinary team.

(d) In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse.

(e) A registered professional nurse shall be on duty at all times in facilities with more than 150 licensed beds.

(f) At least 20 percent of the hours of care required by (b) above shall be provided by individuals who are either registered professional nurses or licensed practical nurses.

(g) The nurse aide component of the facility's total hourly nurse staffing requirement, as specified in (b) above, shall be met by nurse aides who have completed a nurse aide training course approved by the New Jersey State Department of Health and Senior Services and have passed the New Jersey Nurse Aide Certification Examination, in accordance with N.J.A.C. 8:39-43 and/or by newly hired individuals who have worked in the facility for less than four months and who are enrolled in a nurse aide training program.

(h) There shall be at least one registered professional nurse on duty in the facility during all day shifts. (During a temporary absence, not to exceed 72 hours, the registered professional nurse may be on duty during the evening or night shift).

(i) There shall be at least one registered professional nurse on duty or on call during all evening and night shifts.

**SUBCHAPTER 26.
ADVISORY NURSE STAFFING**

8:39-26.1 Advisory structural organization for nurse staffing

Facilities with more than 200 licensed beds employ at least one full-time equivalent staff educator; facilities with between 100 and 200 licensed beds employ at least a half-time staff educator; or facilities with fewer than 100 licensed beds employ a staff educator at least one-fifth time.

8:39-26.2 Advisory policies and procedures for nurse staffing

(a) The facility establishes and implements a system for assigning nursing personnel on the basis of a classification system involving resident acuity.

(b) The facility uses a primary system in which nurse aides are assigned on a regular basis to specific residents to provide continuity of care.

8:39-26.3 Advisory nurse staffing amounts and availability

(a) A registered professional nurse is on duty at all times in facilities with fewer than 100 licensed beds, two registered professional nurses are on duty at all times in facilities with 100 to 200 licensed beds, and three registered nurses are on duty at all times in facilities with more than 300 beds.

(b) The facility provides direct nursing services pursuant to N.J.A.C. 8:39-25.2(b) which are increased by at least ten percent.

(c) At least 50 minutes per resident per day of resident care is provided by licensed nurses, that is, registered professional nurses and licensed practical nurses. (This is an average. It is equal to one full-time equivalent nurse for every ten residents.)

(d) All nurse aides working in the facility have completed a training and orientation program to all services of at least two weeks full-time duration within the facility prior to their permanent assignment in the facility.

(e) Each resident care unit in the facility meets the nurse staffing requirements mandated in N.J.A.C. 8:39-25.2(b).

8:39-26.4 Advisory qualifications for nurse staffing

(a) The director of nursing has a baccalaureate or master's degree in nursing or a health-related field.

(b) An advanced practice nurse who is Board certified in family, adult, or geriatric practice is available on staff or under contract with the facility to perform assessments and to provide consultation to other staff members.

(c) The facility employs an advanced practice nurse certified in gerontology or psychiatric nursing on at least a half time basis.

(d) A nurse who holds certification in gerontological nursing, rehabilitation nursing, or a related field of nursing from the American Nurses Credentialing Center of the American Nurses Association, is available on staff or under contract with the facility.

SUBCHAPTER 27. MANDATORY QUALITY OF CARE

8:39-27.1 Mandatory policies, procedures and practices for quality of care

(a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical (including pain_management), emotional and social well-being, in accordance with individual assessments and care plans.

(b) All resident care policies shall be written and developed by a resident care committee, shall be available to physicians, advanced practice nurses, staff, residents, their relatives or guardians, and the public, and shall be implemented in accordance with acceptable professional standards of practice.

(c) The interdisciplinary committee or equivalent shall develop, review at least annually, revise as needed, and ensure implementation of written policies and procedures for the use of restraints and assure that the facility continuously attempts to eliminate the need for restraints. Guidance for such policies and procedures is provided in Appendix D of this chapter. Policies shall include the collection of the following data:

1. All emergency restraint applications;
2. Indicators for the frequency of the use of restraints in the facility;
3. Evaluation of all cases in which there is:
 - i. A failure to obtain or receive a physician's or advanced practice nurse's order;
 - ii. A negative clinical outcome; and
4. Indicators of the frequency of the use of psychopharmacological agents.

(d) All nursing and professional staff of the facility shall receive orientation and annual training in the use of restraints, including at least:

1. Emergency and non-emergency procedures;
2. Practice in the application of restraints and alternative methods of intervention; and
3. Interventions by licensed and non-licensed nursing personnel.

(e) The facility shall take preventive measures against the development of pressure sores, including assessing the resident's skin daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sores shall be identified, documented, and treated.

(f) The facility shall conduct a bladder and bowel retraining program for selected residents on a 24-hour basis with results documented.

8:39-27.2 Mandatory resident services for personal care

(a) Residents shall be weighed accurately every month. Whenever there is a gain or loss of five percent or more, a note shall be entered into the medical record stating whether the care plan should be modified. If the resident cannot be weighed, alternate measures shall be used to monitor weight change.

(b) Nonambulatory residents shall be repositioned at least once every two hours.

(c) Effective and safe measures shall be taken to ensure that residents do not harbor parasitic insects.

(d) Effective and safe measures shall be taken to ensure that residents are not malodorous.

(e) Any dehydrated and/or malnourished resident shall be accurately evaluated and effectively treated.

(f) Oral hygiene care shall be offered to the resident by staff on a daily basis.

(g) The resident's hair and nails shall be groomed.

(h) Each resident shall be kept clean and dry.

(i) Each resident shall receive at least one bath (tub or shower) per week unless contraindicated.

(j) Each resident's bed shall be made daily. Clean linen shall be provided for each resident at least once a week or whenever linens are soiled or wet.

(k) Each resident shall have access to fresh drinking water or juice at all times, unless contraindicated.

(l) Non-bedfast residents shall be provided with the means for leaving and returning to their beds and rooms each morning and afternoon.

(m) Measures to prevent contractures shall be used, and contractures shall be identified, documented, and managed by rehabilitative nursing and physical therapy.

(n) Indwelling catheters shall not be used for the convenience of staff.

8:39-27.3 Mandatory general resident services

(a) Residents shall be afforded the opportunity to eat in a group setting unless contraindicated with the reasons noted in the resident's medical record. The need for feeding assistance shall not constitute an acceptable contraindication.

(b) Residents shall be afforded an opportunity to go outdoors on a regular basis.

(c) Clothing, including undergarments and footwear, shall be clean, comfortable, and personally assigned to each resident, and shall reflect personal preference and safety. The facility shall promote residents' sense of personal control in acquiring clothing, for example, through the establishment of a clothing concession in the facility or clothing vendors' periodic visits to the facility, the arrangement of shopping excursions, and/or the use of catalogue shopping by residents.

(d) Residents shall be encouraged and helped to select the clothing they will wear each day.

8:39-27.4 Mandatory post-mortem policies and procedures

(a) Deceased residents shall be removed in a timely fashion from rooms where other residents are staying and transported within the facility in a dignified manner.

(b) The next of kin or guardian shall be notified at the time of the resident's death.

(c) Deceased residents shall receive post-mortem care, including cleaning and shrouding in conformance with each resident's religious practices.

(d) The deceased shall not be removed from the facility until pronounced dead with the death documented in the resident's medical record. Prostheses shall accompany the body out of the facility.

(e) The body of a deceased resident who, at the time of death, had a communicable disease, as defined in N.J.A.C. 8:57-1.2 shall be tagged accordingly before being released from the facility.

(f) Personal effects and financial accounts of deceased residents shall be safeguarded.

8:39-27.5 Mandatory supplies and equipment for resident care

(a) Prostheses, including eyeglasses, dentures, and hearing aids, shall be functional and individualized, and shall be kept available to the resident, unless the resident specifically rejects their use.

(b) Adaptive devices and equipment shall be functional and individualized, and shall be kept available to the resident unless the resident specifically rejects their use.

(c) All drinking water containers shall be washed daily and sanitized weekly. Containers that cannot be sanitized shall be discarded.

(d) The facility shall maintain at least one bag-valve-mask resuscitator.

(e) Bath thermometers or other temperature controls shall be used to monitor the temperatures of each bath or shower.

**SUBCHAPTER 28.
ADVISORY QUALITY OF CARE**

8:39-28.1 Advisory policies and procedures for resident care

(a) The facility conducts scheduled interdisciplinary staff discussions, and discussions with residents and families, about the right of residents to die with dignity.

(b) The facility develops and provides individualized non-restrictive equipment meeting individual needs which fosters and supports a restraint-free environment for all residents.

(c) The facility maintains an on-going and on-site program of preventative treatment and referral to mental health services which includes prevention, treatment, and referral directed by a qualified mental health professional.

8:39-28.2 Advisory resident care services

(a) There are education programs provided on at least a quarterly basis, open and accessible to residents, families, and significant others addressing the following issues:

1. The enhancement and maintenance of physical and mental well-being;
2. The prevention of deterioration;
3. The teaching of self-care; and
4. Death, dying and bereavement.

(b) There are education and training programs provided on at least a quarterly basis, open and accessible to families and significant others, which teach skills and help in the provision of support services that enable residents to leave the facility for visits and vacations.

(c) Donated clothing is made available so that residents can select desired items.

(d) The facility provides a non-commercial washer and dryer for residents who wish to launder their own personal items.

SUBCHAPTER 29 MANDATORY PHARMACY

8:39-29.1 Mandatory pharmacy organization

(a) A facility shall have a consultant pharmacist and either a provider pharmacist or, if the facility has an in-house pharmacy, a director of pharmaceutical services.

(b) A New Jersey licensed pharmacist shall serve as director of pharmaceutical services or as consultant pharmacist. The pharmacist shall comply with Federal and State statutes, rules, regulations and currently accepted standards of practice.

(c) The facility shall have an interdisciplinary pharmacy and therapeutics committee, appointed by and reporting to the administrator and consisting of at least the administrator, a representative of the nursing staff, and the consultant pharmacist, with oversight as needed by the medical director. The committee may include a licensed pharmacist representing the provider pharmacy. The committee shall hold meetings as needed but at least quarterly and records, including the dates of meetings, attendance, activities, findings, and recommendations, shall be maintained.

(d) The facility shall appoint a consultant pharmacist who is not also the director of pharmaceutical services or pharmacist provider and does not have an affiliation with either the director of pharmaceutical services or the pharmacist provider.

(e) If the facility keeps emergency injectable or oral controlled substances, a current Drug Enforcement Administration registration and Controlled Dangerous Substance registration for that location shall be available. (See N.J.S.A. 24.21-10 for registration requirements; registration application procedures are specified at N.J.A.C. 8:65-1.4.)

8:39-29.2 Mandatory drug administration policies and procedures

(a) The pharmacy and therapeutics committee shall establish and enforce procedures for documenting drug administrations in accordance with law.

(b) The facility shall have a system to accurately identify recipients before any drug is administered.

(c) Self-administration of drugs shall be permitted by qualified residents only as specified by the policy of the pharmacy and therapeutics committee and the assessment of the interdisciplinary team. Self-administration procedures shall include, at a minimum, the following:

1. The written order of the prescriber;
2. Storage of medications in the resident's room, based on resident assessments;
3. Specifications for labeling, including directions for use;
4. Methods for documentation in the medical record, based on resident assessment;
5. Training of residents in self-administration by the nursing staff or the consultant pharmacist; and
6. Policies for individual assessment of residents' ability to self-administer medications.

(d) Medications shall be accurately administered and documented by properly authorized individuals, as per prescribed orders and stop order policies.

8:39-29.3 Mandatory pharmacy reporting policies and procedures

(a) The consultant pharmacist shall conduct a drug regimen review and enter appropriate comments into the medical record of every resident receiving medication, at least monthly, on a pharmacist consultation sheet or another portion of the medical record in accordance with N.J.A.C. 13.39. The drug regimen review shall be performed in accordance with Federal and State Statutes, rules and regulations, and currently accepted standards of practice for rational drug therapy.

1. The consultant pharmacist shall report any irregularities promptly to the attending physician or advanced practice nurse and to the director of nurses and these reports shall be acted upon. These reports shall include, but are not limited to, problems and recommendations about drug therapy which may be affected by biologicals, laboratory tests, special dietary requirements and foods used or administered concomitantly with other medication to the same recipient. Also, these reports are required to include monitoring for potential adverse effects, allergies, drug interactions, contraindications, rationale, and drug evaluation.

2. Drug product defects and adverse drug reactions shall be reported in accordance with the ASHSP-USP-FDA (American Society of Health System Pharmacists, United States Pharmacopoeia, Food and Drug Administration) Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System.

3. All known drug allergies shall be documented in the resident's medical record including the medication administration records and physician or advanced practice nurse order sheets and on the outside front cover and communicated to the provider or dispensing pharmacy.

4. Drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The resident's attending physician or advanced practice nurse shall be notified of the automatic stop order prior to the last dose so that he or she may decide whether to continue use of the drug.

5. If medication is withheld, the reason for withholding the medication shall be documented in the resident's medical record.

6. Medication errors and adverse drug reactions shall be reported immediately to the director of nursing or the alternate to the director of nursing, and a description of the error or adverse drug reaction shall be entered into the medical record before the end of the employee shift. If the resident has erroneously received medication, the resident's physician or advanced practice nurse shall be notified immediately. If a medication error originated in the pharmacy, the pharmacy shall be notified immediately. The Department shall be notified of an adverse drug reaction that results in death.

8:39-29.4 Mandatory pharmacy control policies and procedures

(a) The label of each resident's individual medication container or package shall be labeled in accordance with the New Jersey State Board of Pharmacy regulations at N.J.A.C. 13:39-5.9, permanently affixed, and contain the following information:

1. The resident's full name;
2. The prescriber's name;
3. The prescription number;
4. The name and strength of drug;
5. The quantity dispensed;
6. The lot number;
7. The date of issue;
8. The expiration date;
9. The manufacturer's name if generic;

10. Cautionary and/or accessory labels.

i. If a generic substitute is used, the drug shall be labeled according to the Drug Utilization Review Council Formulary, N.J.S.A. 24:6E-1et seq. and N.J.A.C. 8:71.

ii. Required information appearing on individually packaged drugs or within an alternate medication delivery system need not be repeated on the label; and

11. The name, address, and telephone number of the pharmacy.

(b) If a unit dose distribution system is used (“unit dose drug distribution” means a system in which drugs are delivered to the resident areas in single unit packaging), the following requirements shall be met:

1. Each resident shall have his or her own medication tray labeled with the resident’s name and location in the facility;

2. Each medication shall be individually wrapped and labeled with the generic or trade (brand) name and strength of the drug, lot number or reference code, expiration date, dose, and manufacturer’s name, and shall be ready for administration to the resident;

3. Cautionary instructions shall appear on the resident’s record of medication, and the system shall include provisions for noting additional information, including, but not limited to, special times or routes of administration and storage conditions; and

4. Delivery and exchange of resident medication trays shall occur promptly, and, if a 24-hour unit-dose system is used, then at least one exchange of resident medication trays shall occur every 24 hours, including weekends and holidays.

(c) Both over-the-counter and prescription medications may be kept as stock. A limited amount of prescription medications may be kept as stock for the administration of stat (emergency) doses, lost doses, or doses not sent by the provider pharmacy. These medications shall be approved by the pharmacy and therapeutics committee, monitored for accountability, and labeled to include drug name, drug strength, manufacturers’ name, lot number, expiration date, recommended dosage for over-the-counter medications, and applicable cautionary and/or accessory labels.

(d) The consultant pharmacist shall:

1. Make monthly inspection of all areas in the facility where medications are dispensed, administered, or stored;

2. Periodically, as determined by the quality assurance program, observe a medication pass and review the crediting system; and

3. Document any problems and propose solutions to these problems.

(e) The contents of emergency kits shall have been approved by the pharmacy and therapeutics committee. Emergency kits shall be stored securely at each nursing unit, but not kept under lock and key, checked after each use, and checked at least monthly by the consultant pharmacist. Emergency kits shall not be accessible to residents but shall be accessible to staff in a timely manner.

(f) All medications repackaged by the pharmacy shall be labeled with an expiration date, name and strength of drug, lot number, date of issue, manufacturer's name if generic, and cautionary and/or accessory labels, in accordance with N.J.A.C. 13:39-5.9, United States Pharmacopoeia (U.S.P.) requirements and applicable FDA regulations.

(g) The pharmacy and therapeutics committee shall establish and enforce procedures for removal of discontinued, unused, expired, recalled, deteriorated, and unlabeled drugs and intravenous solutions and for removal of containers of medications with worn, illegible, damaged, incomplete, or missing labels.

(h) All medications shall be stored in accordance with manufacturers' and United States Pharmacopoeia (U.S.P.) requirements and all medications shall be kept in locked storage areas.

(i) All medication destruction in the facility shall be witnessed by at least two persons, each of whom shall be either the pharmacist consultant, a registered professional nurse or a licensed practical nurse. A record of each instance of drug destruction shall be maintained.

(j) Where allowable by law, the facility shall generate a crediting mechanism for medications dispensed in a unit-of-use drug distribution system, or other system that allows for the re-use of medications. The crediting system shall be monitored by the provider pharmacist and a facility representative.

(k) The pharmacy and therapeutics committee shall establish and enforce procedures for the inventory of controlled substances in accordance with law.

(l) Based on prescriber's orders for medications, drug tests, diet and treatments, the facility shall implement written methods and procedures for obtaining prescribed prescription medications and biologicals from a pharmacy that has a permit from the New Jersey State Board of Pharmacy, in accordance with N.J.A.C. 13:39-4. The telephone number of the pharmacy and procedures for obtaining drugs shall be posted at each nursing unit.

(m) If the facility utilizes drugs marked “sample”, the pharmacy and therapeutics committee shall develop a mechanism for the control and limitation of these drugs, in accordance with N.J.A.C. 13:35-6.6.

(n) The facility shall develop and implement a system whereby instructions for use are provided whenever medications are released to residents. Instructions shall be written in a manner intended to promote proper storage, secure handling, and safe administration of medications released to residents. Documentation of released medications shall be entered into the resident’s medical record.

8:39-29.5 Mandatory pharmacy staff qualifications

If the facility maintains a pharmacy in-house, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy, and shall possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the New Jersey State Department of Law and Public Safety.

8:39-29.6 Mandatory resident pharmacy services

(a) The facility shall provide pharmaceutical services, either directly or by contract with a provider pharmacy, 24 hours a day, seven days a week.

(b) If a resident obtains medications from a pharmacy that is not the facility provider pharmacy, the following conditions shall be met:

1. The pharmacy provider shall comply with all labeling requirements specified at N.J.A.C. 8:39-29.4(a); and

2. The facility shall establish a plan for obtaining the resident’s drugs on an emergency basis.

(c) A resident may obtain medications from a pharmacy that is not the facility provider pharmacy unless:

1. The resident is expressly informed during the admission process and within the admission agreement that this service is not permitted in the facility; or

2. For existing residents, the facility submits documentation to the Department, prior to denying the request, demonstrating a significant risk to the health and safety of residents as a result of this practice.

8:39-29.7 Mandatory pharmacy supplies and equipment

(a) Medication containers and carts shall be handled properly to prevent damage, injury and harm.

(b) Needles and syringes shall be stored, used, and disposed of in accordance with New Jersey State law, and a record shall be maintained of the purchase, storage, and disposal of needles and syringes.

(c) Controlled substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts and all other Federal and State laws and regulations concerning procurement, storage, dispensation, administration, and disposition.

(d) Pharmaceutical reference materials and other information sources about drugs, including investigational drugs, if used, shall be approved by the pharmacy and therapeutics committee and shall be current.

8:39-29.8 Mandatory pharmacy quality assurance

The pharmacy and therapeutics committee shall review reports of medication errors and suspected adverse drug reactions and shall summarize these reports yearly.

SUBCHAPTER 30. ADVISORY PHARMACY

8:39-30.1 Advisory pharmacy staffing amounts and availability

The consultant pharmacist or a licensed pharmacist representing the provider pharmacy provides or arranges for quarterly meetings open to residents, families, and interested others to discuss medication issues.

8:39-30.2 Advisory pharmacy resident services

The consultant pharmacist reviews drug records within 48 hours of admission via a facsimile service. All dated and signed comments and recommendations made by the consultant pharmacist shall be added to the resident's medical record and shall be distributed to the attending physician or advanced practice nurse and director of nurses for review and action.

8:39-30.3 Advisory provider formulary criteria

The provider pharmacy through the Pharmacy and Therapeutics Committee, may establish a formulary which is not in contradiction to the Drug Utilization Review Council Formulary, N.J.S.A. 24:6E-1et seq., and N.J.A.C. 8:71. The formulary policies must be approved by the Pharmacy and Therapeutics Committee and every prescriber with prescriptive authority in the facility. The Pharmacy and Therapeutics Committee establishes policies for the prescribing of non-formulary agents. The formulary is developed to avoid negative outcomes.

8:39-30.4 Advisory consultant pharmacist certification

The consultant pharmacist holds current certification by the Joint Board of Certification of Consultant Pharmacists.

