"Facility" means a facility or distinct part of a facility licensed by the New Jersey State Department of Health to provide health care under medical supervision and continuous nursing supervision for 24 or more consecutive hours to two or more residents who are not related to the members of the governing authority by marriage, blood, or adoption; who do not require the degree of care and treatment which a hospital provides; and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board.

"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 the administration of the wrong medication or dose of medication, drug, diagnostic agent, chemical or treatment requiring use of such agents to the wrong resident, or at the wrong time, or the failure to administer such agents at the specified time, or in the manner prescribed or normally considered as accepted practice. Errors may be classified as "commissions," that is, medications incorrectly administered to the resident, such as unordered medication or medication in the wrong strength; and "omissions," that is, medications not administered at prescribed times.

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

"Physician" means a person licensed to practice medicine by the New Jersey State Board of Medical Examiners.

"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 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), verifying it with the directions on the label, and 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.

Amended by R.1998 d.304, effective June 15, 1998.
See: 30 N.J.R. 329(a), 30 N.J.R. 2302(a).
Deleted "Federal Level A deficiency".

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:

Certificate of Need and Acute Care Licensure Program
New Jersey State Department of Health and Senior Services
PO Box 360
Trenton, NJ 08625–0360

(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.

Amended by R.1998 d.304, effective June 15, 1998.
See: 30 N.J.R. 329(a), 30 N.J.R. 2302(a).
In (b), changed names and address.

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 forms prescribed by the Department 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:

Long Term Care Licensing Program
Division of Long Term Care Systems Development and Quality
New Jersey State Department of Health and Senior Services
PO Box 367
Trenton, NJ 08625–0367

(b) The Department shall charge a nonrefundable fee of $1,000 plus $4.00 per bed for the filing of an application for licensure and each annual renewal of a long-term care facility. These fees shall not exceed the maximum caps as set forth at N.J.S.A. 26:2H–12, as may be amended from time to time.

(c) The Department shall charge a nonrefundable fee of $500.00 for the filing of an application to add bed or non-bed related services to an existing long-term care facility, except for those services provided for at N.J.A.C. 8:39–2.10 and 2.12.

(d) The Department shall charge a nonrefundable fee of $250.00 for the filing of an application to reduce services at an existing long-term care facility.

(e) The Department shall charge a nonrefundable fee of $250.00 for the filing of an application for the relocation of a long-term care facility.

(f) The Department shall charge a nonrefundable fee of $1,000 for the filing of an application for the transfer of ownership of a long-term care facility.

(g) 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 Program.

(h) The Department shall examine and evaluate the licensing track record of each applicant.

1. In the case of an application for which a certificate of need is required, the 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.

2. 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 and an application to add one or more beds in accordance with N.J.A.C. 8:39–2.12, the track record provisions regarding certificate of need applications at N.J.A.C. 8:33–4.10 shall be applied. These provisions 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.

i. In the case of an application to add one or more beds in accordance with N.J.A.C. 8:39–2.12, the track record provisions 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.

(i) Any applicant denied a license to operate a facility shall have the right to a fair hearing in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

Amended by R.1995 d.127, effective March 6, 1995.
See: 26 N.J.R. 1772(c), 27 N.J.R. 937(b).
Amended by R.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).
Amended by R.1998 d.304, effective June 15, 1998.
See: 30 N.J.R. 329(a), 30 N.J.R. 2302(a).
In (a), changed names and address; in (g), substituted a reference to the Long Term Care Licensing Program for a reference to the Licensing, Certification and Standards Program at the end; rewrote (h); deleted former (i) through (k); and recodified former (*l*) as (i).

8:39–2.3 Newly constructed or expanded facilities

(a) The application for a license pursuant to N.J.A.C. 8:39–2.2 for the operation of a new facility shall include written approval of final construction of the physical plant by:

Health Care Plan Review
Division of Codes and Standards
New Jersey State Department of Community Affairs
PO Box 815
Trenton, NJ 08625–0815

(b) A final on-site inspection of the construction of the physical plant shall be made by representatives of Health Care Plan Review, Division of Codes and Standards, Department of Community Affairs and the Department of Health and Senior Services to verify that the building has been constructed in accordance with the architectural plans approved in accordance with N.J.A.C. 8:39.

(c) Any health care facility with a construction program, whether a Certificate of Need is required or not, shall submit plans to Health Care Plan Review of the Department of Community Affairs for review and approval prior to the initiation of any work.

Amended by R.1998 d.304, effective June 15, 1998.
See: 30 N.J.R. 329(a), 30 N.J.R. 2302(a).
In (a), changed names and address; rewrote (b); and in (c), substituted a reference to Health Care Plan Review of the Department of Community Affairs for a reference to the Health Facilities Construction Service of the Department.

8:39–2.4 Surveys and temporary license

(a) When the written application for licensure pursuant to N.J.A.C. 8:39–2.2 is approved and the building is ready for occupancy, a survey of the facility by representatives of the Health Facilities Inspection Program of the Department shall be conducted to determine if the facility meets the standards set forth in this chapter.

1. The Health Facilities Inspection Program of the Department shall notify the facility in writing of the findings of the survey, including any deficiencies found.

2. The facility shall notify the Health Facilities Inspection Program of the Department when the deficiencies, if any, have been corrected, and the Health Facilities Inspection Program will schedule one or more resurveys of the facility prior to occupancy.

