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.

Administrative correction.
See: 33 N.J.R. 4101(b).

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.

(e) The facility shall promptly notify a family member, guardian or other designated person about a resident's death.

1. Notification shall be made at the time of the pronouncement of the resident's death, and the time between the pronouncement of the resident's death and notification shall not exceed one hour unless the family member, guardian or other designated person to be contacted provided other instructions as to when the required notification is to occur.

2. The facility shall enter any alternate instructions in the resident's record alongside the contact information.

3. The facility shall maintain confirmation and written documentation of that notification.

4. The facility shall adopt and maintain in its manual of policies and procedures a delineation of the responsibilities of the facility's staff in making such prompt notification regarding the death of a resident as required by this paragraph.

Amended by R.2006 d.331, effective September 18, 2006.
See: 37 N.J.R. 4150(a), 38 N.J.R. 3896(a).
Added (e).

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.

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.

New Rule by R.2005 d.400, effective November 21, 2005.
See: 37 N.J.R. 1932(a), 37 N.J.R. 4437(a).

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)) 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 State 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); and

(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 percent 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 gastrostormy.