**SUBCHAPTER 31.
MANDATORY PHYSICAL ENVIRONMENT**

8:39-31.1 Mandatory construction standards

(a) No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Long-Term Care Licensing and Certification Program and/or the Department of Community Affairs, Health Care Plan Review Unit.

(b) New construction, alterations and additions of long-term care facilities shall comply with the Uniform Construction Code (N.J.A.C. 5:23) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Construction Code may be obtained from the Construction Code Element of the Department of Community Affairs, P.O. Box 805, Trenton, New Jersey 08625-0805.

(c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809.

(d) Required annual maintenance inspections by the Department of Health and Senior Services for a facility participating in the Medicare or Medicaid programs shall be conducted in accordance with the edition of the National Fire Protection Association's Life Safety Code that has been adopted by the Federal Health Care Financing Administration, incorporated herein by reference, as amended and supplemented; however, this code shall not be enforced to exceed the requirements of the Uniform Construction Code referenced in (b) above. A facility that does not participate in either the Medicare or Medicaid programs shall be inspected under the version of the Life Safety Code in effect at the time of original licensure; however, this code shall not be enforced to exceed the requirements of the Uniform Construction Code referenced in (b) above. (Copies of the Life Safety Code may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02200).

8:39-31.2 Mandatory general maintenance

(a) Personnel engaged in general maintenance activities shall receive orientation upon employment and, at least once a year, education or training in principles of asepsis, cross-infection control, and safe practices.

(b) There shall be a system for reporting physical plant, safety, and maintenance problems to a designated staff member and documentation of the correction of such problems.

(c) A current, written preventive maintenance program shall be implemented. Records of inspections and repairs shall be maintained for at least one year.

(d) Written instructions for operating and maintaining equipment shall be systematically retained and followed.

(e) The facility shall be kept in good repair and maintained without harm or jeopardy to residents.

(f) There shall be a maintenance contract on elevators that includes routine maintenance inspections.

(g) The standby emergency power generator shall be checked weekly, tested under load monthly, and serviced in accordance with generally accepted engineering practices.

(h) Temperature shall be in accordance with requirements specified in the 1996-97 edition of "Guidelines For Design and Construction of Hospital and Health Care Facilities" (American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Department of Health and Human Services. The American Institute of Architects Press: Washington, DC), incorporated herein by reference.

(i) There shall be a comprehensive, current, written preventive maintenance program for the electrical system that is documented and followed.

8:39-31.3 Mandatory quality assurance for housekeeping

Facilities that contract with a housekeeping service shall use quality assurance measures to ensure that the housekeeping requirements of this chapter are met.

8:39-31.4 Mandatory housekeeping policies and procedures

(a) The facility shall provide and maintain a safe, clean and orderly environment for residents.

(b) The facility shall have a written schedule that determines the frequency of cleaning and maintaining all equipment, structures, areas, and systems.

(c) Mattresses, mattress pads and coverings, pillows, bedsprings, and other furnishings shall be properly maintained and kept clean and replaced as needed. They shall be thoroughly cleaned and disinfected on a regular schedule and whenever a new resident is using them.

(d) Scatter rugs shall be not permitted and floors shall be coated with slip-resistant floor finish.

(e) Carpeting shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled.

(f) All equipment and environmental surfaces shall be clean to sight and touch.

8:39-31.5 Pest control

(a) Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility.

1. The premises shall be kept in such condition as to prevent the breeding, harborage, or feeding of vermin.

2. All openings to the outer air shall be effectively protected against the entrance of insects.

8:39-31.6 Mandatory fire and emergency preparedness

(a) Employees shall be trained in procedures to be followed in an emergency operations plan and instructed in the use of fire fighting equipment and resident evacuation of the buildings as part of their initial orientation and at least annually thereafter.

(b) Fire drills shall be conducted a total of 12 times per year, with at least one drill on each shift and one drill on a weekend. The facility shall attempt to have the local fire department participate in at least one fire drill per year. An actual alarm shall be considered a drill if it is documented.

(c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility.

(d) There shall be a procedure for investigating and reporting fires. All fires shall be reported to the Department immediately by phone and followed up in writing within 72 hours. In addition, a written report of the investigation by the fire department containing all pertinent information shall be forwarded to the Department as soon as it becomes available.

(e) Smoking regulations shall be developed, implemented, and enforced in accordance with N.J.S.A. 26:3D-1 et seq. and 26:3D-7 et seq.

1. Residents shall not be permitted to smoke in their rooms and in other secluded areas. The facility may enforce a no-smoking rule for staff and visitors.

2. Restricted smoking areas shall be designated and rules governing such smoking promulgated and rigidly enforced. Nonflammable ashtrays in sufficient numbers shall be provided in permitted smoking areas. In any area where smoking is permitted, there shall be adequate outside ventilation.

3. At the facility's option, it may institute a smoke-free policy. Any prospective smoke-free policy shall be set forth in the facility's admission agreement and shall only apply to residents entering the facility on or after the policy's effective date. The facility shall protect the rights of residents who smoke by providing a designated area with adequate outside ventilation for controlled smoking. If inside, the designated smoking room shall be adequately ventilated to prevent recirculation of smoke to other areas of the facility. If outside, the designated area shall provide reasonable protection from inclement weather.

(f) The facility shall have a written comprehensive emergency operations plan developed in coordination with the local office of emergency management. This plan shall:

1. Identify potential hazards that could necessitate an evacuation, including natural disasters, national disasters, industrial and nuclear accidents, and labor work stoppage;

2. Identify the facility and an alternative facility to which residents would be relocated, and include signed, current agreements with the facilities;

3. Identify the number, type and source of vehicles available to the facility for relocation and include signed current agreements with transportation providers. Specially configured vehicles shall be included;

4. Include a mechanism for identifying the number of residents, staff, and family members who would require relocation and procedures for evacuation of non-ambulatory residents from the facility;

5. List the supplies, equipment, records, and medications that would be transported as part of an evacuation, and identify by title the individuals who would be responsible;

6. Identify essential personnel who would be required to remain on duty during the period of relocation;

7. Identify by title and post in a prominent place the name(s) of the persons who will be responsible for the following:

i. Activating the emergency operations plan, issuing evacuation orders, and notifying of State and municipal authorities;

ii. Alerting and notifying of staff and residents;

iii. Facility shutdown and restart;

iv. In place sheltering of residents and continuity of medical care; and

v. Emergency services such as security and firefighting; and

8. Describe procedures for how each item in (f)7 above will be accomplished.

(g) There shall be a written plan for receiving residents who are being relocated from another facility due to a disaster. This plan shall include at least an estimate of the number and type of residents the facility would accommodate and how staffing would be handled at different occupancy levels.

(h) Copies of the emergency operations plan shall be sent to municipal and county emergency management officials for their review.

(i) The administrator shall serve as, or appoint, a disaster planner for the facility.

1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management.

2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.

(j) Any staff member who is designated as the acting administrator shall be knowledgeable about and authorized to implement the facility's plans in the event of an emergency.

(k) All staff shall be oriented to the facility's current plans for receiving and evacuating residents in the event of a disaster, including their individual duties.

(l) The facility shall ensure that residents receive nursing care throughout the period of evacuation and return to the original facility.

(m) The facility shall ensure that evacuated residents who are not discharged are returned to the facility after the emergency is over.

(n) The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency.

(o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance.

(p) The facility shall establish a written heat emergency action plan which specifies procedures to be followed in the event that the indoor air temperature is 82 degrees Fahrenheit or higher for a continuous period of four hours or longer.

1. These procedures shall include the immediate notification of the Department of Health and Senior Services.

2. In implementing a heat emergency action plan, a facility shall not prevent a resident from having a room temperature in his or her resident room in excess of 82 degrees Fahrenheit if the resident and the resident's roommate, if applicable, so desire, and if the resident's physician approves.

3. A heat emergency plan need not be implemented if the resident care areas are not affected by an indoor temperature in excess of 82 degrees Fahrenheit.

4. The heat emergency action plan shall include a comprehensive series of measures to be taken to protect residents from the effects of excessively high temperatures.

8:39-31.7 Mandatory safety requirements

(a) An outlet that is connected to an emergency power supply shall be used wherever life-sustaining equipment is in operation.

(b) All draperies, curtains, and wastebaskets shall be maintained flame retardant.

(c) All decorations shall be flame retardant. Open flames used for decoration or religious ceremonies shall not be left unsupervised.

(d) Cooking equipment shall be properly installed and maintained.

(e) Lint traps in clothes dryers shall be kept in a clean and safe condition.

(f) Kerosene heaters and staff and resident-owned heating devices shall not be permitted.

(g) Extension cords shall not be permitted unless they are provided by the maintenance or engineering department of the facility, inspected regularly, and inventoried by the maintenance and engineering department. Extension cords shall be for temporary use only in resident care areas.

(h) Hot (95 to 110 degrees Fahrenheit) and cold running water shall be provided. Hot water in resident areas shall not exceed 110 degrees Fahrenheit.

8:39-31.8 Mandatory space and environment; all facilities

(a) The facility shall provide for and operate adequate ventilation in all areas used by residents. All areas of the facility used by residents shall be equipped with air conditioning and the air conditioning shall be operated so that the temperature in these areas does not exceed 82 degrees Fahrenheit.

(b) All exit doors to the facility shall be kept externally locked from 8:00 P.M. until 6:30 A.M.

(c) All residents shall have, in their rooms:

1. A bed and a mattress of the correct size to fit the bed;
2. Sheets, blankets, a pillow, and additional pillow if required or desired;
3. A bed table with drawer;
4. A separate closet area and shelves for personal needs;
5. A privacy curtain around the bed excepting private rooms;
6. An unobstructed doorway;
7. Window coverings that are properly mounted and maintained;
8. Night lights;
9. Call bells immediately accessible to the resident in bed or an individual at bedside;
10. A comfortable chair for each resident in his or her room for use by the resident or resident's visitor;
11. An individual light for each resident in a room;
12. Supplies for oral needs, including a denture cup, if needed, and a clean toothbrush;

13. A basin, comb, and bedpan and/or urinal unless clearly unnecessary, stored in an appropriate storage space convenient to the resident; and

14. A waste receptacle.

(d) Glare from windows and reflections on floors and tables in the multi-purpose or dining room shall be controlled.

(e) All supplies and equipment in the facility shall be of such quality as not to break or tear easily.

(f) Each facility shall provide:

1. Good lighting at entrances and, where applicable, in parking areas;

2. A walker or a tripod cane to each resident who requires mechanical assistance to walk; and

3. A wheelchair to each resident who is not ambulatory.

SUBCHAPTER 32.
ADVISORY PHYSICAL ENVIRONMENT

8:39-32.1 Advisory general maintenance

(a) Inspections or rounds are conducted at least monthly by a designated person or committee on all units and areas for maintenance problems. Results of these rounds are reported to the administrator.

(b) Maintenance services are under the supervision of an employee with at least one of the following:

1. Five years of experience in maintaining a physical plant;
2. A baccalaureate degree in engineering from an accredited college or university and two years of experience in maintaining a physical plant; or
3. Professional licensure in New Jersey as an engineer with one year of experience in maintaining a physical plant.

8:39-32.2 Advisory fire and emergency preparedness

(a) The facility conducts at least two evacuation drills each year, either simulated or using selected residents, at least one of which is conducted on a weekend or during an evening or night work shift. Results of the drills are to be summarized in a written report, which is shared with the county and municipal emergency management coordinators.

(b) A municipal, county, or State emergency management official conducts an education or training program in the facility on disaster planning and emergency preparedness at least once a year.

(c) Fire drills are conducted annually on each weekend shift.

8:39-32.3 Advisory safety

(a) There is a committee responsible for physical plant and resident safety and maintenance, which includes, at a minimum, representatives from administration, nursing, and maintenance services and meets at least quarterly.

(b) Regularly scheduled training meetings are held for residents and families, addressing safety issues in the facility.

SUBCHAPTER 33.
MANDATORY QUALITY ASSESSMENT AND/OR QUALITY IMPROVEMENT

8:39-33.1 Mandatory quality assessment and/or quality improvement structural organization

(a) Quality assessment and/or quality improvement procedures shall be developed and implemented through a written plan that specifies time frames.

(b) Responsibility for the quality assessment and/or quality improvement program shall be assumed by designated individuals, who shall include the director of nursing services, a physician or advanced practice nurse, and at least three other staff members, and who shall report directly to the administrator.

(c) Summary findings of the quality assessment and/or quality improvement program shall be submitted in writing to the administrator and the administrator shall take action that includes staff education or training on the basis of the program's findings.

(d) The quality assessment and/or quality improvement program shall review at least inventory control, maintenance inspections and reports, procedures for reporting incidents and hazards, and procedures for emergency response to incidents and hazards.

(e) Quality assessment and/or quality improvement program findings shall be presented to the administrator with recommendations for corrective actions to address problems.

8:39-33.2 Mandatory quality assessment and/or quality improvement policies and procedures

(a) The quality assessment and/or quality improvement program shall identify problems in the care and services provided to the residents and shall include the audit of medical records.

(b) The quality assessment and/or quality improvement program shall monitor the performance of each service.

(c) The quality assessment and/or quality improvement program shall monitor trends in the following:

1. The prevalence of pressure sores and skin breakdowns;
2. Psychoactive drug use;
3. Transfers to hospitals;

4. Medication errors;
 5. Catheterization rates and catheterization care;
 6. Weight loss and fluid intake;
 7. Infection rates in all residents;
 8. Resident depression;
 9. Restoration of function following specific types of events, such as hip fractures;
 10. Use of restraints;
 11. Resident falls resulting in injury;
 12. Incidents of abuse, neglect or misappropriation of resident property;
- and
13. Other possible indicators of level of quality care not listed in this subchapter.

(d) The quality assessment and/or quality improvement program shall develop and implement a system to measure the effectiveness of the reassessment process with respect to: frequency, comprehensiveness, accuracy, implementation, and interdisciplinary approach.

8:39-33.3 Mandatory quality assessment and/or quality improvement of resident services

The quality assessment and/or quality improvement program shall include the gathering of resident care information from residents and visitors.

8:39-33.4 Mandatory quality assessment and/or quality improvement of staff education and training

The quality assessment and/or quality improvement program shall evaluate staff education programs.

SUBCHAPTER 34.
ADVISORY QUALITY ASSESSMENT AND/OR QUALITY IMPROVEMENT

8:39-34.1 Advisory quality assessment and/or quality improvement policies and procedures

(a) The facility develops and maintains an active, continuous quality improvement process that involves staff, residents, families and/or the community in improving the quality of services provided by the facility.

(b) The quality assessment and/or quality improvement program uses a resident classification system, such as acuities or specified diagnostic classifications, as an indicator in measuring resident outcomes.

(c) The quality assessment and/or quality improvement program includes periodic surveys of families to ascertain their satisfaction, suggestions, knowledge of resident's health conditions and treatments, and/or knowledge of facility policies and staff members' roles.

(d) There is a system to receive input on resident safety issues.

**SUBCHAPTER 35
MANDATORY MEDICAL RECORDS**

8:39-35.1 Mandatory organization for medical records

At least 14 days before a facility plans to cease operations, it shall notify the New Jersey State Department of Health and Senior Services in writing of the location and method of retrieval of medical records.

8:39-35.2 Mandatory policies and procedures for medical records

(a) Each active medical record shall be kept at the nurses' station for the resident's unit.

(b) The facility shall maintain for staff use a current list of standard professional abbreviations commonly used in the facility's medical records.

(c) Medical records shall be organized with a uniform format across all records.

(d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available:

1. Legible identifying data, such as resident's name, date of birth, sex, address, and next of kin, and person to notify in an emergency;
2. The name, address, and telephone number of the resident's physician, an alternate physician or advanced practice nurse, and dentist;
3. Complete transfer information from the sending facility, including results of diagnostic, laboratory, and other medical and surgical procedures, and a copy of the resident's advance directive, if available, or notice that the resident has informed the sending facility of the existence of an advance directive;
4. A history and results of a physical examination, including weight, performed by the physician or advanced practice nurse on admission, in accordance with N.J.A.C. 8:39-11.2(c) and results of the most recent examination by the physician, or advanced practice nurse, or New Jersey licensed physician assistant;
5. An assessment and plan of care made by each discipline involved in the resident's care;
6. Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms,

treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided;

7. All physician's or advanced practice nurse's orders for the last three months;

8. Telephone orders, each of which shall be countersigned by a physician or advanced practice nurse within seven days, except for orders for non-prescription drugs or treatments, which shall be signed at the physician's or advanced practice nurse's next visit to the resident;

9. Records of all medications and other treatments that have been provided during the last three months;

10. Consultation reports for the last six months;

11. Records of all laboratory, radiologic, and other diagnostic tests for the last six months;

12. Records of all admissions, discharges, and transfers to and from the facility that occurred in the last three months;

13. Signed consent and release forms;

14. Documentation of the existence, or nonexistence, of an advance directive and the facility's inquiry of the resident concerning this;

15. A discharge plan for those residents identified by the facility as likely candidates for discharge into the community or a less intensive care setting; and

16. A discharge note written on the day of discharge for residents discharged to the community, a less intensive care setting, another nursing home or hospital, which includes at least the diagnosis, prognosis, and psychosocial and physical condition of the resident.

(e) The medical record shall be completed within 30 days of discharge.

(f) If part of a care plan is not implemented, the record shall explain why.

(g) All entries in the resident's medical record shall be written legibly in ink, dated, and signed by the recording person or, if a computerized medical records system is used, authenticated.

1. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.

2. If computer-generated orders with an electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of computer-generated signatures.

3. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:

i. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall sign the original order, history and/or examination at an off-site location;

ii. The original shall be FAXed to the long-term care facility for inclusion into the medical record;

iii. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall submit the original for inclusion into the medical record within 72 hours; and

iv. The FAXed copy shall be replaced by the original. If the facsimile reports are produced by a plain-paper facsimile process that produces a permanent copy, the plain-paper report may be included as a part of the medical record, as an alternate to replacement of the copy by the original report.

(h) If a resident or the resident's legally authorized representative requests, orally or in writing, a copy of his or her medical record, a legible photocopy of the record shall be furnished at a fee based on actual costs, which shall not exceed prevailing community rates for photocopying. ("Legally authorized representative" means spouse, immediate next of kin, legal guardian, resident's attorney, or third party insurer where permitted by law.) A copy of the medical record from an individual admission shall be provided to the resident or the resident's legally authorized representative within two working days of request.

1. The facility shall establish a policy assuring access to copies of medical records for residents who do not have the ability to pay; and

2. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The resident or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.

(i) Access to the medical record shall be limited only to the extent necessary to protect the resident. A verbal explanation for any denial of access shall be given to the resident or legal guardian by the physician or advanced practice nurse and there shall be documentation of this in the medical record. In

the event that direct access to a copy by the resident is medically contraindicated (as documented by a physician or advanced practice nurse in the resident's medical record), the medical record shall be made available to a legally authorized representative of the resident or the resident's physician or advanced practice nurse.

(j) The resident shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

(k) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the resident, or until the resident reaches the age of 23 years, whichever is the longer period of time. A summary sheet of each medical record shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years.

**SUBCHAPTER 36.
ADVISORY MEDICAL RECORDS**

8:39-36.1 Advisory policies and procedures for medical records

(a) The name by which the resident wishes to be called is entered on the cover or first page of the medical record.

(b) There is a comprehensive discharge summary with statistical and narrative information from each service completed for each resident.

(c) The full medical records for all discharged or deceased residents are completed within 15 days.

(d) Telephone orders are countersigned by a physician or advanced practice nurse within 48 hours except for orders for non-prescription drugs or treatments, which are countersigned within seven days.

8:39-36.2 Advisory staff education and training for medical records

The facility requires that staff use only standard professional abbreviations in medical records and maintains a current list of such abbreviations.

8:39-36.3 Advisory staff qualifications for medical records

(a) The facility utilizes the services of a medical record practitioner or consultant who is:

1. Certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611); or

2. A graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611).

SUBCHAPTER 37 MANDATORY REHABILITATION

8:39-37.1 Mandatory policies and procedures for rehabilitation

(a) Orders from physicians or from advanced practice nurses, to the extent allowable by applicable laws, for speech therapy, physical therapy, occupational therapy, and audiology services shall include specific modalities and the frequency of treatment, and shall be entered into the resident's medical record.

(b) Orders from physicians or from advanced practice nurses, to the extent allowable by applicable laws, for medically appropriate speech therapy, physical therapy, occupational therapy and audiology services shall be properly followed, and the results of these services shall be entered into the resident's medical record.

8:39-37.2 Mandatory rehabilitation staff qualifications

(a) Speech therapy and audiology services shall be provided by a speech-language pathologist who holds a current New Jersey license issued by the Audiology and Speech-Language Pathology Advisory Committee, Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

(b) Physical therapy shall be provided by a physical therapist licensed by the New Jersey State Board of Physical Therapy, or by a licensed physical therapy assistant under the direction of a licensed physical therapist, in accordance with N.J.S.A. 45:9-37.1.