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

1. An office conference for review of the conditions for licensure and operation has taken place between the Licensing, Certification and Standards Program and representatives of the facility, who have been advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance 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, and the rules pursuant thereto;

2. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities;

3. 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

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

(c) No health care facility shall accept residents until the facility has written approval and/or a license issued by the Licensing, Certification and Standards Program of the Department.

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

(e) 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.

(f) Upon compliance with N.J.A.C. 8:39–2.2(e), a temporary license shall be issued to the operator of a facility for a period of six months and shall be renewed as determined by the Department, based upon the achievement of a substantial degree of compliance with this chapter.

1. The temporary license shall be conspicuously posted in the facility.

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

Public Notice: Waiver of Temporary Licensing of Facilities.
See: 29 N.J.R. 5107(b).

8:39–2.5 Full license

(a) A full license shall be issued to the operator on expiration of the temporary license, if the surveys by the Department have determined that the health care facility is operated as required by 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 by the rules pursuant thereto.

(b) A license shall be granted for a period of one year or less as determined by the Department in accordance with (a) above.

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

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

(e) The license, unless sooner suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the licensure date, 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) 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department; and

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

8:39–2.6 Surrender of license

The facility shall obtain any required Certificate of Need and shall directly notify each resident, the resident's physician, 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 Licensing, Certification and Standards Program of the Department within seven calendar days from voluntary surrender, order of revocation, expiration, or suspension of license, whichever is applicable.

8:39–2.7 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 resident or public.

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

(c) A written application for waiver shall include 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 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.

8:39–2.8 Action against licensee

(a) Violations of this subchapter may result in action by the New Jersey State Department of Health to impose a fine, cease admissions to a facility, remove residents from a facility, revoke a license, and/or impose other lawful remedies.

(b) If the Department determines that operational or safety deficiencies exist, it may require that all admissions to the facility cease. This may be done simultaneously with, or in lieu of, action to revoke licensure and/or impose a fine. The Commissioner or his or her designee shall notify the facility in writing of such determination.

(c) The Commissioner may order the immediate removal of residents from a facility whenever he or she determines imminent danger to any person's health or safety.

(d) This section shall apply to all facilities.

(e) Any licensee made subject to action by the Department under terms of this section shall have the right to a fair hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

(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. 8:39–2.10(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 Licensing 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.

8:39–2.12 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 $750.00 for the filing of an application to add beds to increase its total licensed capacity.

(c) The Department shall deny an application for add-a-bed based on the facility track record, if any of the following conditions exist:

1. The track record evaluation addressed at N.J.A.C. 8:39–2.2(h) results in a determination to deny the application; or

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 Guidelines for Construction and Equipment of Hospital and Medical Facilities (1992–1993), as published by the American Institute of Architects and approved by the U.S. Department of Health and Human Services. (Available from the American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006); or

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; or

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

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

Amended by R.1995 d.127, effective March 6, 1995.
See: 26 N.J.R. 1772(c), 27 N.J.R. 937(b).
Amended by R.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).
Amended by R.1998 d.304, effective June 15, 1998.
See: 30 N.J.R. 329(a), 30 N.J.R. 2302(a).
Rewrote (c)1.

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 New Jersey State Department of Health may take any or all of the following measures or any other lawful remedy:

1. Action to impose a fine;

2. Cessation of all admissions;

3. Removal of residents from the facility when there is an imminent danger to any person's health or safety; and

4. Revocation of the license held by the facility's operator.

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 fine, cessation of admissions, removal of residents, or revocation of a license, imposed pursuant to action by the New Jersey State Department of Health.

(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) Reports of individual facilities' compliance with advisory standards shall be available at the New Jersey State Department of Health, Office of Licensing and Inspection, for the inspection of the public, during normal business hours.

(c) 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 will 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 assurance (N.J.A.C. 8:39–34).

(d) 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 the resident chooses, at the resident's own expense or through a health care plan;

2. To have a physician 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;

6. To be free from chemical and physical restraints, unless they are authorized by a physician 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 must 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;

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 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 a 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:

1. 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;

2. That the patient shall be notified as soon as practical prior to transfer or discharge; and

3. 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) and Appendix D, Minimum Data Set), to be performed within the first five days of a patient's stay.

(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, and to an independent utilization review organization (IURO), 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.

i. An IURO which has been approved by the Department shall review a representative sample of all admissions to the hospital-based subacute care unit in order to verify the accuracy of the quarterly reports regarding length of stay.

ii. The hospital shall be responsible for the cost of the services provided by the IURO.

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 findings of the IURO which verified the accuracy of the hospital-based subacute care unit's quarterly utilization reports shall be submitted to the Department prior to, or as part of, the application for licensure renewal. The findings of the IURO shall include at least verification of individual length of stay for a representative patient sample, determination of aggregate length of stay for a representative patient sample, and specification of sample size for each quarter.

(c) 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.

8:39–47.6 Penalties

Compliance with P.L. 1996, c.102, shall be determined in part by adherence to the clinical admission criteria and utilization review protocols addressed in N.J.A.C. 8:39–47.4, and failure to comply with them or any other provision of these rules shall subject the facility to licensure revocation and/or other penalty action as specified at N.J.A.C. 8:43E.

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 clean-up 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.