(c) Occupational therapy shall be provided by an occupational therapist who is licensed by the New Jersey Occupational Therapy Advisory Council, or by a licensed occupational therapy assistant under the direction of a licensed occupational therapist, in accordance with N.J.S.A. 45:9-37.51.

8:39-37.3 Mandatory rehabilitation staffing amounts and availability

Speech-language pathology evaluation, physical therapy evaluation, occupational therapy evaluation, and audiology evaluation shall take place within 72 hours of the original physician or advanced practice nurse order, excluding weekends.

8:39-37.4 Mandatory rehabilitation supplies and equipment

(a) Space for rehabilitation therapy shall be provided in the facility. If space is unavailable, arrangements shall be made for transportation or transfer of residents who require rehabilitation therapy services.

(b) Visual privacy and provisions for auditory privacy shall be provided for residents during evaluation and rehabilitation treatment, when clinically indicated.

(c) If the facility provides physical therapy on-site, physical therapy equipment available to the residents shall include at least parallel bars, stairs, mats, and padded tables.

SUBCHAPTER 38. ADVISORY REHABILITATION

8:39-38.1 Advisory rehabilitation staff qualifications

Speech therapy and audiology services are provided by individuals who hold a Certificate of Clinical Competence issued by the American Speech-Language-Hearing Association.

8:39-38.2 Advisory rehabilitation space and environment

The facility has an examination and treatment room for rehabilitation therapy.

8:39-38.3 Advisory rehabilitation supplies and equipment

(a) In addition to parallel bars and stairs, physical therapy equipment available to residents includes a whirlpool for hydrotherapy and ultrasound.

(b) The occupational therapy program provides individually designed adaptive equipment as needed to enhance residents' independence.

SUBCHAPTER 39. MANDATORY SOCIAL WORK

8:39-39.1 Mandatory social work policies and procedures

A social worker shall develop and implement specific criteria to identify residents who are likely candidates for discharge into the community or a less intensive care setting and to coordinate discharge planning.

8:39-39.2 Mandatory social work staff qualifications

Social work services shall be provided by one or more social workers who are certified or licensed by the New Jersey State Board of Social Work Examiners, in accordance with the Social Worker's Licensing Act of 1991 (N.J.S.A. 45:15BB-1 et seq.) and all amendments thereto and with the rules of the New Jersey Board of Social Work Examiners, N.J.A.C. 13:44G.

8:39-39.3 Mandatory social work amounts and availability

(a) The facility shall provide an average of at least 20 minutes of social work services per week for each resident, which requires at least one full-time equivalent social worker for every 120 residents.

(b) A social worker shall assist staff in coping with the personal needs and demands of particular residents.

8:39-39.4 Mandatory resident social work services

(a) A social worker shall interview the resident and family within 14 days before or after admission to the facility to identify any social work needs or problems, and to take a social history that includes family, education, and occupational background, adjustment and level of functioning, interests, support systems, and observations.

(b) A social worker shall provide counseling for residents and families.

(c) A social worker shall facilitate communication between staff and non-English speaking residents.

(d) A social worker shall offer information and help to each resident and family on obtaining financial assistance and on the meaning of administrative forms and releases to be signed by the resident or family.

(e) A social worker shall coordinate the facility's outreach services to the families of residents.

(f) A social worker shall coordinate discharge services for residents, which shall include linking the resident to necessary community services.

(g) A social worker shall perform advocacy services on behalf of the residents to ensure that concrete needs are met, such as clothing, laundry, and the resident's personal needs allowance if one is maintained.

(h) A social worker shall help residents and families identify and gain access to community services, using resource materials and a knowledge of the residents' needs and abilities.

(i) The facility shall provide clinical social work services to residents as needed and to families if related to issues that directly affect the resident.

8:39-39.5 Mandatory space and environment for social work

The facility shall provide visual and auditory privacy for resident or family social service interviews, and for confidential telephone calls by social workers.

SUBCHAPTER 40. ADVISORY SOCIAL WORK

8:39-40.1 Advisory staff qualifications for social work

A social worker has a master's degree in social work from an accredited university or education program. He or she should provide consultant services at least eight hours per month, or be on the facility's staff.

8:39-40.2 Advisory staff amounts and availability for social work

(a) A social worker is available to the facility on evenings and weekends at scheduled times or by previously arranged appointments for interaction with residents and families, and is available seven days a week in cases of emergency or serious need.

(b) A social worker assists staff with problems and issues related to aging and illness.

(c) A social worker orients nurse aides to the social needs of new residents before the resident's arrival in the facility.

8:39-40.3 Advisory resident social work services

(a) A social worker meets with the resident on the day of admission.

(b) A social worker conducts support groups for families.

(c) A social worker conducts group counseling sessions for residents and families.

(d) A social worker participates in pre-admission planning with residents and families prior to their admission to the nursing home.

(e) The social worker encourages and monitors a regular visiting pattern by families and provides outreach services to families where the visiting pattern has changed.

8:39-40.4 Advisory space and environment for social work

Social workers are to be provided with a private office equipped with a telephone or, in facilities with 60 or fewer licensed beds, with access to a private office equipped with a telephone.

8:39-40.5 Advisory social work staff education and training

The facility encourages the social worker to participate in community agency associations and other professional organizations.

**SUBCHAPTER 41.
(RESERVED)**

**SUBCHAPTER 42
(RESERVED)**

SUBCHAPTER 43
CERTIFICATION OF NURSE AIDES IN LONG-TERM CARE FACILITIES

8:39-43.1 Nurse aide competency

(a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey:

1. Has a currently valid nurse aide in long-term care facilities certificate and is registered in good standing on the New Jersey Nurse Aide Registry; or
2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or
3. Has been employed for no more than 120 days, has completed the required training specified in (a) 2, above, and has been granted a conditional certificate by the Department while awaiting clearance from the criminal background investigation conducted in accordance with N.J.A.C. 8:43I.

8:39-43.2 Requirements for nurse aide certification

(a) An applicant for certification as a nurse aide in long-term care facilities shall:

1. Successfully complete a nurse aide in long-term care facilities training program that has been approved by the Department; and
2. Provide evidence that he or she is of good moral character, including, but not limited to, compliance with the requirements of the Criminal Background Investigation Program in accordance with N.J.A.C. 8:43I; and
3. Pass both the Department's clinical skills competency exam and written/oral exam.

(b) An applicant shall fulfill the requirements in (a) above in order to be listed on the New Jersey Nurse Aide Registry.

8:39-43.3 Exceptions

(a) The following persons may take the Department's written/oral examination without first completing a nurse aide training course and clinical skills evaluation approved in accordance with N.J.A.C. 8:39-43.10:

1. Students, graduate nurses, or foreign licensed nurses, pending licensure, who submit evidence of successful completion of a course in the fundamentals of nursing;

2. Persons who submit evidence of the successful completion of a course in the fundamentals of nursing within the 12 months immediately preceding application to take the written/oral competency examination, including:

i. Persons certified as a nurse aide in long term care facilities in another state by a state governmental agency and listed on that state's nurse aide registry, who do not meet the requirements for equivalency specified at N.J.A.C. 8:39-43.3 (a) 1, above; and

ii. Persons who have had training and experience as a nurse aide in a military service, equivalent to that of a nurse aide; and

3. Persons who are certified as homemaker-home health aides by the New Jersey Board of Nursing, in accordance with N.J.A.C. 13:37-14, as amended and supplemented, and who successfully complete the Long-Term Care Module of the Core Curriculum for Unlicensed Assistive Personnel approved by the Department; and

4. Persons who successfully complete the Core Curriculum for Unlicensed Assistive Personnel approved by the Department and the New Jersey Board of Nursing, and the Long-Term Care Module of the Core Curriculum for Unlicensed Assistive Personnel approved by the Department.

8:39-43.4 Certificates

(a) A nurse aide in long term care facilities certificate shall be valid for a period of two years from the date of issue.

(b) A nurse aide certificate shall not be retained by an employer for any reason.

(c) A nurse aide certificate is not transferable by sale, gift, duplication, or other means and shall not be forged or altered.

8:39-43.5 Revocation and suspension of certificates

(a) A certificate issued to a nurse aide in accordance with this subchapter shall be revoked in the following cases:

1. Finding of abuse, neglect or misappropriation of property of a resident of a long-term care facility or assisted living residence, or of a patient, resident, or client of any other facility or agency licensed by the Department;

2. Conviction or guilty plea as specified at N.J.A.C. 8:39-9.3(b) or other crime or offense as specified at N.J.A.C. 8:43I –2.1 (b); or

3. Sale, purchase, or alteration of a certificate; use of fraudulent means to secure the certificate, including filing false information on the application; or forgery, imposture, dishonesty, or cheating on an examination.

(b) The Commissioner or his or her designee may summarily suspend the certificate of a nurse aide when the continued certification of an individual poses an immediate threat to the health, safety or welfare of the public, including residents and patients of long term care facilities, assisted living facilities and other licensed health care facilities or agencies. An individual whose certificate is summarily suspended shall have the right to appeal to the Commissioner for an expedited hearing at the Office of Administrative Law, which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and N.J.S.A. 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If the summary suspension is upheld at the Office of Administrative Law, the individual whose certificate has been summarily suspended shall have the right to apply for injunctive relief in the Superior Court of New Jersey. Nothing in this subsection shall be construed to prevent the Commissioner from thereafter revoking the license in accordance with (a) above.

8:39-43.6 Recertification

(a) The Department shall require the renewal and updating of a nurse aide listing on the registry at least once every two years on a schedule established by the Department.

(b) In order to be recertified, an individual shall have a currently valid nurse aide in long term care facilities certificate and shall have been employed performing nursing or nursing-related services for at least seven hours for pay, in a licensed health care facility or for an agency licensed by the Department, within the past 24 months from the date of expiration as specified on the nurse aide certificate, and shall not have had his or her certificate revoked in accordance with N.J.A.C. 8:39-43.5 (a), and shall not have his or her certificate suspended in accordance with N.J.A.C. 8:39-43.5 (b).

(c) The designated facility representative shall verify such employment by signing the individual's recertification data mailer upon request of the individual.

(d) Any individual who does not meet the recertification requirement listed in (b) above and who wishes to be recertified, shall repeat the requirements for certification at N.J.A.C. 8:39-43.2, unless the original date of issue of the certificate is within the five years prior to the expiration date listed on the certificate and the nurse aide successfully completes the skills evaluation and written/oral examination.

1. Any individual who has allowed his or her certificate to expire must undergo a criminal background investigation as required by N.J.A.C. 8:43I, regardless of whether the person must complete a training program.

8:39-43.7 Nurse aide registries

(a) The Department shall establish and maintain a nurse aide registry in accordance with 42 CFR 483.156, as supplemented and amended.

(b) The Department shall establish and maintain a nurse aide abuse registry in accordance with 42 CFR 483.156, as supplemented and amended.

1. The nurse aide abuse registry shall include the names of individuals who are found to have abused, neglected or misappropriated the property of any resident while working in a long-term care facility as an uncertified nurse aide.

8:39-43.8 Hearings for resident abuse, resident neglect, or misappropriation of resident property

(a) Prior to entering a finding on the nurse aide abuse registry, the Department shall provide an opportunity of at least 30 days notice to the certified nurse aide or uncertified nurse aide, identifying the intended action, the factual basis and source of the finding, and the individual's right to a hearing.

(b) If a hearing is requested, it shall be conducted by the Office of Administrative Law or by a hearing officer of the Department in accordance with hearing procedures established by the Administrative Procedure Act., N.J.S.A. 52:14B-1 et seq., and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(c) No further right to an administrative hearing shall be offered to a certified nurse aide or uncertified nurse aide who has been afforded a hearing before a state or local administrative agency or other neutral party, or in a court of law, at which time the nurse aide received adequate notice and an opportunity to testify and to confront witnesses, and where there was an impartial hearing officer who issued a written decision verifying the findings of abuse, neglect, or misappropriation of property of a resident. The individual shall have a right to enter a statement to be included in the registry contesting such findings.

8:39-43.9 Equivalency for nurse aides registered in other states

(a) A nurse aide certificate received in another state or territory of the United States may be entered on the registry, provided that the following conditions are satisfied:

1. The Department receives documentation from the state's or U.S. territory's registry that such nurse aide has completed a training and competency evaluation program at least equal to that required in New Jersey;

2. The nurse aide has not been convicted of any crimes and has no documented findings of abuse, neglect, or misappropriation of resident property on the registry; and

3. The nurse aide complies with the requirements for a criminal background investigation as required by N.J.A.C. 8:43I.

8:39-43.10 Approval of a nurse aide in long term care facilities training program

(a) Written approval of the Department is required prior to enrollment of students and the commencement of a training program in an educational institution, a facility, or a proprietary program. Training program approval, when granted, shall be granted for a 24-month period.

(b) An approved training program for nurse aides shall consist of 90 hours of training. This shall include 50 hours of classroom instruction and 40 hours of clinical experience in a New Jersey licensed long-term care facility. All training programs shall use the curriculum approved by the Department, in accordance with (c) below.

(c) The New Jersey Curriculum for Nurse Aide Personnel in Long Term Care Facilities ("the curriculum"), which has been approved by the Department, shall be the approved curriculum for a 90 hour training program. The entire content of the curriculum shall be taught. A copy of the curriculum and the form needed to apply for approval of a training course may be obtained by contacting the following office:

Certification Program
New Jersey Department of Health and Senior Services
P.O. Box 367
Trenton, NJ 08625-0367

(d) The New Jersey competency evaluation shall consist of both a skills examination and a written/oral examination.

(e) A facility-based approved training program and the New Jersey competency evaluation shall be scheduled so as to be completed within 120 days of the starting date of employment for a nurse aide.

(f) A training program offered in an educational institution to train and test certified nurse aides shall be approved by the Department.

(g) No resident care unit shall serve as the site of clinical instruction for more than one training program at a time.

(h) The training program for nurse aides shall not be used as a substitute for staff orientation or staff education programs.

(i) Classroom and clinical instruction for particular tasks or procedures shall be scheduled concurrently to the extent practicable.

(j) The Department may request submission of additional information or require the redesign and/or revision of the program materials. Redesign or revision of the program application does not ensure that approval will be granted.

(k) Any changes in a training program, such as changes in location, dates, times or instructors, shall be reported in writing, to the Certification Program at least 30 working days prior to the planned change. No change shall be implemented without the written approval of the Certification Program.

(l) The facility or educational institution conducting a training program shall maintain on file a copy of the lesson plans for the course. Each lesson plan shall state, at a minimum, the following:

1. The objective(s) of the lesson;
2. The content of the lesson;
3. A description of clinical activities for each lesson, consistent with the objectives in the curriculum;
4. The hours of instruction;
5. Methods of presentation and teacher strategies; and
6. Methods for evaluation of students with respect to their classroom and clinical performance in the facility.

(m) Each nurse aide training program instructor/evaluator shall:

1. Be currently licensed in New Jersey as a registered professional nurse;
2. Possess at least three years of full-time or full-time equivalent experience in a licensed health care facility;

3. Possess at least one year of full-time or full-time equivalent experience as a registered professional nurse in a licensed long term care facility, within the five years immediately preceding submission of the instructor/evaluator resume to the Certification Program of the Department for approval; and

4. Have successfully completed a training workshop offered by the Department for instructors/evaluators.

(n) The student-to-instructor ratio for classroom instruction shall not exceed a ratio of 20 students to one instructor.

(o) The student-to-instructor ratio for clinical instruction shall not exceed a ratio of 10 students to one instructor.

(p) Each student shall be under the supervision of the registered professional nurse instructor at all times when providing resident care as part of the student's clinical experience in the facility. The registered professional nurse instructor shall be responsible for evaluating the student's classroom and clinical performance.

(q) The resume of each nurse instructor/evaluator currently teaching the training program shall be available in the facility or educational institution.

8:39-43.11 Evaluation of training programs

(a) The facility or educational institution conducting a training program shall develop, implement, and document a process for evaluating the effectiveness of the training program. The evaluation process shall include, at a minimum, the following:

1. Assignment of responsibility for the evaluation process;
2. An annual written evaluation report, including findings, conclusions, and recommendations;
3. A written evaluation by the facility or educational institution of the performance of instructors/evaluators;
4. Written evaluations, by students, of the training program; and
5. Statistical data that shall be maintained on file in the facility or educational institution. The statistical data shall include, at a minimum, the following for each course:
 - i. The beginning and ending dates;
 - ii. The number of students enrolled;

iii. The number and percentage of students who satisfactorily completed the course;

iv. The number and percentage of students who failed the course;

v. The number and percentage of students who passed the New Jersey Nurse Aide Competency Evaluation Program, including written/oral examination and skills; and

vi. The number and percentage of students who failed the New Jersey Nurse Aide Competency Evaluation Program, including written/oral examination and skills.

(b) The facility or training program shall retain all evaluation reports for at least three years and shall submit a report to the Department upon request.

8:39-43.12 Student records

(a) Each facility or educational institution that conducts a training program shall establish a student record for each student. The student record shall include, at a minimum, the following:

1. The beginning and ending dates of the training program;
2. An attendance record;
3. A signed skills competency task form; and
4. An evaluation of the student's classroom and clinical performance, completed by the student's instructor.

(b) The facility shall retain the records specified at (a) above for at least four years.

(c) The facility or educational institution conducting a training program shall ensure that a student who is absent receives a reasonable and timely opportunity to obtain the classroom and/or clinical instruction missed, as documented in the student's record.

8:39-43.13 Denial or termination of a nurse aide in long-term care facilities training program

(a) The Department shall conduct unannounced site visits of a nurse aide in long-term care facilities training program.

(b) The Department may deny, suspend, or withdraw approval if it determines that a nurse aide training program fails to follow the application as submitted to, and approved by, the Department.

(c) Approval of a nurse aide training program offered by or in a facility that participates in the Medicare or Medicaid Programs shall be denied in accordance with 42 CFR 483.151 (b).

(d) If the Department proposes to deny, suspend, or revoke approval of a nurse aide training and/or skills competency examination programs, except where governed by the Federal Requirements noted in (c) above, the facility or educational institution may, within 30 days, request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(e) Suspension or withdrawal of training program approval shall not affect currently enrolled students, who shall be permitted to complete the training program unless the Department determines that continuation of the program would jeopardize the health or safety of residents in any long-term care facility.

(f) If a nurse aide training program is discontinued for any reason, but the facility or educational institution continues to operate, the facility or educational institution shall be responsible for maintaining the records of students and graduates.

(g) If a nurse aide training program is discontinued for any reason and the facility or educational institution ceases to operate, the records of students and graduates shall be transferred to an agency acceptable to the Department. The Department shall be advised, in writing, of the arrangements made to safeguard the records.

(h) If a nurse aide training program is discontinued for any reason, the facility or educational institution shall:

1. Assist in the transfer of students to other approved nurse aide training programs;

2. Provide the Department with a list of the students who have transferred to another training program, and the dates on which the students were transferred; and

3. Notify the Department that the requirements for closing have been fulfilled and provide notice of final closing.

(i) If a facility or educational institution plans to voluntarily discontinue a nurse aide training program, the facility or educational institution shall:

1. Provide the Department with a written statement of the rationale and plan for the intended closing;
2. Continue the program until the class established for currently enrolled students has been completed; and
3. Notify the Department, in writing, of the closing date of the program at least 90 days prior to that date.

8:39-43.14 Responsibilities of Administrator

(a) The licensed nursing home administrator or administrator of the educational institution conducting the training program shall be responsible for implementation of the training program in accordance with the rules in this subchapter. This responsibility shall include, but not be limited to, ensuring that:

1. The curriculum is implemented in accordance with the application as submitted and approved by the Certification Program of the Department;
2. Resident care provided by the student does not exceed the tasks and procedures that the student has satisfactorily demonstrated, as documented by the registered professional nurse on a skills competency task form; and
3. Job descriptions are established indicating the responsibilities of each nurse instructor/evaluator.

8:39-43.15 Employment of a nurse aide

(a) No licensed long term care facility shall employ a person as a nurse aide without making inquiry to the New Jersey nurse aide registry on the Promissor website at <http://www.promissor.com>, and to any other state where the facility believes the nurse aide is registered.

(b) The facility shall have a system in place to document compliance with (a) above.

(c) The facility shall maintain records sufficient to verify the previous employment of nurse aides who are not currently working but whose employment at the facility makes him or her eligible for recertification in accordance with N.J.A.C. 8:39-43.6(c).

8:39-43.16 Nurse aide functions

The nurse aide shall function under the supervision and direction of a registered professional nurse and shall perform tasks that are delegated in accordance with the provisions of N.J.A.C. 13:37-6.2.

8:39-43.17 Mandatory nurse aide education and training

(a) A program of individualized orientation of each nurse aide shall be conducted by a registered professional nurse. The orientation program shall include resident care training and demonstrations in basic nursing skills, followed by an internship of two to five days, depending on experience.

(b) Each nurse aide shall receive, at a minimum, 12 hours of regular in-service education per year, the content of which shall be based on the outcome of performance reviews of every nurse aide, which are completed at least once every 12 months. (The 12 hours may include topics that are covered under OBRA requirements, Pub. L. 100-239 (1989) which overlap or are duplicative of those required at N.J.A.C. 8:39-13.4 (b), up to a maximum of six hours of in-service training per year.)

8:39-43.18 Fees

(a) In accordance with 42 CFR 483.154, as amended and supplemented, fees may be charged by the testing agency for the following:

1. Clinical skills and written examination;
2. Clinical skills and oral examination;
3. Clinical skills and Spanish oral examination;
4. Written examination only;
5. Clinical skills examination only;
6. Oral examination only;
7. Spanish oral examination only;
8. Duplicate or updated certificate, which shall be charged to the individual; and
9. Recertification certificate, which shall be charged to the individual if the individual is neither currently employed nor has been offered employment by a long-term care facility.

(b) The fee charged by the Department for a two-year approval of a training program shall be \$75.00.

(c) The Department shall provide timely notice of any changes in fees specified in (a) above in the Public Notices section of the New Jersey Register.

(d) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may not be charged for any portion of the program identified in (a) above, including tuition and testing, and fees for textbooks or other required course materials.

(e) If a nurse aide who is not employed, or does not have an offer to be employed as a nurse aide becomes employed by, or receives an offer of employment from, a licensed long term care facility not later than 12 months after completing a nurse aide training and competency evaluation program, the facility shall provide for the reimbursement of reasonable costs incurred in completing the program. Such costs include, but are not limited to, tuition, testing, and fees for textbooks or other required course materials.

(f) A nurse aide shall be reimbursed the costs of certification within one year of the successful completion of a reasonable probationary period established by the long-term care facility.

(g) No nurse aide shall be required, as a condition of employment, to pay the cost of the training program in the event of voluntary or involuntary termination of employment.

(h) All fees referenced at (a) and (b) above are non-refundable.

SUBCHAPTER 44.
MANDATORY STANDARDS FOR RESPITE CARE SERVICES

8:39-44.1 Scope and purpose

(a) Long-term care facilities are authorized by law to accept short-term residents whose regular caregivers are participating in a respite care program. A caregiver is defined as any individual, paid or unpaid, who provides regular in-home care for an elderly, disabled, or cognitively impaired person.

(b) When a caregiver desires respite from this responsibility, continuity of care for the elderly, disabled, or cognitively impaired person is available through temporary placement in a long-term care facility for a period of time specified in advance.

(c) The standards in this subchapter apply only to those long-term care facilities that operate a respite care program.

8:39-44.2 Mandatory policies and procedures

(a) The long-term care facility shall have written respite care policies and procedures that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.

(b) The facility shall obtain the following information from the resident's attending physician or advanced practice nurse prior to admission:

1. A summary of the resident's medical history and most recent physical examination;
2. Signed and dated medication and treatment orders for the resident's stay in the facility; and
3. Phone numbers of the attending physician or advanced practice nurse and an alternate physician or advanced practice nurse for consultation or emergency services.

(c) The facility shall choose whether to follow the resident care plan provided by the attending physician or advanced practice nurse or to establish a plan in accordance with N.J.A.C. 8:39-11. The facility is exempt from compliance with N.J.A.C. 8:39-11, if it chooses to follow the care plan provided by the resident's attending physician.

(d) The facility shall obtain the following information from the resident's regular caregiver(s):

1. Nursing care needs, including personal hygiene and restorative maintenance care;

2. Dietary routine and preferences; and

3. Social and activity routine and preferences.

(e) The facility shall choose whether to follow the dietary, social, and resident activity plan provided by the caregiver(s) or to establish a plan in accordance with N.J.A.C. 8:39-7, 17 and 39. The facility is exempt from compliance with N.J.A.C. 8:39-7, 17 and 39, if it chooses to follow the plan provided by the caregiver(s).

(f) The pharmacy and therapeutics committee shall establish policies and procedures for providing pharmacy services for the respite care program according to the New Jersey State Board of Pharmacy and other applicable rules and regulations. These policies and procedures shall include the following:

1. Options, if any, for provision of resident medications by sources other than the facility's usual provider(s);

2. Labeling and packaging of medications;

3. Self-administration of medications, if applicable; and

4. Control measures.

(g) The facility shall apply to respite care residents all the standards contained in this chapter, except those exemptions cited in this section, and in the following: N.J.A.C. 8:39-4.1(a)31, 4.1(b), 5.1(a)through(e), 11.3(a), 15.1(b), 29, 35.2(d)3 through 16, and 37.3.

**SUBCHAPTER 44A.
ADVISORY STANDARDS FOR RESPITE CARE SERVICES**

8:39-44A.1 Advisory staffing

A long-term care facility assigns specific staff members to an individual respite care resident to provide continuity of care during the resident's stay in the facility.

**SUBCHAPTER 45.
ALZHEIMER'S/DEMENTIA PROGRAMS**

8:39-45.1 Scope and purpose

(a) Long-term care facilities may establish Department approved programs to meet the needs of residents with Alzheimer's disease or other dementias. In addition to meeting all mandatory requirements specified in this chapter, the program shall provide individualized care based upon assessment of the cognitive and functional abilities of Alzheimer's and dementia residents who have been admitted to the program.

(b) No facility shall advertise or hold itself out as providing an Alzheimer's/dementia program unless it meets the data reporting requirements of N.J.S.A. 8:39-45.2 and is recognized by the Department as meeting at least 65 percent of all current advisory standards in N.J.A.C. 8:39-46.

8:39-45.2 Mandatory data reporting requirements

(a) Each facility qualified pursuant to this subchapter to hold itself out as providing an Alzheimer's/dementia program, shall:

1. Compile and maintain daily records for each shift in the facility and provide to a member of the public, upon request, information that indicates for each shift, as appropriate:

i. The number of nurses, including the aggregate total of registered nurses and licensed practical nurses and licensed practical nurses providing direct care to residents diagnosed with Alzheimer's disease and related disorders; and

ii. The number of certified nurse aides providing direct care to residents diagnosed with Alzheimer's disease and related disorders; and

2. Provide a member of the public seeking placement of a person diagnosed with Alzheimer's disease and related disorders in the facility with a clear and concise written list that indicates:

i. The activities that are specifically directed towards residents diagnosed with Alzheimer's disease and related disorders, including, but not limited to, those designed to maintain dignity and personal identity, enhance socialization and success, and accommodate the cognitive and functional ability of a resident;

ii. The frequency of the activities listed in (a)2 above; and

iii. The safety policies and procedures and any security monitoring system that is specific to residents diagnosed with Alzheimer's disease and related disorders.

(b) As used in this section, "Alzheimer's disease and related disorders" means the conditions defined at N.J.S.A. 26:2M-10(b).

SUBCHAPTER 46.
ALZHEIMER'S/DEMENTIA PROGRAMS – ADVISORY STANDARDS

8:39-46.1 Advisory Alzheimer's/dementia program policies and procedures

(a) The long-term care facility has written policies and procedures for the Alzheimer's/dementia program that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.

(b) The facility has established criteria for admission to the program and criteria for discharge from the program when the resident's needs can no longer be met, based upon an interdisciplinary assessment of the resident's cognitive and functional status.

8:39-46.2 Advisory staffing

(a) Staffing levels are sufficient to provide care and programming, based upon resident census in the program and an interdisciplinary assessment of the cognitive and functional status of residents in the program.

(b) The facility has established criteria for the determination of each staff member's abilities and qualifications to provide care to residents in the program.

(c) The facility provides an initial and ongoing educational, training and support program for each staff member which includes at least the causes and progression of dementias, the care and management of residents with dementias, and communication with dementia residents.

(d) Each Alzheimer's/dementia program has a full-time employee, with specialized training and/or experience in the care of residents with dementia, who has been designated as coordinator/director and whose duties include responsibility for the operation of the program.

(e) A consultant gerontologist is available to residents and to the program, as needed, to address the medical needs of the resident. "Consultant gerontologist" means a physician, psychiatrist, or geriatric advanced practice nurse who has specialized training and/or experience in the care of residents with dementia.

8:39-46.3 Advisory environmental modification

(a) The program includes appropriate facility modifications to ensure a safe environment which allows each Alzheimer's/dementia resident to function with maximum independence and success.

(b) The facility has developed safety policies and procedures and a security monitoring system which are specific to the program, based upon the physical location of the program as well as the individual needs of the Alzheimer's/dementia residents.

(c) The facility provides indoor and outdoor arrangements that allow residents freedom to ambulate in a controlled setting.

(d) Doors are marked with items familiar to the individual resident, which enhance the resident's ability to recognize his or her room, and bathrooms are specially marked and easily accessible.

8:39-46.4 Advisory activity programming

The Alzheimer's/dementia program provides a daily schedule of special activities, seven days a week and at least two evenings per week, designed to maintain residents' dignity and personal identity, enhance socialization and success, and to accommodate the various cognitive and functional abilities of each resident.

8:39-46.5 Advisory nutrition

(a) The Alzheimer's/dementia program provides nutritional intervention as needed, based upon assessment of the eating behaviors and abilities of each resident. Interventions may include, but are not limited to, the following:

1. Verbal and non-verbal eating cues;
2. Modified cups, spoons, or other assistive devices; and
3. Simplified choices of foods or utensils.

(b) The Alzheimer's/dementia program provides a small dining room, separate room, or designated dining area furnished to meet the needs of the residents, with staff members or trained volunteers to assist.

8:39-46.6 Advisory social services

(a) The facility provides individual and group counseling to residents if appropriate, utilizing techniques designed to reach the dementia resident and to maintain the resident's maximum level of functioning.

(b) Families are encouraged and provided with opportunities to participate in planning and providing resident care.

(c) The facility provides individual and group counseling, support and education groups for families, and information and referral on bioethical and legal issues related to dementia, including competence, guardianship, conservatorship and advance directives.

(d) Family members are referred to community Alzheimer's disease support groups or other family counseling agencies, as required.

(e) Discharge care plans, including preparation for discharge from the unit, are discussed with the legal next of kin, and, if possible, with the resident at the time of admission to the program.

SUBCHAPTER 47.
SUBACUTE CARE UNIT IN AN ACUTE CARE GENERAL HOSPITAL

8:39-47.1 Scope

All hospital-based subacute care units shall comply with the rules in this subchapter, all other pertinent rules in this chapter, the provisions of State of New Jersey P.L. 1996, c.102, and Federal Medicare requirements at P.L. 89-97 (42 U.S.C. §§ 1395 et seq.).

8:39-47.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Hospital-based subacute care unit” means a distinct unit located within an acute care general hospital that utilizes licensed long-term care beds to provide subacute care.

“Subacute care” in an acute care general hospital means a comprehensive inpatient program for patients who have had an acute illness, injury, or exacerbation of a disease process, have a determined course of treatment prescribed, and do not require intensive diagnostic or intensive invasive procedures, but the patient’s condition requires physician direction, intensive nursing care, frequent recurrent patient assessment and review of the clinical course and treatment plan for a period of time, significant use of ancillary medical services and an interdisciplinary approach using professional teams of physicians, nurses and other relevant professional disciplines to deliver complex clinical interventions.

8:39-47.3 Licensure of hospital-based subacute care units

A hospital-based subacute care unit shall obtain a license to operate from the Department prior to accepting any patients. The hospital shall contact the Long-Term Care Assessment and Survey Program of the Department in order to schedule an initial licensure survey. A license shall be issued by the Long-Term Care Licensing Program only upon a finding by the Department that the unit is in compliance with the licensure requirements specified at N.J.A.C. 8:39-47.4.

8:39-47.4 Licensure requirements

(a) Prior to receiving a license and prior to the initial licensure survey by representatives of the Department, the hospital-based subacute care unit shall develop written clinical admission criteria and utilization review protocols as described in this section.

1. A resident of a long-term care facility who is admitted to, and discharged from, an acute care hospital shall not, upon discharge from the hospital, be admitted to the hospital-based subacute care unit, unless the long-term care facility is unable to readmit the resident within 24 hours after written notification to the long-term care facility that the resident is to be discharged from the hospital. In this case, the patient shall be discharged to the long-term care facility of origin as soon as such facility is able to readmit the individual. The hospital-based subacute care unit shall, on a daily basis, document in the patient's medical record the continuing inability of the long-term care facility of origin to readmit the patient.

2. The hospital shall identify clinical admission criteria for its hospital-based subacute care unit which shall include:

- i. Prospective clinical admission criteria; and
- ii. Clinical exclusion criteria.

3. The hospital shall specify within the clinical admission criteria that the hospital-based subacute care unit is intended for patients who will need post-acute care for eight days or fewer.

4. Except as provided in (a)5 below, patients shall be admitted to the hospital-based subacute care unit on the recommendation of the attending physician, if such admission is in accordance with the written clinical admission and exclusion criteria.

5. Except as set forth at (a)6 below, the hospital-based subacute care unit shall not admit a clinically stable patient with one of the diagnoses listed at (a)5i below and meeting all of the criteria for inpatient rehabilitation hospital care listed at (a)5ii below.

i. Nonadmissible diagnostic categories shall include patients with stroke; congenital anomaly; major multiple trauma; polyarthritis, including rheumatoid arthritis; neurological disorder, including multiple sclerosis, motor neuron disease, polyneuropathy, muscular dystrophy, and Parkinson's disease; traumatic or nontraumatic brain injury; spinal cord injury; amputation; joint replacement; fracture of the femur, including hip fracture; and burns.

ii. Criteria for inpatient rehabilitation hospital care shall include the following:

(1) The need for close medical supervision by a physician with specialized training or experience in rehabilitation;

(2) The need for 24-hour per day rehabilitation nursing;

- (3) The need for a relatively intense level of rehabilitation services;
- (4) The need for a multidisciplinary team approach to the delivery of the program;
- (5) The need for a coordinated program of care;
- (6) The expectation of significant practical improvement in a reasonable period of time; and
- (7) The establishment of realistic goals of self-care or independence in activities of daily living.

6. In order to admit a patient described at (a)5 above, the hospital-based subacute care unit shall:

i. Forward information pertaining to the clinically stable patient to either a licensed comprehensive rehabilitation hospital or an acute care hospital which has licensed comprehensive rehabilitation beds;

ii. Receive a favorable recommendation from either the licensed comprehensive rehabilitation hospital or the acute care hospital which has licensed comprehensive rehabilitation beds;

iii. Receive a written concurring recommendation regarding the patient's admission from the case manager at the acute care hospital; and

iv. Receive a recommendation to admit from the patient's attending physician.

(b) Upon determination that admission of a patient to a hospital-based subacute care unit is appropriate, information concerning the patient's rights shall be provided to the patient. Such information shall include the rights enumerated at N.J.A.C. 8:39-4 and shall assure the patient of at least the following:

That, although the patient's stay is not expected to exceed eight days, the patient has the right to remain in the unit until a transfer or discharge is medically necessary to meet the patient's needs or until transfer or discharge is appropriate due to improvement in condition;

1. That the patient shall be notified as soon as practical prior to transfer or discharge; and

2. That, during the patient's stay, the hospital-based subacute care unit shall provide all care and services necessary to maximize the physical, mental, and psychosocial well-being of the patient.

(c) The hospital-based subacute care unit shall establish a procedure for a patient assessment, utilizing the Standardized Resident Assessment Instrument (see N.J.A.C. 8:39-11.2(e)) to have an assessment reference date of any day, one through eight, with days one through five being optimal, but days six through eight being acceptable.

(d) The hospital-based subacute care unit shall develop written utilization review protocols in accordance with the following:

1. Utilization review protocols shall be prospective, concurrent, and retrospective in nature. The protocols shall be designed to verify, in all cases, the stringent use of the clinical admission criteria, the provision of continual discharge planning, and appropriateness of stay;

2. Prospective utilization review shall occur before the patient is discharged from the acute care hospital or while the patient is completing the preadmission process for the hospital-based subacute care unit;

3. Utilization review staff shall visit each patient and review the patient's medical record prior to admission in order to ensure that for each patient:

- i. An appropriate length of stay is expected;
- ii. The level of care provided in the unit is commensurate with the patient's needs; and
- iii. A discharge plan has been prepared prior to admission;

4. Utilization review staff shall assess each patient on the first day, the fourth day, and daily thereafter to ensure the continued appropriateness of the patient's stay in the unit; and

5. Utilization review staff shall retrospectively examine diagnostic and length of stay information concerning each admission. Such information shall be reported to the Department quarterly on a form and in a manner prescribed by the Department. The \$35.00 per admission health care quality fee prescribed by P.L. 1996, c.102, shall accompany submission of the form to the Department. Such form shall be submitted to the Department within 30 days after the conclusion of each quarter.

8:39-47.5 Licensure renewal

(a) Renewal of a license to operate a hospital-based subacute care unit shall be based upon the unit's compliance with the rules in this subchapter, all other pertinent rules in this chapter, the provisions of State of New Jersey P.L. 1996, c.102, and Federal Medicare requirements at P.L. 89-97 (42 U.S.C. §§ 1395 et seq.).

(b) The Department shall use the aggregate length of stay (total patient days/number of admissions) for the hospital-based subacute care unit as a monitoring benchmark, as an indicator of conformance with provisions of P.L. 1996, c.102, and as a condition of licensure renewal. For each annual renewal of the license, if the aggregate length of stay for patients admitted to the hospital-based subacute care unit during the four quarters immediately preceding the renewal application is determined to be greater than eight days, the Department shall not renew the subacute care license for the next annual licensure renewal cycle. A hospital shall not be permitted to reapply for a new certificate of need for a hospital-based subacute care unit for six months from the date of licensure nonrenewal or revocation.

1. In the case of licensure renewal applications submitted to the Department within one year after initial licensure, the aggregate length of stay shall be determined for the three quarters immediately preceding the licensure renewal application and used by the Department in accordance with (c) above.

2. For any patient who remains in the hospital-based subacute care unit in accordance with all provisions of N.J.A.C. 8:39-47.4(a)1, patient days accrued after the hospital has issued its written notice to discharge to the long-term care facility of origin shall not be included in the calculation of aggregate length of stay for the unit.

APPENDIX A

GUIDELINES AND CONSIDERATIONS FOR PET FACILITATED THERAPY IN NEW JERSEY INSTITUTIONS

I. All Pets

A. Companion pets should not pose a threat or nuisance to the patients, staff, or visitors because of size, odor, sound, disposition, or behavioral characteristics. Aggressive or unprovoked threatening behavior should mandate the pet's immediate removal.

B. Animals which may be approved include: dogs, cats, birds (except carnivorous), fish, hamsters, gerbils, guinea pigs, and domestic rabbits. Wild animals such as turtles and other reptiles, ferrets, and carnivorous birds should not be permitted in the program.

C. In order to participate, dogs or cats should be either altered or determined not to be in estrus ("heat").

D. Sanitary constraints:

1. Pets should be prohibited from the following areas:

a. Food preparation, storage, and serving areas, with the exception of participating resident's bedroom;

b. Areas used for the cleaning or storage of human food utensils and dishes;

c. Vehicles used for the transportation of prepared food;

d. Nursing stations, drug preparation areas, sterile and clean supply rooms;

e. Linen storage areas; and

f. Areas where soiled or contaminated materials are stored.

2. Food handlers should not be involved in the cleanup of animal waste.

3. The administrator is responsible for acceptable pet husbandry practices and may delegate specific duties to any other staff members except food handlers. The areas of responsibility include: feeding and watering, food cleanup/cage cleaning, exercising, and grooming.

4. Spilling or scattering of food and water should not lessen the standard of housekeeping or contribute to an increase in vermin or objectionable odor.

5. Dogs and cats must be effectively housebroken and provisions made for suitably disposing of their body wastes.

6. Animal waste should be disposed of in a manner which prevents the material from becoming a community health or nuisance problem and in accordance with applicable sanitation rules and ordinances. Accepted methods include disposal in sealed plastic bags (utilizing municipally approved trash removal systems) or via the sewage system for feces.

7. Proper and frequent handwashing shall be a consideration of all persons handling animals.

E. Animals found to be infested with external parasites (ticks, fleas, or lice) or which show signs of illness (for example, vomiting or diarrhea) should be immediately removed from the premises and taken to the facility's veterinarian.

F. The parent or guardian of a child bitten by a dog, cat, or other animal, when no physician attends such child, shall, within 12 hours after first having knowledge that the child was so bitten, report to the person designated by law or by the local board, under authority of law, to receive reports of reportable communicable diseases in the municipality in which the child so bitten may be the name, age, sex, color, and precise location of the child (N.J.S.A. 26:4-80).

If an adult is bitten by a dog, cat, or other animal and no physician attends him, the adult, or, if he is incapacitated, the person caring for him, shall report to the person designated by law or by the local board of health to receive reports of communicable diseases in the municipality in which the adult so bitten may be the name, age, sex, color, and the precise location of the adult. The report shall be made within 12 hours after the adult was so bitten, or if he is incapacitated, the report shall be made within 12 hours after the person caring for him shall first have knowledge that the adult was so bitten (N.J.S.A. 26:4-81).

G. The local health department must be promptly notified by telephone of any pet that dies on the premises.

1. If the deceased is a bird, the body should be immediately taken to the facility's veterinarian. If the veterinarian is not available, the deceased bird should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available. Payment for a laboratory examination should be the responsibility of the institution, or the pet's owner.

2. If the deceased is another type of animal, the body should not be disposed until it is determined by the local department of health that rabies testing is not necessary.

H. The rights of residents who do not wish to participate in the pet program must be considered first. Patients not wishing to be exposed to animals should have available a pet free area within the participating facility.

II. Visiting Pets

A. Visiting pets are defined as any animal brought into the facility on a periodic basis for pet therapy purposes. The owner should accompany the animal and be responsible for its behavior and activities while it is visiting at the facility.

B. Visiting dogs should:

1. Be restricted to the areas designated by the facility administrator;
2. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus, coronavirus, bordetella (kennel cough), and rabies. Proof of vaccination shall be included on a health certificate that is signed by a licensed veterinarian and kept on file at the facility;
3. Be determined not to be in estrus ("heat") at the time of the visit;
4. Be licensed and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number; and
5. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the approval of the administrator.

C. Visiting cats should:

1. Maintain current vaccination against feline pneumonitis, panleukopenia, rhinotracheitis, calcivirus, chlamydia, and rabies. Proof of vaccination should be included on a health certificate that is signed by a licensed veterinarian and kept on file at the facility; and
2. Determined not be in estrus ("heat") at the time of the visit.

D. Visiting hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice, or rats:

1. The owner should be liable and responsible for the animal's activities and behavior.

E. No visiting birds should be allowed to participate in the program.

III. Residential Pets:

A. Residential pets are defined as any animal that resides at a facility in excess of four hours during any calendar day and is owned by a staff member, patient, the facility, or a facility approved party. The financial responsibility for the residential animal's maintenance is the animal owner's responsibility.

B. All documentation of compliance will be maintained by the facility administrator in a file for review and inspection. The official health records should include the rabies vaccination certificate and a current health certificate.

C. Residential animals should have a confinement area separate from the patients where they can be restricted when indicated. An area should be available for each participating unit and should be approved by the administrator.

D. A licensed veterinarian should be designated as the facility's veterinarian and should be responsible for establishing and maintaining a disease control program for residential pets.

E. Specific Species:

1. Residential dogs should:

a. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus and rabies. In addition, the animal's file should include a currently valid Rabies Vaccination Certificate, NASPHV # 51. A three-year type rabies vaccine should be utilized;

b. Have an annual heartworm test commencing at one year of age and should be maintained on heartworm preventive medication;

c. Have a fecal examination for internal parasites twice yearly. Test results should be negative before the dog's initial visit to the facility;

d. Follow the recommended procedures of the facility's veterinarian for controlling external parasites;

e. Be neutered;

f. Be licensed with the municipality and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number;

g. Have a health certificate completed by a licensed veterinarian within one week before the animal's initial visit to the facility. The certificate should be updated annually thereafter;

h. Be immediately removed from the premises and taken to the facility's veterinarian if infested with internal or external parasites, vomit, or have diarrhea, or show signs of a behavioral change or infectious disease. Medical records of the veterinarian's diagnosis and treatment should be maintained in the animal's file. The animal should not have patient contact until authorized by the facility's veterinarian;

i. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the requirements of the administrator;

j. Be fed in accordance with the interval and quantity recommended by the facility's veterinarian. Feeding and watering bowls should be washed daily and stored separately from dishes and utensils used for human consumption;

k. Be provided fresh water daily and have 24-hour access to the water dish;

l. Be provided a suitable bedding area. Bedding should be cleaned or changed as needed. Dirty bedding should be processed or disposed of as necessary;

m. Be permitted outside the facility only if under the supervision of a staff member, a responsible person or within a fenced area; and

n. Be regularly groomed and receive a bath whenever indicated.

2. Residential birds:

a. Should be treated by a licensed veterinarian with an approved chlortetracycline treatment regimen prior to being housed at the institution to ensure the absence of psittacosis. The period of treatment varies between 30 to 45 days and is species-dependent. A signed statement from the veterinarian indicating such treatment should be kept in the bird's file; and

b. That die, or are suspected of having psittacosis, should be immediately taken to the facility's veterinarian. In the event the bird dies and the veterinarian is not available, the bird's body should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available.

3. Residential hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice or rats should be examined yearly by a licensed veterinarian for health status. A health certificate should be completed for each animal or group of animals. Any animal that becomes sick or dies should be promptly taken to the facility's veterinarian.

APPENDIX B

GUIDELINES FOR THE MANAGEMENT OF INAPPROPRIATE BEHAVIOR AND RESIDENT TO RESIDENT ABUSE

I. The initial resident assessment should include a psychosocial behavior component with interventions, if appropriate, in the care plan. Reassessment should be done at least quarterly, or at any time when a resident's pattern of behavior changes. Resident response to interventions should be recorded in the medical record.

II. Inappropriate behavior and/or actions should trigger an immediate reassessment with adjusted interventions; notification of the physician and/or the designated resident representative. Resident response should be recorded in the medical record. The facility's actions/interventions in response to behavior changes should also be part of the plan of care and should be appropriately recorded. Prompt reassessment of behavioral changes will in most cases avert the continued progression of inappropriate behavior.

III. Inappropriate behavior and/or actions involving other residents should be identified in the records of all involved residents including assessments, interventions and responses. Notifications of physician and/or designated resident representatives should also be recorded in medical records of all involved residents.

IV. Incidents of inappropriate behavior or actions of abuse between residents should result in the following actions, as applicable:

- A. Immediate assessments of involved residents.
- B. Notification of attending physicians or advanced practice nurses.
- C. Interventions and responses of residents.
- D. Notification of residents' designated representatives.
- E. Protection of involved residents' civil and constitutional rights.
- F. Determination by administrator of facility's ability to assure safety and security of all patients.
- G. Implementation of emergency or short-term precautions to assure safety while working toward resolution.
- H. Notification of police if necessary.

V. In the event that it is determined that a resident must be removed from the facility, the transfer should be initiated in accordance with the provisions of this chapter.

VI. Transfer from the facility should be based on the appropriate evaluation and transfer order of the attending physician, advanced practice nurse, facility medical director and/or consultant psychiatrist.

VII. In the event of an immediate emergency situation only:

1. Have patient removed to emergency room of local hospital for medical and/or psychiatric evaluation and consultation by a physician or advanced practice nurse. Return of patient to the long-term care facility should be based on the physician's or advanced practice nurse's written notation of the appropriateness of returning the resident to the long-term care setting. The administrator is responsible for the decision to accept or deny the return of the resident according to N.J.A.C. 8:39;

2. A police complaint should be filed against the abuser and have the individual removed. The complaint can be filed by the facility or the abused party; and

3. Notify all agencies (that is, Medicaid if applicable, Ombudsman for the Institutionalized Elderly, if applicable (over 60) and the Department of Health and Senior Services.)

VIII. In the event all guidelines have been followed and resolution has not taken place, assistance should be requested from the Department.

IX. Facility policies and procedures to address inappropriate resident behavior, including resident to resident abuse, should include all of the above outlined actions.

X. To determine resident's emotional adjustment to the nursing facility, including his/her general attitude, adaptation to surroundings, and change in relationship patterns, the following areas should be evaluated:

1. Sense of Initiative/Involvement

Intent: To assess degree to which the resident is involved in the life of the nursing home and takes initiative in activities.

Process: Selected responses should be confirmed by the resident's behavior (either verbal or nonverbal) over the past seven days. The primary source of information is the resident. Secondly, staff members who have regular contact with the resident should be consulted (for example, nursing assistants, activities personnel, social work staff, or therapists if the person

receives active rehabilitation). Also, consider how resident's cultural standards affect the level of initiative or involvement.

Definition: At ease interacting with others--Consider how resident behaves during time you are together, as well as reports of how resident behaves with other residents, staff, and visitors. Does resident try to shield himself/herself from being with others? Does he/she spend most time alone? How does he/she behave when visited?

At ease doing planned or structured activities--Consider how resident responds to such activities. Does he/she feel comfortable with the structure or restricted by it?

At ease with self-initiated activities--These include leisure activities (for example, reading, watching TV, talking with friends), and work activities (for example, folding personal laundry, organizing belongings). Does resident spend most of his/her time alone, or does resident always look for someone to find something for him/her to do?

Establishes his/her own goals--Consider statements resident makes like, "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. Some things may not be stated.

Involvement in life of the facility--Consider whether resident partakes of facility events, socializes with peers, discusses activities.

Resident accepts invitations into most group activities--Is resident willing to try group activities even if later, deciding the activity is not suitable and leaving? Does resident regularly refuse to attend group programs?

2. Unsettled Relationships

Intent: To indicate the quality and nature of the resident's interpersonal contacts (that is, how resident interacts with staff members, family, and other residents).

Process: During routine nursing care activities, observe how the resident interacts with staff members and with other residents. Do you see signs of conflict? Talk with direct-care staff (for example, nursing assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that the staff members describing these relationships may be biased.

Definition: Covert/open conflict with and/or repeated criticism of staff--Resident chronically complains about some staff members to other staff members; resident verbally criticizes staff members in therapeutic group situations, causing disruption within the group; or resident constantly disagrees with routines of daily living. [Note: Checking this item does not require any assumption about why the problem exists or how it could be remedied.]

Unhappiness with roommate--Includes frequent requests for roommate changes, grumbling about roommate spending too long in the bathroom, or complaints about roommate rummaging in another's belongings.

Unhappiness with residents other than roommate--Includes chronic complaints about the behaviors of others, poor quality of interaction with other residents, lack of peers for socialization. This refers to conflict or disagreement outside of the range of normal criticisms or requests (that is, beyond a reasonable level).

Openly expresses conflict/anger with family or close friends--Includes expressions of feelings of abandonment, ungratefulness, lack of understanding, or hostility regarding relationships with family/friends.

Absence of personal contact with family/friends--Absence of visitors or telephone calls from significant others in the last seven days.

Recent loss of close family member/friend--Includes relocation of family member/friend to a more distant location, even temporarily (for example, for the winter months); incapacitation or death of a significant other; a significant relationship that recently ceased.

3. Past Roles

Intent: To indicate recognition or acceptance of feelings regarding role or status now that the person is in the nursing home.

Definition: Strong identification with past roles and life status--This may be indicated, for example, when resident enjoys telling stories about own past; or takes pride in past accomplishments or family life; or prefers to be connected with prior lifestyle (for example, celebrating family events, carrying on life-long traditions).

Expresses sadness/anger/empty feelings over lost roles/status--Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use; I'm not capable of doing the things I always liked to do." Resident cries when reminiscing about past accomplishments. Be careful not to take the reaction out of context.

Process: Discuss past life with resident. Use environmental cues to prompt discussions (for example, family photos, grandchildren's letters or artwork). This information may emerge from discussions around other MDS topics (for example, Customary Routine, Activity Pursuits, ADLs). Direct-care staff may also have useful insights relevant to these items.

XI. To determine resident's mood and behavior patterns, the following elements should be considered:

1. Sad or Anxious Mood

Intent: To identify the presence of behaviors that may be interpreted as physical or verbal expressions of sadness or anxiety.

Definition: A distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful). This may be a disorder of mood which is usually, but not always, accompanied by a painful mood of such magnitude that it calls for relief because it is severely, or unnecessarily, distressing or threatening to physical health and life, or interferes with functional performance and adaptation. These symptoms may be preceded by anger or withdrawal.

Process: Determine if resident expressed signs of a sad or anxious mood over the past 30 days. Draw on your own interactions with the resident. Pay particular attention to statements of direct-care staff, social workers, and licensed personnel who may have evaluated the resident in this area. Does the resident cry or look dejected (unhappy) when no one is talking with him/her? When you talk with the resident, does he/she sound hopeless, fearful, sad, anxious? Does the resident report feelings of worthlessness, guilt? Does the resident appear withdrawn, apathetic, without emotion?

If you are unsure, seek confirming information from others who regularly come in contact with the resident (for example, activities professionals, social workers, or family members).

2. Mood Persistence

Intent: To identify a persistent sad/anxious mood that has existed on each day over the last seven days and was not easily altered by attempts to "cheer up" the resident.

Process: Normally, these moods apply to one or more of the indicators mentioned above of sad/anxious mood.

3. Problem Behavior

Intent: To identify the presence of problem behaviors in the last seven days that cause disruption to facility residents or staff members, including those that are potentially harmful to the resident or disruptive in the environment, even though staff and residents appear to have adjusted to them (for example, "Mrs. R's calling out isn't much different than others on the unit; there are many noisy residents.")

Definition: Wandering--Movement with no identified rational purpose; resident appears oblivious to needs or safety. This behavior must be differentiated from purposeful movement—for example, a hungry person moving about the unit in search of food; pacing.

Report on the most disruptive resident behavior across all three shifts. Code "1" if the described behavior occurred less than daily and "2" if the behavior occurred daily or more frequently.

4. Resident Resists Care

Intent: Identify problem behaviors related to delivering care/ treatment to the resident. These behaviors are not necessarily positive or negative; they provide observational data. They may prompt further investigation of causes in the care-planning process (for example, fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness to participate in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Consult medical record and primary staff caregiver. How does the resident respond to staff members' attempts to deliver care to him/her? Signs of resistance may be verbal and/or physical (for example, verbally refusing care, pushing caregiver away, scratching).

5. Behavior Management Program

Intent: Determine if a behavior-management program is in place wherein staff members identified causal factors and developed a plan of action based on that understanding. There must be evidence of structure and continuity of care in the program (for example, written documentation). This category does NOT include behavioral management by physical restraints or psychoactive drugs, if these are the only interventions used.

Process: Consult medical record (including current care plan); consult primary caregiver.

Examples

Mrs. S has been observed on numerous occasions to hit, shove, and curse the woman seated next to her at each meal. After observing the pattern of Mrs. S's behavior for several days, staff noticed that her tablemate was in the habit of moving toward Mrs. S to take food from her tray. As a result of their observations, the primary nurse made a change in seating arrangements. (Note: Although staff might have increased the amount of food provided at meals, the real issue was the taking of food; Mrs. S would not want to share with others, no matter how much food she was given.) Mrs. S does not tend to ask staff for help when she is annoyed; she takes direct and aggressive action on her own. Now that staff understand this behavior, they are aware of the need to be vigilant. Code "1" for Yes.

Provisions were made for safety monitored wandering for Mr. V (including use of "secure bands" that activate an alarm if he wanders away from a designated area). Mr. V does not really disturb others (he does not go into others' rooms). Without this "band," however, staff lost track of him and he was in danger of harming himself if he got off the unit (a busy street is very near his unit). Code "1" for Yes.

6. Change in Mood

Intent: Determine whether the resident's mood changed in the past 90 days, that is, onset of recent mood problem or changes in a longstanding problem. Changes may have been expressed verbally or demonstrated physically; they include increased/decreased number of signs/symptoms, or increase/decrease in the frequency, intensity, or persistence of sad or anxious mood.

Examples

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was disruptive. After the medication was discontinued, these feelings and behaviors improved. She is better than she was, but still has feelings of sadness. Code "1" for "Improved." Mrs. D is now better than her worst status in the 90-day period, but she has not fully recovered. [Note: If the mood problem was no longer present due to the continued efficacy of the treatment program, the correct code would also be "1" (Improved).]

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About 2 months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital. For the last 30 days (following readmission), Mrs. Y has improved and her appetite is restored. Code "1" for Improved.

7. Change in Problem Behavior

Intent: Determine if problem behaviors or resistance to care increased/decreased in number, frequency, or intensity in the past 90 days-- that is, onset of recent behavior problems or changes in a more longstanding problem. Changes can occur in many different areas, including (but not limited to) wandering, verbal or physical abuse, socially inappropriate behavior, or resistance to care.

Changes can be exhibited as increases/decreases in the number of signs/symptoms and/or change in the frequency or intensity of the behavior(s).

Process: Review nursing notes, medical records, and consult with primary staff caregiver.

APPENDIX D
GUIDELINES FOR THE USE OF RESTRAINTS

A. Written policies and procedures for use of restraints should address at least the following:

1. Protocol for the use of alternatives to restraints, such as staff or environmental interventions, structured activities, or behavior management. Alternatives should be utilized whenever possible to avoid the use of restraints;
2. Protocol for the use and documentation of a progressive range of restraining procedures from the least restrictive to the most restrictive;
3. A delineation of indications for use, which should be limited to:
 - i. Prevention of imminent harm to the resident or other persons when other means of control are not effective or appropriate; or
 - ii. Prevention of serious disruption of treatment or significant damage to the physical environment;
4. Contraindications for use, which should include, at least, clinical contraindications, convenience of staff, or discipline of the resident;
5. Identification of restraints which may be used in the facility, which should be limited to methods and mechanical devices that are specifically manufactured for the purpose of physical restraint. Locked restraints, double restraints on the same body part, four-point restraints, and confinement in a locked or barricaded room should not be permitted;
6. Protocol for informing the resident and obtaining consent when clinically feasible, and documenting the consent in the resident's record;
7. Protocol for notifying the family or guardian, obtaining consent if the resident is unable to give consent, and documenting the consent in the resident's record; and
8. Protocol for removal of restraints when goals have been accomplished.

B. Procedures for the application of restraints in an emergency should include at least the following:

1. Licensed nursing staff only should initiate the use of emergency restraints;
2. The application of restraints should begin with the least restrictive alternative that is clinically feasible;
3. Emergency restraints should be used only when the safety of the resident or others is endangered, or there is imminent risk that the resident will cause substantial damage to the physical environment;
4. The facility should notify the attending physician or advanced practice nurse or another designated physician and request an order within two hours;
5. The facility should obtain a physician's or advanced practice nurse's order within eight hours;
6. Licensed nursing personnel should evaluate and document the physical and mental condition of the resident in emergency restraints at least every two hours;
7. There should be an assessment of the resident by a registered professional nurse within 24 hours; and
8. Continuation of emergency restraints should occur only upon physician or advanced practice nurse orders, which should be renewed every 24 hours to a maximum of seven days.

C. The facility should continuously attempt to remediate the resident's condition to eliminate or lessen the need for restraints. If the use of restraints is needed beyond one week, at least the following should be done:

1. The need for the continued use of restraints should be implemented only as part of the physician's medical care plan; and
2. Every resident in restraints should be assessed by a registered professional nurse at least every 48 hours for the continued use of restraints; and
3. After remediation attempts, there should be an interdisciplinary review of the record of any resident whose assessment indicates the need for continued use of restraints. This review should occur within thirty days of the initiation of the use of restraints.

D. Continuation of the use of restraints beyond 30 days should occur only upon written approval of the committee or its equivalent, and should include at least the following actions:

1. The registered professional nurse should assess the need for continued restraints at least weekly; and

2. An interdisciplinary review should be conducted at least every 30 days to approve the continued use of restraints.

E. The facility should have written policies and procedures to ensure that interventions while a resident is restrained, except as indicated in F below, are performed by nursing personnel in accordance with nursing scope of practice as set forth by the New Jersey Board of Nursing. The policies and procedures should include at least the following:

1. Periodic visual observation, which should be performed with the following frequency:

i. Continuously, if clinically indicated by the resident's condition; or

ii. At least every 15 minutes while the resident's condition is unstable; and thereafter at least every one to two hours, based upon an assessment of the resident's condition.

2. Release of restraints at least once every two hours in order to:

i. Assess circulation;

ii. Perform skin care;

iii. Provide an opportunity for exercise or perform range of motion procedures for a minimum of five minutes per restrained limb and repositioning; and

iv. Assess the need for toileting and assist with toileting or incontinence care.

3. Ensuring adequate fluid intake;

4. Ensuring adequate nutrition through meals at regular intervals, snacks, and assistance with feeding if needed;

5. Assistance with bathing as required at least daily; and

6. Ambulation at least once every two hours, if clinically feasible.

F. The facility should have written policies and procedures for interventions by nursing personnel for residents in restraints for overnight sleeping. These policies and procedures should include at least the following and should be implemented in accordance with nursing scope of practice, as set forth by the New Jersey Board of Nursing;

1. Visual observation based on resident's condition, occurring at least every one to two hours;

2. Administration of fluids as required;

3. Toileting as required;

4. Release of restraints at least once every two hours for repositioning and skin care, if clinically indicated; and

5. Prohibition of any method of restraint which places the resident at clinical risk for circulatory obstruction.

**APPENDIX E
APPLICATION FOR A HEALTH CARE FACILITY LICENSE**

Type of Application: <input type="checkbox"/> New – CN#: _____ <input type="checkbox"/> New – No CN Required, ID#: _____ <input type="checkbox"/> Transfer of Ownership #: _____ <input type="checkbox"/> Other: _____		Date of Application:		Date of Check/Money Order:	
		Check/Money Order #: No: _____		Amount of Check/Money Order: \$ _____	
Official Name of Facility (Provider Name):				EIN Number:	
Site Address:					
City:		State:	Zip:	County:	
Telephone Number:		Fax Number:		Email Address:	
Name of Administrator:				License Number (LNHA/CALA if applicable):	
Emergency Contact:					
Emergency Telephone:		Emergency Fax Number:		Emergency Email Address:	
Mailing Address (if different from above):					
City:		State:	Zip:	County:	
Owner / Corporate Name (<u>Licensed Operator</u>):				EIN Number:	
Doing Business As (if applicable):					
Address:					
City:		State:	Zip:	County:	
Telephone Number:		Fax Number:		Email Address:	
Management Company (if applicable):					
Address:					
City:		State:	Zip:	County:	
Telephone Number:		Fax Number:		Email Address:	

<i>Contact:</i>	<i>Title:</i>
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Primary Type of Facility (check one)

<input type="checkbox"/> Adult Day Health Services	<input type="checkbox"/> Hospital Based Subacute	<input type="checkbox"/> Long-Term Care T18 only
<input type="checkbox"/> Alternate Family Care	<input type="checkbox"/> Pediatric Day Health Services	<input type="checkbox"/> Long-Term Care T19 only
<input type="checkbox"/> Assisted Living Program	<input type="checkbox"/> Residential Health Care Facility	<input type="checkbox"/> Long-Term Care T18/19
<input type="checkbox"/> Assisted Living Residence	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Long-Term Care Private
<input type="checkbox"/> Comprehensive Personal Care Home		

Enter the Quantity of all Beds / Slots at this Location

Adult Day Health Service Slots..... _____	Long-Term Care Beds..... _____
Assisted Living Beds _____	Pediatric Day Health Slots _____
Comprehensive Personal Care Beds _____	Residential Health Care Beds _____
Hospital Based Subacute..... _____	Other / Type _____

<u>Type of Ownership (check one)</u>	
For-Profit____(Y/N) Non-Profit____(Y/N) Facility is Hospital Based____Y/N)	Government Owned ____ (Y/N)
<input type="checkbox"/> *Corporation <input type="checkbox"/> Proprietorship <input type="checkbox"/> Limited Liability Corp.	<input type="checkbox"/> Federal <input type="checkbox"/> City
<input type="checkbox"/> Partnership <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Religious Affiliation	<input type="checkbox"/> State <input type="checkbox"/> City/County
<input type="checkbox"/> Other(specify)_____	<input type="checkbox"/> County <input type="checkbox"/> Hospital District

**If the corporate entity is a wholly-owned subsidiary, identify the parent corporation below:*

Name: _____

Address: _____

City/ST/Zip: _____

Building Ownership (check one)

____ Wholly owned by licensed operator identified on page one

____ Leased (Identify owner of physical assets and submit a copy of the signed lease)

Name and Title of Individual or Current Registered Agent Upon Whom Orders May Be Served (Must be NJ Resident)

Name: _____

Address: _____

City/ST/Zip: _____

Owner, Officers, Partners, Stockholders, or Corporate Officers

- IDENTIFY 100% OF THE OWNERSHIP BELOW (attach additional sheets if necessary)
- For a publicly held corporation, identify all stockholders with 10% or more of the outstanding stock
- **If an owner, partner or shareholder is an entity, rather than an individual, provide the individual ownership of that entity as well**
- For Non-Profit entities, list Board Members

<p>Name: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip _____</p> <p>SSN-TAXID: _____ % Ownership: _____</p> <p>Proprietor ___ Partner ___ Limited Partner ___ Gen. Partner ___</p> <p>LLC-Member ___ Stockholder ___ Corporate Officer ___</p>	<p>Name: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip _____</p> <p>SSN-TAXID: _____ % Ownership: _____</p> <p>Proprietor ___ Partner ___ Limited Partner ___ Gen. Partner ___</p> <p>LLC-Member ___ Stockholder ___ Corporate Officer ___</p>
<p>Name: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip _____</p> <p>SSN-TAXID: _____ % Ownership: _____</p> <p>Proprietor ___ Partner ___ Limited Partner ___ Gen. Partner ___</p> <p>LLC-Member ___ Stockholder ___ Corporate Officer ___</p>	<p>Name: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip _____</p> <p>SSN-TAXID: _____ % Ownership: _____</p> <p>Proprietor ___ Partner ___ Limited Partner ___ Gen. Partner ___</p> <p>LLC-Member ___ Stockholder ___ Corporate Officer ___</p>
<p>Name: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip _____</p> <p>SSN-TAXID: _____ % Ownership: _____</p> <p>Proprietor ___ Partner ___ Limited Partner ___ Gen. Partner ___</p> <p>LLC-Member ___ Stockholder ___ Corporate Officer ___</p>	<p>Name: _____</p> <p>Title: _____</p> <p>Address: _____</p> <p>City: _____ ST: _____ Zip _____</p> <p>SSN-TAXID: _____ % Ownership: _____</p> <p>Proprietor ___ Partner ___ Limited Partner ___ Gen. Partner ___</p> <p>LLC-Member ___ Stockholder ___ Corporate Officer ___</p>

<p><u>Please indicate whether or not your facility offers the following:</u></p> <p>Separate Units for Young Adults (Ages 21 through 64): _____ (Y/N) # of Beds: _____</p> <p>Pediatrics: _____ (Y/N) # of Beds: _____</p> <p>Ventilator: _____ (Y/N) # of Beds: _____</p> <p>Behavioral Management: _____ (Y/N) # of Beds: _____</p> <p>Private Long Term Care: _____ (Y/N) # of Beds: _____</p> <p>Alzheimer's / Dementia: _____ (Y/N) # of Beds: _____</p> <p>IV Therapy: _____ (Y/N)</p>	<p style="text-align: center;"><u>Chronic Dialysis:</u></p> <p>Performed by In-House Staff: Peritoneal: _____ (Y/N) Hemodialysis: _____ (Y/N)</p> <p>Performed by Outside Firm: Peritoneal: _____ (Y/N) Hemodialysis: _____ (Y/N)</p>
<p><u>Assisted Living Programs and Alternate Family Care list counties served from office site listed on page one.</u></p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><u>Please answer the following questions (attach additional sheets if necessary).</u></p> <p>1. Have you or any person mentioned in this application ever had an interest, directly or indirectly, in any application for health care facility in New Jersey or any other state, which was denied or revoked?</p> <p>_____ (Y/N) If yes, indicate whom and give details (<i>attach additional sheets if necessary</i>): _____</p> <p>_____</p> <p>2. Do any of the principals have ownership, management or operational interest in any other licensed health care facility in New Jersey, or any other state?</p> <p>_____ (Y/N) If yes, indicate whom and give details (<i>attach additional sheets if necessary</i>): _____</p> <p>_____</p> <p>3. Are you related to any person who now operates or has ever operated a health care facility in New Jersey or elsewhere?</p> <p>_____ (Y/N) If yes, indicate whom and give details(<i>attach additional sheets if necessary</i>): _____</p> <p>_____</p> <p>4. Have any principals, owners, operators or managers of the facility ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?</p> <p>_____ (Y/N) If yes, indicate whom and give details (<i>attach additional sheets if necessary</i>): _____</p> <p>_____</p> <p>5. Have any principals, owners, operators or managers of the facility ever been indicted for or convicted of a felony crime?</p> <p>_____ (Y/N) If yes, indicate whom and give details(<i>attach additional sheets if necessary</i>): _____</p> <p>_____</p>	
<p>CERTIFICATION</p> <p>The applicant certifies:</p> <p>1). that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;</p> <p>2). that the application been duly authorized by the governing body of the applicant; and</p> <p>3) that the facility has been and will be operated in accordance with applicable licensing requirements.</p>	
<p>NAME OF AUTHORIZED INDIVIDUAL COMPLETING FORM (PRINT OR TYPE)</p>	<p>TITLE</p>
<p>SIGNATURE</p>	<p>DATE</p>

APPENDIX F APPLICATION FOR A HEALTH CARE FACILITY LICENSE RENEWAL

New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
PO Box 358
Trenton, NJ 08625-0358

APPLICATION FOR A HEALTH CARE FACILITY LICENSE RENEWAL

Facility ID:	License #:	Expiration Date:	Date of Application:	Date of Check/Money Order:
Medicare #:	Medicaid #:		Check / Money Order Number: No.	Amount of Check/Money Order \$
Official Name of Facility (Provider Name):			Owner / Corporation Name (Licensed operator):	
Site Address:			Address:	
City:	State:	Zip:	City:	State
County:			Telephone Number:	Fax Number:
Telephone Number:	Fax Number:	Facility Email Address:	Name of Management Company (if applicable):	
Name of Administrator:	License Number (LNHA if applicable):		Doing Business As:	
Type of Facility :			Address:	
Total License Capacity: _____			City: _____ State: _____ Zip _____	
Title 18 _____			_____	
Title 19 _____			Name of Management Company Contact (First, Last)	
Title 18/19: _____			Title:	
Bed Type(s):			Telephone Number:	

Type of Ownership: (check one)

- 1) *Corporation Limited Liability Company Limited Partnership Proprietorship Partnership
 Religion Affiliated Government: (Federal State County City City/County Hospital District
 Other (specify) _____

*If the corporate entity is a wholly – owned subsidiary, please identify the parent corporation:

- 2) Above Ownership type is: For-Profit Non-Profit

Building Identification: (check one)

___ Wholly owned by licensed operator identified within:

___ Leased – Owner of physical assets: _____

Lease Attached * **IF THE BUILDING IS LEASED, A COPY OF THE LEASE MUST BE ATTACHED FOR RENEWAL OF YOUR FACILITY LICENSE ***

Name and Title of Individual or Current Registered Agent Upon Whom Orders May be Served (Must be NJ Resident):

Name: _____

Address: _____

City, State, Zip: _____

<i>Name of Facility:</i>	<i>Facility ID:</i>	<i>License #.:</i>	<i>Expiration Date:</i>
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OWNER, OFFICERS, PARTNERS, STOCKHOLDERS, CORPORATE OFFICERS, BOARD MEMBERS

IDENTIFY 100% OF THE OWNERSHIP BELOW (attach additional sheets if necessary)

- IF OWNER IS AN ENTITY, IDENTIFY INDIVIDUAL PERSONS WHO MAKE UP THE ENTITY
- IF APPLICABLE, PLEASE ATTACH LIST OF BOARD MEMBERS

<p><i>Name:</i></p> <p><i>SSN -TAXID:</i> _____ <i>Ownership: %</i></p> <p><i>Title:</i></p> <p>Proprietor<input type="checkbox"/> Partner<input type="checkbox"/> Limited Partner<input type="checkbox"/></p> <p>General Partner <input type="checkbox"/> LLC-Member<input type="checkbox"/> Stockholder<input type="checkbox"/></p> <p>Corporate Officer<input type="checkbox"/> Board Member<input type="checkbox"/></p>	<p><i>Name:</i></p> <p><i>SSN -TAXID:</i> _____ <i>Ownership: %</i></p> <p><i>Title:</i></p> <p>Proprietor<input type="checkbox"/> Partner<input type="checkbox"/> Limited Partner<input type="checkbox"/></p> <p>General Partner <input type="checkbox"/> LLC-Member<input type="checkbox"/> Stockholder<input type="checkbox"/></p> <p>Corporate Officer<input type="checkbox"/> Board Member<input type="checkbox"/></p>
--	--

<p><i>Name:</i></p> <p><i>SSN -TAXID:</i> _____ <i>Ownership: %</i></p> <p><i>Title:</i></p> <p>Proprietor<input type="checkbox"/> Partner<input type="checkbox"/> Limited Partner<input type="checkbox"/></p> <p>General Partner <input type="checkbox"/> LLC-Member<input type="checkbox"/> Stockholder<input type="checkbox"/></p> <p>Corporate Officer<input type="checkbox"/> Board Member<input type="checkbox"/></p>	<p><i>Name:</i></p> <p><i>SSN -TAXID:</i> _____ <i>Ownership: %</i></p> <p><i>Title:</i></p> <p>Proprietor<input type="checkbox"/> Partner<input type="checkbox"/> Limited Partner<input type="checkbox"/></p> <p>General Partner <input type="checkbox"/> LLC-Member<input type="checkbox"/> Stockholder<input type="checkbox"/></p> <p>Corporate Officer<input type="checkbox"/> Board Member<input type="checkbox"/></p>
--	--

<p><i>Name:</i></p> <p><i>SSN -TAXID:</i> _____ <i>Ownership: %</i></p> <p><i>Title:</i></p> <p>Proprietor<input type="checkbox"/> Partner<input type="checkbox"/> Limited Partner<input type="checkbox"/></p> <p>General Partner <input type="checkbox"/> LLC-Member<input type="checkbox"/> Stockholder<input type="checkbox"/></p> <p>Corporate Officer<input type="checkbox"/> Board Member<input type="checkbox"/></p>	<p><i>Name:</i></p> <p><i>SSN -TAXID:</i> _____ <i>Ownership: %</i></p> <p><i>Title:</i></p> <p>Proprietor<input type="checkbox"/> Partner<input type="checkbox"/> Limited Partner<input type="checkbox"/></p> <p>General Partner <input type="checkbox"/> LLC-Member<input type="checkbox"/> Stockholder<input type="checkbox"/></p> <p>Corporate Officer<input type="checkbox"/> Board Member<input type="checkbox"/></p>
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Name of Facility:	Facility ID:	License #.:	Expiration Date:
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Please answer the following questions (attach additional sheets if necessary).

1: Have you or any person mentioned in this application ever had an interest, directly or indirectly, in any application for health care facility approval in New Jersey, or any other state, which was denied or revoked? _____ (yes/no)

If yes, indicate whom and give details:

.....

2: Do any of the principals have an ownership, management or operational interest in any other licensed health care facility in New Jersey, or any other state? _____ (yes/no)

If yes, explain and give name and address of each facility:

.....

3: Are you related to any person who now operates or has ever operated a health care facility in New Jersey or elsewhere? _____ (yes/no)

If yes, give name and address of facility, and full name and relationship of relative:

.....

4: Have any principals, owners, operators or managers of the facility ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge? _____ (yes/no)

If yes, explain in detail:

.....

5: Have any principals, owners, operators or managers of the facility ever been indicted for or convicted of a felony crime? _____ (yes/no)

If yes, explain in details:

.....

CERTIFICATION

The applicant certifies:

- 1) that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
- 2) that the application has been duly authorized by the governing body of the applicant; and
- 3) that the facility has been and will be operated in accordance with applicable licensing requirements.

Name of authorized individual completing form (print or type)	Title
Signature	Date

N.J.A.C. 8:43E

**GENERAL LICENSURE PROCEDURES
AND ENFORCEMENT OF LICENSURE REGULATIONS**

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CHAPTER 43E

GENERAL LICENSURE PROCEDURES AND ENFORCEMENT OF LICENSURE REGULATIONS

SUBCHAPTER 1. SCOPE AND GENERAL PURPOSE

8:43E-1.1 Scope

The rules in this chapter pertain and apply to all health care facilities licensed by the Department pursuant to the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq. The rules set forth the procedures for the conduct of surveys of health care facilities, the basis and procedures for imposition of penalties and other enforcement actions and remedies, and the rights and procedures available to facilities to request a hearing to contest survey findings and the imposition of penalties.

8:43E-1.2 Purpose

The rules in this chapter are intended to promote the health, safety, and welfare of patients or residents of health care facilities through establishing rules and regulations implementing the Department's legislative mandate to enforce violations of licensing regulations. The rules also are intended to afford health care facilities with appropriate and adequate due process rights and procedures upon the finding of a violation or assessment of a penalty or other enforcement action.

8:43E-1.3 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Commissioner" means Commissioner of the New Jersey Department of Health and Senior Services.

"Curtailment" means an order by the Department which requires a licensed health care facility to cease and desist all admissions and readmissions of patients or residents to the facility or affected service.

"Deficiency" means a determination by the Department of one or more instances in which a State licensing regulation or Federal certification regulation has been violated.

"Department" means the New Jersey Department of Health and Senior Services.

"Division" means Division of Health Care Systems Analysis, New Jersey Department of Health and Senior Services.

"Facility" means the entity which has been issued a license to operate a health care facility pursuant to N.J.S.A. 26:2H-1 et seq. For the purposes of this chapter, "facility" includes ambulance and invalid coach services.

"Immediate and serious threat" means a deficiency or violation that has caused or will imminently cause at any time serious injury, harm, impairment, or even death to residents or patients of the facility and therefore requires immediate corrective action.

"Patient" means an individual under the medical and nursing care and supervision of a licensed health care facility. For purposes of this chapter, "patient" is synonymous with "resident."

"Plan of correction" means a plan developed by the facility and reviewed and approved by the Department which describes the actions the facility will take to correct deficiencies and specifies the time frame in which those deficiencies will be corrected.

"Resident" means an individual residing in a licensed health care facility and under the supervision of that facility for the purpose of receiving medical, nursing, and/or personal care services. For purposes of this chapter, "resident" is synonymous with "patient."

"Survey" means the evaluation of the quality of care and/or the fitness of the premises, staff, and services provided by a facility as conducted by the Department and/or its designees to determine compliance or non-compliance with applicable State licensing regulations, statutes, or Federal Medicare/Medicaid certification regulations or statutes.

SUBCHAPTER 2 SURVEY PROCEDURES

8:43E-2.1 Scope and types of surveys

(a) The Department, or another State agency to which the Department has delegated the authority for conduct of surveys either partially or fully, may conduct periodic or special inspections of licensed health care facilities to evaluate the fitness and adequacy of the premises, equipment, personnel, policies and procedures, and finances, and to ascertain whether the facility complies with all applicable State and Federal licensure regulations and statutes.

(b) The Department or its designee may also conduct periodic surveys of facilities on behalf of the U.S. Department of Health and Human Services or other Federal agency for purposes of evaluating compliance with all applicable Federal regulations or Medicare and Medicaid certification regulations.

(c) The Department may evaluate all aspects of patient care, and operations of a health care facility, including the inspection of medical records; observation of patient care where consented to by the patient; inspection of all areas of the physical plant under the control or ownership of the licensee; and interview of the patient or resident, his or her family or other individuals with knowledge of the patient or care rendered to him or her.

(d) All information pertaining to an individual patient shall be maintained as confidential by the Department and shall not be available to the public in a manner that identifies an individual patient, unless so consented to by the patient or pursuant to an order by a court of law.

(e) The Department may conduct a survey of a facility upon the receipt of complaint or allegation by any person or agency, including a patient, his or her family, or any person with knowledge of the services rendered to patients or operations of a facility.

(f) The Department may evaluate the quality of patient care rendered by a facility through analysis of statistical data reported by facilities to the Department or other agency, or by review of reportable event information or other notices filed with the Department pursuant to regulation. Upon receipt of information indicating a potential risk to patient safety or violations of licensing regulations, the Department may conduct a survey to investigate the causes of this finding, or request a written response from the facility to ascertain the validity of the data and to describe the facility's plan or current actions to address the identified findings.

(g) Following a reasonable opportunity for facilities to review and comment on the validity of the Department's statistical data related to the quality of patient care by facilities, the Department may make such information, as appropriately amended available to the public.

8:43E-2.2 Deficiency findings

(a) A deficiency may be cited by the Department upon any single or multiple determination that the facility does not comply with a licensure regulation. Such findings may be made as the result of either an on-site survey or inspection or as the result of the evaluation of written reports or documentation submitted to the Department, or the omission or failure to act in a manner required by regulation.

(b) At the conclusion of a survey or within 10 business days thereafter, the Department shall provide a facility with a written summary of any factual findings used as a basis to determine that a licensure violation has occurred, and a statement of each licensure regulation to which the finding of a deficiency relates.

8:43E-2.3 Informal dispute resolution

(a) A facility may request an opportunity to discuss the accuracy of survey findings with representatives of the Department in the following circumstances during a survey:

1. During the course of a survey to the extent such discussion does not interfere with the surveyor's ability to obtain full and objective information and to complete required survey tasks; or
2. During the exit interview or other summation of survey findings prior to the conclusion of the survey.

(b) Following completion of the survey, an acute care facility may contact the Inspections, Complaints and Compliance Program and a long term care facility may contact the Long Term Care Assessment Survey Program to request an informal review of deficiencies cited. The request must be made in writing within 10 business days of the receipt of the written survey findings. The written request must include:

1. A specific listing of the deficiencies for which informal review is requested; and
2. Documentation supporting any contention that a survey finding was in error.

(c) The review will be conducted within 10 business days of the request by supervisory staff of the Inspections, Complaints and Compliance Program or the Long Term Care Assessment Survey Program, as applicable, who did not directly participate in the survey. The review can be conducted in person at the offices of the Department or, by mutual agreement, solely by review of the documentation as submitted.

(d) A decision will be issued by the Department within seven business days of the conference or the review, and if the determination is to agree with the facility's contentions, the deficiencies will be removed from the record. If the decision is to disagree with the request to remove deficiencies, a plan of correction is required within five business days of receipt of the decision. The facility retains all other rights to appeal deficiencies and enforcement actions taken pursuant to these rules.

8:43E-2.4 Plan of correction

(a) The Department may require that the facility submit a written plan of correction specifying how each deficiency that has been cited will be corrected along with the time frames for completion of each corrective action. A single plan of correction may address all events associated with a given deficiency.

(b) The plan of correction shall be submitted within 10 business days of the facility's receipt of the notice of violations, unless the Department specifically authorizes an extension for cause. Where deficiencies are the subject of informal dispute resolution pursuant to N.J.A.C. 8:43E-2.3, the extension shall pertain only to the plans of correction for the deficiencies under review.

(c) The Department may require that the facility's representatives appear at an office conference to review findings of serious or repeated licensure deficiencies and to review the causes for such violations and the facility's plan of correction.

(d) The plan of correction shall be reviewed by the Department and will be approved where the plan demonstrates that compliance will be achieved in a manner and time that assures the health and safety of patients or residents. If the plan is not approved, the Department may request that an amended plan of correction be submitted within five business days. In relation to violations of resident or patient rights, the Department may direct specific corrective measures that must be implemented by facilities.

SUBCHAPTER 3. ENFORCEMENT REMEDIES

8:43E-3.1 Enforcement remedies available

(a) Pursuant to N.J.S.A. 26:2H-13, 14, 15, 16 and 38, the Commissioner or his or her designee may impose the following enforcement remedies against a health care facility for violations of licensure regulations or other statutory requirements:

1. Civil monetary penalty;
2. Curtailment of admissions;
3. Appointment of a receiver or temporary manager;
4. Provisional license;
5. Suspension of a license;
6. Revocation of a license;
7. Order to Cease and Desist operation of an unlicensed health care facility; and
8. Other remedies for violations of statutes as provided by State or Federal law, or as authorized by Federal survey, certification, and enforcement regulations and agreements.

8:43E-3.2 Notice of violations and enforcement actions

The Commissioner shall serve notice to a facility of the proposed assessment of civil monetary penalties, suspension or revocation of a license, or placement on a provisional license, setting forth the specific violations, charges or reasons for the action. Such notice shall be served on a licensee or its registered agent in person or by certified mail.

8:43E-3.3 Effective date of enforcement actions

The assessment of civil monetary penalties, or revocation of a license, or the placement of a license on provisional status shall become effective 30 days after the date of mailing or the date personally served on a licensee, unless the licensee shall file with the Department a written answer to the charges and give written notice to the Department of its desire for a hearing in which case the assessment, suspension, revocation or placement on provisional license status shall be held in abeyance until the administrative hearing has been concluded

and a final decision is rendered by the Commissioner. Hearings shall be conducted in accordance with N.J.A.C. 8:43E-4.1.

8:43E-3.4 Civil monetary penalties

(a) Pursuant to N.J.S.A. 26:2H-13 and 14, the Commissioner may assess a penalty for violation of licensure regulations in accordance with the following standards:

1. For operation of a health care facility without a license, or continued operation of a facility after suspension or revocation of a license, \$1,000 per day from the date of initiation of services;

2. For violation of an order for curtailment of admissions, \$250.00 per patient, per day from the date of such admission to the date of discharge or lifting of the curtailment order;

3. For failure to obtain prior approval from the Inspections, compliance and Complaints Program or the Long Term Care Assessment and Survey Program, as applicable, for occupancy of an area or initiation of a service following construction or application for licensure, \$250.00 a day;

4. For construction or renovation of a facility without the Department of Community Affairs' approval of construction plans, \$1,000 per room or area renovated and immediate suspension of use in the room or area from the date of initial use until determined by the Department to be in compliance with licensure standards. This determination shall take into account any waivers granted by the Department.

5. For the transfer of ownership of a health care facility without prior approval of the Department, \$500.00 per day from the date of the transfer of interest to the date of discovery by the Department. Such fine may be assessed against each of the parties at interest;

6. For maintaining or admitting more patients or residents to a facility than the maximum capacity permitted under the license, except in an emergency as documented by the facility in a contemporaneous notice to the Department, \$25.00 per patient per day plus an amount equal to the average daily charge collected from such patient or patients;

7. For violations of licensure regulations related to patient care or physical plant standards that represent a risk to the health, safety, or welfare of patients or residents of a facility or the general public, \$500.00 per violation where such deficiencies are isolated or occasional and do not represent a pattern or widespread practice throughout the facility;

8. Where there are multiple deficiencies related to patient care or physical plant standards throughout a facility, and/or such violations represent a direct risk that a patient's physical or mental health will be compromised, or where an actual violation of a resident's or patient's rights is found, a penalty of \$1,000 per violation may be assessed for each day noncompliance is found;

9. For repeated violations of any licensing regulation within a 12-month period or on successive annual inspections, or failure to implement an approved plan of correction, where such violation was not the subject of a previous penalty assessment, \$500.00 per violation, which may be assessed for each day noncompliance is found. If the initial violation resulted in the assessment of a penalty, within a 12-month period or on successive annual inspections, the second violation shall result in a doubling of the original fine, and the third and successive violations shall result in a tripling of the original fine;

10. For violations resulting in either actual harm to a patient or resident, or in an immediate and serious risk of harm, \$2,500 per violation, which may be assessed for each day noncompliance is found;

11. For failure to report information to the Department as required by statute or licensing regulation, after reasonable notice and an opportunity to cure the violation, \$250.00 per day;

12. For failure to implement a Certificate of Need condition of approval, \$1,000 per day, which shall be assessed either from the date specified in the Certificate of Need for implementation of the specific condition of approval, if identified, or from the date on which the Certificate of Need was considered to be implemented; or

13. For violations of regulations governing the prohibition of mandatory overtime contained in N.J.A.C. 8:43E-8, \$1,000 per violation, which may be assessed for each day noncompliance is found.

(b) Except for violations deemed to be immediate and serious threats, the Department may decrease the penalty assessed in accordance with (a) above, based on the compliance history of the facility; the number, frequency and/or severity of violations by the facility; the measures taken by the facility to mitigate the effects of the current violation, or to prevent future violations; the deterrent effect of the penalty; and/or other specific circumstances of the facility or the violation.

(c) The Department may increase the penalties in (a) above up to the statutory maximum per violation per day in consideration of the economic benefit realized by the facility for noncompliance.

8:43E-3.5 Failure to pay a penalty; remedies

(a) Within 30 days after the mailing date of a Notice of Proposed Assessment of a Penalty, a facility which intends to challenge the enforcement action shall notify the Department of its intent to request a hearing pursuant to the Administrative Procedure Act.

(b) The penalty becomes due and owing upon the 30th day from mailing of the Notice of Proposed Assessment of Penalties, if a notice requesting a hearing has not been received by the Department. If a hearing has been requested, the penalty is due 45 days after the issuance of a Final Agency Decision by the Commissioner, if the Department's assessment has not been withdrawn, rescinded, or reversed, and an appeal has not been timely filed with the New Jersey Superior Court, Appellate Division pursuant to New Jersey Court Rule 2:2-3.

(c) Failure to pay a penalty within 30 days of the date it is due and owing pursuant to (b) above may result in one or more of the following actions:

1. Institution of a summary civil proceeding by the State pursuant to the Penalty Enforcement Law (N.J.S.A. 2A:58-1 et seq.); or
2. Placing the facility on a provisional license status.

8:43E-3.6 Curtailment of admissions

(a) The Department may issue an order curtailing all new admissions and readmissions to a health care facility in the following circumstances:

1. Where violations of licensing regulations are found that have been determined to pose an immediate and serious threat of harm to patients or residents of a health care facility;
2. Where the Department has issued a Notice of Proposed Revocation or Suspension of a health care facility license, for the purpose of limiting the census of a facility if patients or residents must be relocated upon closure;
3. Where the admission or readmission of new patients or residents to a health care facility would impair the facility's ability to correct serious or widespread violations of licensing regulations related to direct patient care and cause a diminution in the quality of care; or

4. For exceeding the licensed or authorized bed or service capacity of a health care facility, except in those instances where exceeding the licensed or authorized capacity was necessitated by emergency conditions and where immediate and satisfactory notice was provided to the Department.

(b) The order for curtailment may be withdrawn upon a survey finding that the facility has achieved substantial compliance with the applicable licensing regulations or Federal certification requirements and that there is no immediate and serious threat to patient safety, or in the case of providers exceeding licensed capacity, has achieved a census equivalent to licensed and approved levels. Such order to lift a curtailment may reasonably limit the number and priority of patients to be admitted by the facility in order to protect patient safety.

8:43E-3.7 Appointment of a receiver

(a) Pursuant to N.J.S.A. 26:2H-42 et seq., the Department may seek an order or judgment in a court of competent jurisdiction, directing the appointment of a receiver for the purpose of remedying a condition or conditions in a residential health care facility, assisted living facility, or long-term care facility, that represent a substantial or habitual violation of the standards of health, safety, or resident care adopted by the Department or pursuant to Federal law or regulation.

(b) The Department shall review and approve the receiver's qualifications prior to submission for court approval. The receiver shall have experience and training in long-term care, assisted living, or residential health care, as appropriate, and, if the facility is a licensed long-term care provider, the receiver shall possess a current New Jersey license as a nursing home administrator and be in good standing. The Department shall maintain a list of interested and approved receivers.

(c) No receiver may be a current owner, licensee, or administrator of the subject facility or a spouse or immediate family member thereof.

8:43E-3.8 Suspension of a license

(a) Pursuant to N.J.S.A. 26:2H-14, the Commissioner may order the summary suspension of a license of a health care facility or a component or distinct part of a facility upon a finding that violations pertaining to the care of patients or to the hazardous or unsafe conditions of the physical structure pose an immediate threat to the health, safety, and welfare of the public or the residents of the facility.

(b) Upon a finding described in (a) above, the Commissioner or the Commissioner's authorized representative shall serve notice in person or by certified mail to the facility or its registered agent of the nature of the findings and violations and the proposed order of suspension. Except in the case of a life-threatening emergency, the notice shall provide the facility with a 72-hour period from receipt to correct the violations and provide proof to the Department of such correction.

(c) If the Department determines the violations have not been corrected, and the facility has not filed notice requesting a hearing to contest the notice of suspension within 48 hours of receipt of the Commissioner's notice pursuant to (e) below, then the license shall be deemed suspended. Upon the effective date of the suspension, the facility shall cease and desist the provision of health care services and effect an orderly transfer of patients.

(d) The Department shall approve and coordinate the process to be followed during an evacuation of the facility or cessation of services pursuant to an order for suspension or revocation.

(e) If the facility requests a hearing within 48 hours of receipt of the Notice of Proposed Suspension of License in accordance with N.J.S.A. 26:2H-14, the Department shall arrange for an immediate hearing to be conducted by the Commissioner and a final agency decision shall be issued within 48 hours by the Commissioner. If the Commissioner shall affirm the proposed suspension of the license, the order shall become final. The licensee may apply for injunctive relief against the Commissioner's order in the New Jersey Superior Court, in accordance with the provisions set forth in N.J.S.A. 26:2H-14.

(f) Notwithstanding the issuance of an order for proposed suspension of a license, the Department may concurrently or subsequently impose other enforcement actions pursuant to these rules.

(g) The Department may rescind the order for suspension upon a finding that the facility has corrected the conditions which were the basis for the action.

8:43E-3.9 Revocation of a license

(a) A Notice of the Proposed Revocation of a health care facility license may be issued in the following circumstances:

1. The facility has failed to comply with licensing requirements, posing an immediate and serious risk of harm or actual harm to the health, safety, and welfare of patients or residents, and the facility has not corrected such violations in accordance with an approved plan of correction or subsequent to imposition of other enforcement remedies issued pursuant to these rules;

2. The facility has exhibited a pattern and practice of violating licensing requirements, posing a serious risk of harm to the health, safety and welfare of residents or patients. A pattern and practice may be demonstrated by the repeated violation of identical or substantially-related licensing regulations during three consecutive surveys, or the issuance of civil monetary penalties pursuant to N.J.A.C. 8:43E-3.4 or other enforcement actions for unrelated violations on three or more consecutive surveys;

3. Failure of a licensee to correct identified violations which had led to the issuance of an order for suspension of a license, pursuant to N.J.A.C. 8:43E-3.6 or 3.8; or

4. Continuance of a facility on provisional licensure status for a period of 12 months or more.

(b) The notice shall be served in accordance with N.J.A.C. 8:43E-3.2, and the facility has a right to request a hearing pursuant to N.J.A.C. 8:43E-4.1.

8:43E-3.10 Provisional license

(a) The Department may place a health care facility on provisional license status in the following circumstances:

1. Upon issuance of a Notice for Revocation or Suspension of a License, pursuant to N.J.A.C. 8:43E-3.8 or 3.9, for a period extending through final adjudication of the action;

2. Upon issuance of an order for curtailment of admissions pursuant to N.J.A.C. 8:43E-3.6, for a minimum period of three months and for a maximum period extending through 90 days following the date the Department finds the facility has achieved substantial compliance with all applicable licensing regulations;

3. For failure to satisfy a civil penalty due and owing pursuant to N.J.A.C. 8:43E-3.4; or

4. Upon a recommendation to the Federal government or the New Jersey Division of Medical Assistance and Health Services for termination of a provider agreement for failure to meet the Federal certification regulations.

(b) A facility placed on provisional license status shall be placed on notice of same, in accordance with the notice requirements set forth in N.J.A.C. 8:43E-3.2. Provisional license status is effective upon receipt of the notice, although the facility may request a hearing to contest provisional license status in accordance with the requirements set forth in N.J.A.C. 8:43E-4.1. Where a facility chooses to contest provisional license status by requesting a hearing in accordance with the

provisions set forth herein and in N.J.A.C. 8:43E-4.1, provisional license status remains effective at least until the final decision or adjudication (as applicable) of the matter, or beyond in instances where the Department's action is upheld, in accordance with these rules. In addition, provisional license status remains effective in cases where the underlying violations which caused the issuance of provisional licensure status are the subject of appeal and/or litigation, as applicable, in accordance with these rules.

(c) While a facility is on provisional license status, the following shall occur:

1. Withholding of authorization or review of any application filed with the Department for approval of additional beds or services;

2. Notification of the action to the Certificate of Need Program, for consideration during any pending application. It may result in withholding of Certificate of Need approval or denial of the Certificate of Need, in accordance with Certificate of Need rules at N.J.A.C. 8:33, or applicable licensing regulations; and

3. Notification of facility placement on provisional license status to any public agency that provides funding or third party reimbursement to the facility or that has statutory responsibility for monitoring the quality of care rendered to patients or residents.

(d) A facility placed on provisional license status shall post the provisional license in a location within the facility which is conspicuous.

8:43E-3.11 Cease and desist order

(a) Pursuant to N.J.S.A. 26:2H-14 and 15, the Commissioner or his or her designee may issue an order requiring the operation of an unlicensed or unauthorized care facility or service to cease and desist.

(b) The Commissioner may also impose other enforcement actions pursuant to these rules for operation of an unlicensed health care facility.

(c) The Department may maintain an action in the New Jersey Superior Court to enjoin any entity from operation of a health care facility without a license or after the suspension or revocation of a license pursuant to these rules.

SUBCHAPTER 4. HEARINGS

8:43E-4.1 Hearings

(a) Notice of a proposed enforcement action shall be afforded to a facility pursuant to N.J.A.C. 8:43E-3.2.

(b) A facility shall notify the Department of its intent to request a hearing in a manner specified in the Notice within 30 days of its receipt.

(c) The Department shall transmit the hearing request to the Office of Administrative Law.

(d) Hearings shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1.1.

8:43E-4.2 Settlement of enforcement actions

(a) The facility may request that the matter be settled in lieu of conducting an administrative hearing concerning an enforcement action.

(b) If the Department and the facility agree on the terms of a settlement, a written agreement specifying these terms shall be executed.

(c) Pursuant to N.J.S.A. 26:2H-16, civil penalties may be settled by the Department in cash or in-kind services to patients where circumstances warrant such agreement and the settlement does not compromise the health, safety, or welfare of patients. In no case shall such settlement reduce a penalty below \$250.00, or \$500.00 for second and subsequent offenses.

(d) The Department may agree to accept payment of penalties over a schedule not exceeding 18 months where a facility demonstrates financial hardship.

(e) All funds received in payment of penalties shall be deposited in the Health Care Facilities Improvement Fund. Such fund shall be designated for use by the Commissioner to make corrections in a health care facility which is in violation of a licensure standard and in which the owner or operator is unable or unwilling to make the necessary corrections. The owner of the facility shall repay the fund any monies plus interest at the prevailing rate that were expended by the State to correct the violation at the facility. If the owner fails to promptly reimburse the fund, the Commissioner shall have a lien in the name of the State against the facility for the cost of the corrections plus interest and for any administrative cost incurred in filing the lien.

(f) If a facility fails to meet the conditions of the settlement, the Department may immediately impose the original enforcement action without any further right to an administrative hearing.

SUBCHAPTER 5. LICENSURE PROCEDURES

8:43E-5.1 Track record evaluation

(a) In the case of an application for licensure of a long-term care facility, subacute care unit in an acute care general hospital, assisted living residence, comprehensive personal care home, assisted living program, alternate family care sponsor agency, or residential health care facility, for which a certificate of need is required, the applicant's track record shall be evaluated as part of the certificate of need application process, in accordance with N.J.A.C. 8:33-4.10.

(b) In the case of an application for which a certificate of need is not required, including an application for transfer of ownership of a long-term care facility, subacute care unit in an acute care general hospital, assisted living residence, comprehensive personal care home, assisted living program, alternate family care sponsor agency, adult day health care facility, or residential health care facility, an application to establish or expand an adult day health care facility or to expand a residential health care facility, and an application for any long-term care beds or services offered as part of a continuing care retirement community, the track record rules regarding certificate of need applications at N.J.A.C. 8:33-4.10 shall be applied. These rules include, but are not limited to, those addressing criteria for denial of applications, the scope of the track record review, the use of categories of health care service similarity or relatedness, the meaning of the term "applicant," and the duration of the waiting period following application denial.

(c) In the case of an application to add one or more beds in accordance with N.J.A.C. 8:39-2.12, for which a certificate of need is not required, the track record rules regarding certificate of need applications at N.J.A.C. 8:33-4.10 shall be applied only to the facility which is requesting the additional beds.

8:43E-5.2 Facility surveys

(a) When the written application for licensure is approved and the building is ready for occupancy, a survey of the facility by representatives of the Department's Inspections, Complaints and Compliance Program or the Long Term Care Assessment and Survey Program, as applicable, shall be conducted to determine if the facility complies with the rules in this chapter.

1. The facility shall be notified in writing of the findings of the survey, including any deficiencies found.

2. The facility shall notify the Department's Inspections, Complaints and Compliance Program or Long Term Care Assessment and Survey Program, as applicable, when the deficiencies, if any, have been corrected, and the program so notified will schedule one or more resurveys of the facility prior to occupancy.

(b) No facility shall admit patients to the facility until the facility has the written approval and/or license issued by the Certificate of Need and Acute Care Licensure Program or the Long Term Care Licensure Program of the Department.

(c) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and patient records and conferences with patients.

8:43E-5.3 Facility licensure

(a) A license shall be issued only where the survey conducted pursuant to N.J.A.C. 8:43E-5.2 demonstrates that the facility meets the requirements as set forth in N.J.S.A. 26:2H-1 et seq. and the applicable rules duly promulgated pursuant thereto.

(b) A license shall be granted for a period of one year or less, as determined by the Department.

(c) The license shall be conspicuously posted in the facility.

(d) The license is not assignable or transferable, and it shall be immediately void if the facility ceases to operate, if the facility's ownership changes, or if the facility is relocated to a different state.

(e) The license, unless suspended or revoked in accordance with these rules, shall be renewed annually on the anniversary date of the issuance of the original license, or within 30 days thereafter. In cases where the license issues after, but within 30 days of, the anniversary date, it shall be deemed to have issued on the anniversary date and dated accordingly. The facility shall receive from the Department a request for licensure renewal fee 30 days prior to the expiration of the license. A renewed license shall not issue unless and until the licensure renewal fee is received by the Department.

(f) The license may not be renewed if local rules, regulations and/or other applicable requirements are not met, or if the Department determines that the facility is in violation of applicable licensure standards.

8:43E-5.4 Conditional license

A conditional license may be issued to a health care facility providing a type or category of health care service neither listed nor otherwise addressed in the applicable licensure chapter for that type of facility.

8:43E-5.5 Surrender of license

The facility shall notify each patient/resident, each patient/resident's physician, and any guarantors of payment at least 30 days prior to the surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of a license. In such cases, the license shall be returned to the Certificate of Need and Acute Care Licensure Program or the Long Term Care Licensure Program, as applicable, within seven working days after the surrender, revocation, non-renewal, or suspension of the license.

8:43E-5.6 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of N.J.S.A. 26:2H-1 et seq., and the licensure rules applicable to the type of facility in question, waive sections of applicable licensure rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

(b) A facility seeking waiver pursuant to this rule shall apply in writing to the Director of the Certificate of Need and Acute Care Licensure Program or the Long Term Care Licensure Program, as applicable.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is sought;
2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility if the waiver does not issue;
3. An alternative proposal, ensuring patient safety and compliance with the general intent and purpose of the applicable licensure rules; and
4. Documentation to support the request for waiver.

(d) In cases where the Department requests additional information before or during the course of processing a waiver request, the facility shall comply with the request for additional information or the waiver shall be denied.

SUBCHAPTER 6. PAIN MANAGEMENT PROCEDURES

8:43E-6.1 Pain management standards; scope

The standards set forth in this subchapter apply to all health care facilities licensed in accordance with N.J.S.A. 26:2H-1 et seq.

8:43E-6.2 Purpose

The rules in this subchapter are intended to promote the health, safety, and welfare of patients or residents of health care facilities by establishing requirements for the assessment, monitoring and management of pain.

8:43E-6.3 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Pain" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

"Pain management" means the assessment of pain and, if appropriate, treatment in order to assure the needs of patients or residents of health care facilities who experience problems with pain are met. Treatment of pain may include the use of medications or application of other modalities and medical devices such as, but not limited to, heat or cold, massage, transcutaneous electrical nerve stimulation (TENS), acupuncture, and neurolytic techniques such as radiofrequency coagulation and cryotherapy.

"Pain rating scale" means a tool that is age cognitive and culturally specific to the patient or resident population to which it is applied and which results in an assessment and measurement of the intensity of pain.

"Pain treatment plan" means a plan, based on information gathered during a patient/resident pain assessment, that identifies the patient's/resident's needs and specifies appropriate interventions to alleviate pain, to the extent feasible and medically appropriate.

8:43E-6.4 Pain assessment procedures

(a) A facility shall formulate a system for assessing and monitoring patients'/residents' pain using a pain rating scale.

1. A facility serving different patient/resident populations shall utilize more than one pain scale, as appropriate.

(b) Assessment of a patient's/resident's pain shall occur, at a minimum, upon admission, on the day of a planned discharge, and when warranted by changes in a patient's/resident's condition, self-reporting of pain and/or evidence of behavioral cues indicative of the presence of pain. In the case of individuals receiving home health care services, assessment shall coincide with a visit by staff of the home health service agency and assessment on the day of discharge is not required if the individual has been admitted to an inpatient or residential health care facility and discharge from the home health service agency takes place after the admission.

(c) If pain is identified, a pain treatment plan shall be developed and implemented within the health care facility or the patient/resident shall be referred for treatment or consultation.

(d) If the patient/resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal patient/resident. Additionally, the facility shall seek information from the patient's/resident's family, caregiver or other representative, if available and known to the facility. The results of the pain rating scales and the response to the additional inquiry shall be documented in the patient's/resident's medical record.

(e) Pain assessment findings shall be documented in the patient's/resident's medical record. This shall include, but not be limited to, the date, pain rating, treatment plan and patient/resident response.

(f) The facility shall establish written policies and procedures governing the management of pain that are reviewed at least every three years and revised more frequently as needed. They shall include at least the following:

1. A written procedure for systematically conducting periodic assessment of a patient's/resident's pain, as specified in (b) above. At a minimum, the procedure must specify pain assessment upon admission, upon discharge, and when warranted by changes in a patient's/resident's condition and self-reporting of pain;

2. Criteria for the assessment of pain, including, but not limited to: pain intensity or severity, pain character, pain frequency or pattern, or both; pain location, pain duration, precipitating factors, responses to treatment and the personal, cultural, spiritual, and/or ethnic beliefs that may impact an individual's perception of pain;

3. A written procedure for the monitoring of a patient's/resident's pain;

4. A written procedure to insure the consistency of pain rating scales across departments within the health care facility;

5. Requirements for documentation of a patient's/resident's pain status on the medical record;

6. A procedure for educating patients/residents and, if applicable, their families about pain management when identified as part of their treatment; and

7. A written procedure for systematically coordinating and updating the pain treatment plan of a patient/resident in response to documented pain status.

8:43E-6.5 Staff education and training programs

(a) Each facility shall develop, revise as necessary and implement a written plan for the purpose of training and educating staff on pain management. The plan shall include mandatory educational programs that address at least the following:

1. Orientation of new staff to the facility's policies and procedures on pain assessment and management;

2. Training of staff in pain assessment tools; behaviors potentially indicating pain; personal, cultural, spiritual and/or ethnic beliefs that may impact a patient's/resident's perception of pain; new equipment and new technologies to assess and monitor a patient's/resident's pain status;

3. Incorporation of pain assessment, monitoring and management into the initial orientation and ongoing education of all appropriate staff; and

4. Patient/resident rights.

(b) Implementation of the plan shall include records of attendance for each program.

8:43E-6.6 Pain management continuous quality improvement

The facility's continuous quality improvement program shall include a systematic review and evaluation of pain assessment, management and documentation practices. The facility shall develop a plan by which to collect and analyze data in order to evaluate outcomes or performance. Data analysis shall focus on recommendations for implementing corrective actions and improving performance.

**SUBCHAPTER 7.
REQUIREMENT TO USE NEEDLES AND SHARP INSTRUMENTS
CONTAINING INTEGRATED SAFETY FEATURES OR NEEDLELESS
DEVICES**

8:43E-7.1 Use of needles and sharp instruments containing integrated safety features

(a) All facilities shall purchase, for use by health care workers only, available sharp devices containing integrated safety features or available needleless devices designed to prevent needle stick injuries, in accordance with N.J.S.A. 26:2H-5.10 through 5.16, as well as this subchapter.

(b) In cases where there is no available sharp device containing integrated safety features or needleless device, for a specific patient use, facilities shall utilize the appropriate sharp device that is available for that specific patient use, including any sharp device which employs non-integrated, add-on safety features, until such time as an appropriate sharp device containing integrated safety features becomes available.

(c) The provisions of this section shall apply to both empty and pre-filled syringes upon the effective date of these rules.

8:43E-7.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Available" means cleared or approved for marketing by the Federal Food and Drug Administration and commercially offered for distribution.

"Department" means the New Jersey Department of Health and Senior Services.

"Emergency" means an unforeseen circumstance involving a patient in need of immediate medical attention in order to save the patient's life and/or limb or prevent serious and/or permanent injury.

"Evaluation committee" means a group of individuals appointed within each facility or health care system which satisfies the requirements of N.J.S.A. 26:2H-5.13 and N.J.A.C. 8:43E-7.3.

"Facility" means a health care facility licensed by the Department, pursuant to the provisions set forth in the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., as amended.

"Health care system" means a licensed health care provider/entity that either owns and operates more than one licensed facility within the State of New Jersey or can document operational control over more than one licensed facility within the State of New Jersey, but which is not a management company.

"Health care worker" or "health care professional" means a physician, physician assistant, advanced practice nurse, registered nurse, licensed practical nurse, or any other individual employed by the facility or having privileges at the facility whose job duties require the use of sharp devices, as that term is defined herein.

"Integrated safety features" means needles and all other sharp instruments with engineered injury prevention protections in the form of a built-in safety feature or mechanism designed to protect the user of the sharp device from needle stick injuries.

"Needleless device" means a device that does not use needles for the following procedures:

1. The collection or withdrawal of bodily fluids after initial venous or arterial access is established;
2. Administration of medication or other fluids; or
3. Any other procedure involving potential for exposure to blood or other potentially exposed infectious material.

"Needle stick injury" means the actual or potential parenteral introduction, into the body of a health care worker, of blood or other potentially exposed infectious material, by any type of sharp device, as that term is defined in this section.

"Sharp device(s)" means needles and all other sharp instruments used by health care workers to administer patient care, the use of which creates the potential for exposure to blood or other potentially exposed infectious material, regardless of whether the specific patient being treated has been diagnosed with a bloodborne disease or infection.

8:43E-7.3 Requirement and responsibilities of evaluation committees

(a) Every licensed health care facility or health care system shall appoint an evaluation committee which shall be responsible for evaluating and selecting sharp devices with integrated safety features or needleless devices for use by health care workers at the facility or facilities.

(b) At least one half of all members of the evaluation committee shall be direct-care health care workers employed by the facility or health care system, whose job duties include the use of sharp devices to treat patients of the facility and resulting potential exposure to blood and other potentially exposed infectious material through accidental needle stick injuries. In the case of a health care system, not only shall at least one half of the evaluation committee be comprised of direct-care health care workers, but the evaluation committee shall also include at least one direct-care health care worker from every facility within the health care system.

(c) In determining which needles and other sharp devices or needleless devices to purchase in compliance with these rules, every evaluation committee shall establish and follow guidelines for determining which devices are to be purchased for use by facility staff. An example of such guidelines may be found in the June 1999 edition of the "California Guide to Preventing Sharps Injuries." That manual is available by contacting the California Healthcare Association by telephone at (800) 494-2001 or (916) 928-5123, via the internet at www.calhealth.org or in writing at the following address:

California Healthcare Association
Publication Sales Center
1101 North Market Boulevard, #9
Sacramento, CA 95834

Guidelines may also be found at www.tdict.org.

(d) All facilities shall develop and maintain policies and procedures for the continual review and evaluation of sharp devices or needleless devices as they are newly introduced and become available. Review of newly marketed devices shall occur at a minimum frequency of once annually. The policies and procedures shall include a requirement that all health care workers receive appropriate training in the use of all safety devices, whether sharp or needleless, purchased for use during the course of their duties. Training shall be provided to the extent necessary to ensure the proper and appropriate use of all devices with integrated safety features or needleless devices used within the facility. The policies and procedures shall be reviewed and reevaluated every three years.

8:43E-7.4 Waiver from the requirement to utilize available sharp devices with integrated safety features or needleless devices

(a) All facilities shall develop policies and procedures setting forth a mechanism for health care professionals to request non-emergency waivers from the requirements set forth in N.J.A.C. 8:43E-7.1. All waiver requests shall be submitted to the evaluation committee on forms prescribed by the Department.

(b) Non-emergency waiver requests shall be presented to the evaluation committee for approval and shall be considered only for a specific device to be used for a specific medical procedure that shall be performed on a specific class of patients. In cases where the evaluation committee determines that the use of a sharp device with integrated safety features may potentially have a negative impact on patient safety or the success of a specific medical procedure, the waiver request shall be granted by the evaluation committee.

(c) In the case of an emergency, a health care professional may utilize sharp devices which do not contain integrated safety features without a waiver, provided:

1. The professional determines that use of a sharp device with integrated safety features potentially may have a negative impact on patient safety or the success of a specific medical procedure; and

2. The professional making the determination required in (c)1 above, notifies the evaluation committee, in writing, on a form prescribed by the Department, within five days of the date the sharp device was used, of the reasons why it was necessary to use a sharp device without integrated safety features.

8:43E-7.5 Recording requirements

All facilities shall maintain a record of needle stick injuries, either in a Sharps Injury Log or an OSHA 300 Log. All entries made pursuant to this subchapter shall include a description of the injury and the type and brand name of the sharp device involved in the injury.

SUBCHAPTER 8. MANDATORY OVERTIME

8:43E-8.1 Mandatory overtime; scope and general purpose

The procedures set forth in this subchapter apply to all health care facilities licensed in accordance with N.J.S.A. 26:2H-1 et seq., including a State or county psychiatric hospital, a State developmental center, or a health care service firm registered by the Division of Consumer Affairs in the Department of Law and Public Safety pursuant to N.J.S.A. 56:8-1.1 et seq. The rules set forth the standards and procedures governing the use by health care facilities of required overtime by hourly wage employees involved in direct patient care activities or clinical services in health care facilities.

8:43E-8.2 Applicability

(a) The rules in this subchapter do not apply to the following:

1. Physicians;
2. Volunteers;
3. Employees who volunteer to work overtime;
4. Employees of assisted living facilities that are licensed in accordance with N.J.A.C. 8:36 and who receive room and board as a benefit of employment and reside at the facility on a full-time basis;
5. Employees who assume on-call duty;
6. Employees participating in a surgical or therapeutic interventional procedure that is in progress, when it would be detrimental to the patient if the employee left. However, in the case of elective procedures, the rules do apply if the procedure was scheduled such that the length of time ordinarily required to complete the procedure would exceed the end of the employee's scheduled shift; and
7. Employees not involved in direct patient care activities or clinical services.

8:43E-8.3 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Chronic short staffing" means a situation characterized by long standing vacancies in that portion of the facility's master staffing plan applicable to the work unit of an employee who files a complaint where such vacancies are the result of open positions that continually remain unfilled over a period of 90 days or more despite active recruitment efforts.

"Commissioner" means the Commissioner of Health and Senior Services.

"Department" means the New Jersey Department of Health and Senior Services.

"Direct patient care activities" or "clinical services" means activities/services in which an employee provides direct service to patient/residents in a clinical setting, including the emergency department, inpatient bedside, operating room, other clinical specialty treatment area, or, in the case of a patient served by a home health care agency or health service firm, the individual's home.

"Employee" means an individual employed by a health care facility who is involved in direct patient care activities or clinical services and receives an hourly wage, but shall not include a physician.

"Employer" means an individual, partnership, association, corporation or person or group of persons acting directly or indirectly in the interest of a health care facility.

"Health care facility" means a health care facility licensed by the Department of Health and Senior Services pursuant to P.L. 1971, c.136 (N.J.S.A. 26:2H-1 et seq.), a State or county psychiatric hospital, a State developmental center, or a health care service firm registered by the Division of Consumer Affairs in the Department of Law and Public Safety pursuant to P.L. 1960, c.39 (N.J.S.A. 56:8-1 et seq.).

"Licenses" means the action taken by a State agency to license, certify, or register a health care facility subject to the jurisdiction of that State agency.

"On-call time" means time spent by an employee who is not currently working on the premises of the place of employment, but who is compensated for availability, or as a condition of employment has agreed to be available, to return to the premises of the place of employment on short notice if the need arises.

"Reasonable efforts" means that the employer shall:

1. Seek persons who volunteer to work extra time from all available qualified staff who are working at the time of the unforeseeable emergent circumstance;
2. Contact all qualified employees who have made themselves available to work extra time;
3. Seek the use of qualified per diem staff; and
4. Seek qualified personnel from a contracted temporary agency when such staff is permitted by law, regulation or applicable collective bargaining agreements.

"Unforeseeable emergent circumstance" means an unpredictable or unavoidable occurrence at unscheduled intervals relating to health care delivery that requires immediate action.

8:43E-8.4 Purpose

The rules in this subchapter are intended to promote the health, safety, and welfare of patients, residents and clients of health care facilities as well as of certain hourly wage employees of those facilities through establishing rules implementing the statutory limitations on health care facilities' authority to require certain hourly wage employees, involved in direct patient care activities or clinical services, to work overtime.

8:43E-8.5 Overtime procedures

(a) Except as provided for in (b) below, an employer shall not require an employee involved in direct patient care activities or clinical services to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, not to exceed 40 hours per week. The acceptance by any employee of work in excess of this shall be strictly voluntary. The refusal of an employee to accept such overtime work shall not be grounds for discrimination, dismissal, discharge, or any other penalty or employment decision adverse to the employee.

(b) The requirements of (a) above shall not apply in the case of an unforeseeable emergent circumstance when:

1. The overtime is required only as a last resort, and is not used to fill vacancies resulting from chronic short staffing; and

2. The employer has exhausted reasonable efforts to obtain staffing. However, exhaustion of reasonable efforts shall not be required in the event of any declared national, State or municipal emergency or a disaster or other catastrophic event which substantially affects or increases the need for health care services or causes the facility to activate its emergency or disaster plan.

(c) In the event that an employer requires an employee to work overtime pursuant to (b) above, the employer shall provide the employee with necessary time, up to a maximum of one hour, which may be taken on or off the facility's premises, to arrange for the care of the employee's minor children, or elderly or disabled family members.

(d) On-call time shall not be construed to permit an employer to use on-call time as a substitute for mandatory overtime.

8:43E-8.6 Records; dissemination of information

(a) An employer shall establish a system for keeping records of circumstances where employees are required to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, or in excess of 40 hours per week. The records shall include, but not be limited to:

1. The employee's name and job title;
2. The name of the employee's work area or unit;
3. The date the overtime was worked, including start time;
4. The number of hours of overtime mandated;
5. The employee's daily work schedule for any week in which the employee is required to work excess time;
6. The reason why the overtime was necessary;
7. A description of the reasonable efforts that were exhausted prior to requiring overtime. This shall include:
 - i. The names of employees contacted to work voluntary overtime;
 - ii. A description of efforts to secure per diem staff; and
 - iii. A list of the temporary agencies contacted; and
8. The signature of individual authorizing the required mandatory overtime.

(b) An employer shall provide the employee with a copy of the documentation in accordance with the requirements set forth in (a) above upon requiring that the employee work overtime, except that the total number, rather than the names, of employees contacted in accordance with (a)7i above shall be provided.

(c) Records as set forth in (a) above shall be kept a period of two years.

(d) A facility shall post in a conspicuous place a notice prepared by the New Jersey Department of Labor concerning New Jersey Mandatory Overtime Restrictions for Health Care Facilities (N.J.S.A. 34:11-56a et seq.)

8:43E-8.7 Enforcement and administrative penalties

(a) If the Commissioner of Labor determines that a facility has violated provisions of this subchapter, the Commissioner of Labor may issue sanctions in accordance with the wage and hour regulations contained at N.J.A.C. 12:56.

(b) In cases where the State agency that licenses the facility and/or Department of Labor requests additional information from a facility concerning mandatory overtime usage, the facility shall comply with this request within 10 working days. The State agency that requested the information from the facility may, at its discretion, grant an extension to this time frame if the facility can demonstrate good cause. Failure to provide these records shall result in the issuance of administrative penalties in accordance with N.J.A.C. 12:56-1.2 and 8:43E-3.4(a)13.

(c) If the State agency that licenses a facility subject to this chapter determines through a survey or complaint investigation that the facility exhibits a pattern or practice of noncompliance with N.J.A.C. 8:43E-8.5, that State agency shall notify the Department of Labor of the violation. The Department of Labor may also share with State agencies that license facilities subject to this chapter any information it develops on Statewide and facility-specific trends, such as number of mandatory overtime complaints filed; the number of complaints found to be valid; the number of enforcement actions appealed; and the number of enforcement actions upheld.

(d) In the event a facility licensed by the Department fails to develop and implement the required recordkeeping in accordance with N.J.A.C. 8:43E-8.6 and the required policies and procedures in accordance with this section, the Department shall take enforcement action in accordance with the provisions of N.J.A.C. 8:43E-3.4(a)13.

(e) Nothing in this subchapter shall be construed to relieve a facility of its obligation to comply with State licensure standards pertaining to minimum employee staffing levels.

8:43E-8.8 Policies and procedures

(a) A facility shall develop, revise as necessary and implement policies and procedures for the purpose of training and educating staff on mandatory overtime. The policies and procedures shall include mandatory educational programs that address at least the following:

1. The conditions under which an employer can require mandatory overtime;
2. Overtime procedures;
3. Employee rights; and
4. Complaint procedures.

(b) A facility shall establish a staffing plan designed to facilitate compliance with the requirements of this subchapter.

1. The staffing plan shall include procedures to provide for replacement staff in the event of sickness, vacations, vacancies and other employee absences.

(c) Upon request, the staffing plan and all related policies and procedures shall be made available to the Department of Labor and/or the State agency that licenses the facility.

8:43E-8.9 Discharge or discrimination against an employee making a complaint

An employer shall not discharge or in any other manner discriminate against an employee because such employee has made any complaint to his or her employer, including the employer's representative; to the Commissioner of Labor; or to the State agency that licenses the facility where the employee works that the employee has been required to work overtime in contravention to the provisions of this chapter.

8:43E-8.10 Complaint system

(a) An employee covered by this subchapter shall have a right to file a complaint up to two years following the date of the assigned mandatory overtime if he or she believes the overtime was not in response to an unforeseen emergent circumstance, and/or required reasonable efforts were not exhausted, and/or he or she was not provided the allowed time to make arrangements for the care of family members. All such complaints shall be submitted to:

Labor Standards and Safety Enforcement Directorate
Division of Wage and Hour Compliance of the
Department of Labor
PO Box 389
Trenton, New Jersey 08625-0389

1. If requested, records of such reports shall be made available upon request to the Department or to the Department of Law and Public Safety or to the Department of Human Services.

8:43E-8.11 Protection of the right to collective bargaining

Nothing in this subchapter shall be construed to impair or negate any employer-employee collective bargaining agreement or any other employer/employee contract in effect as of January 1, 2003 for licensed general hospitals and July 1, 2003 for all other facilities subject to these rules as set forth at N.J.A.C. 8:43E-8.1.

8:43E-8.12 Data

A facility shall submit data related to the effects of prohibiting mandatory overtime in accordance with this chapter as well as data required to determine whether chronic staffing shortages exist, as the State agency which licenses the facility shall request from time to time directly from each facility.