CHAPTER 43

STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES

Authority

N.J.S.A. 26:2H–1 et seq., specifically 26:2H–5.

Source and Effective Date

R.1993 d.473, effective October 4, 1993
(operative February 12, 1994).
See: 25 N.J.R. 25(a), 25 N.J.R. 4631(a).

Executive Order No. 66(1978) Expiration Date

Chapter 43, Standards for Licensure of Residential Health Care Facilities, expires on October 4, 1998.

Chapter Historical Note

Chapter 43, originally Boarding Homes for Sheltered Care, was adopted as R.1974 d.319, effective November 19, 1974. See: 6 N.J.R. 396(c), 6 N.J.R. 472(e). Chapter 43 was redesignated "Residential Health Care Facilities" by R.1980 d.366, effective August 8, 1980. See: 12 N.J.R. 394(b), 12 N.J.R. 518(d).

Pursuant to Executive Order No. 66(1978), Chapter 43 was readopted as R.1990 d.568, effective October 24, 1990 and set to expire November 19, 1992. See: 22 N.J.R. 2499(a), 22 N.J.R. 3581(a). Pursuant to Executive Order No. 66(1978), Chapter 43 was further readopted as R.1992 d.502, effective November 19, 1992 and set to expire November 19, 1994. See: 24 N.J.R. 2506(a), 25 N.J.R. 109(a).

Chapter 43 was repealed and new Standards for the Licensure of Residential Health Care Facilities were adopted as R.1993 d.473. See: Source and Effective Date.

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SUBCHAPTER 1. DEFINITIONS AND QUALIFICATIONS

8:43–1.1 Scope

The rules in this chapter pertain to all facilities which provide residential health care services. These rules constitute the basis for the licensure of residential health care facilities by the New Jersey State Department of Health.

8:43–1.2 Purpose

Residential health care facilities provide sheltered care and services to residents who do not require skilled nursing care, in order to assist residents to maintain personal interests and dignity as well as to protect their health and safety. The aim of this chapter is to establish minimum rules with which a residential health care facility must comply in order to be licensed to operate in New Jersey.

8:43–1.3 Definitions

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

"Assistive device" means a leg brace, splint, cane, crutch, special shoe, back brace, walker, wheelchair, or prosthesis.

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

"Basic physical plant services" means heat, power, lighting, water, food and staff.

"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.

"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 1970, N.J.S.A. 24:21–1 et seq.

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

"Department" means the New Jersey State Department of Health.

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

1. "High-level disinfection" means that disinfection which kills vegetative bacteria, tubercle bacillus, some spores, fungi, lipid and non-lipid viruses.

2. "Intermediate-level disinfection" means that disinfection which kills vegetative bacteria, tubercle bacillus, fungi, lipid and non-lipid viruses and does not kill resistant bacterial spores.

3. "Low-level disinfection" means that disinfection which kills most vegetative bacteria, fungi, and lipid viruses and does not kill spores and non-lipid viruses. Low-level disinfection is sometimes less active against some of the gram-negative rods *(Pseudomonas) and* Mycobacterium (TB).

"Documented" means written, signed, and dated.

"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 and nurse's clinical notes, physician's orders and progress notes, in order to monitor for potentially significant adverse drug reactions, drug-drug and drug-food interactions, allergies, contraindications, rationality of therapy, drug use evaluation, and laboratory test results.

"Employee" means a member of the administrator's family or a person who is gainfully employed in the residential health care facility on a full or part-time basis and for whom a record of hours worked and wages paid are maintained and who meets the health, age and other requirements of this chapter. Reimbursement for such employment may include salaries, wages, room and board, or any combination thereof. A resident of the residential health care facility may not be considered an employee, except where this is voluntary and where no direct services or resident supervision is provided.

"Epidemic" means the occurrence 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.

"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.

"Governing authority" means the organization, person, or persons designated to assume legal responsibility for the management, operation, and financial viability of the facility.

"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.

"Job description" means written specifications developed for each position in the facility, containing the qualifications, duties and responsibilities, and accountability required of employees in that position.

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

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

"Residential health care facility" means a facility which provides food, shelter, supervised health care and related services to four or more persons 18 years of age or older who are unrelated to the owner or administrator.

"Resident" means a person who is 18 years of age or over, mobile under his or her own power with or without assistive devices and able to effectuate his or her own evacuation from the building. A licensed physician must certify that the resident does not have medical or personal care needs which exceed the level of services provided in a residential health care facility, is free from communicable diseases (that is, does not have a reportable, communicable disease which is not controlled through prophylaxis or medication), and does not require skilled nursing care.

"Resident supervision" means the provision of direct services required by this manual to residents.

"Responsible person" means a person who has been designated by the resident and who has agreed to assist the resident, as needed, in arranging for health, social and financial services or making decisions regarding such services.

"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.

"Staff education plan" means a written plan which describes a coordinated program for staff education for each service, including inservice programs and on-the-job training.

"Staff orientation plan" means a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he or she has been assigned, as well as to the personnel policies of the facility.

"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.

8:43–1.4 Qualifications of the administrator of a residential health care facility

(a) The administrator of a residential health care facility shall be in good physical and mental health, be of good moral character, exhibit concern for the safety and well-being of residents, and shall:

1. Complete a training course approved by the Department of Human Services, or other equivalent training as approved by the Department of Health, within one year of his or her employment as administrator; or

2. Hold a current New Jersey license as a nursing home administrator, or be eligible to take the New Jersey Nursing Home Administrator's Licensing Examination, according to the Department of Health requirements found in N.J.A.C. 8:34.

(b) The owner of a residential health care facility who meets the qualifications listed in (a) above may also serve as the administrator.

8:43–1.5 Qualifications of dietitians

Each dietitian shall be registered or eligible for registration by the Commission on Dietetic Registration (Office on Dietetic Credentialing, 216 W. Jackson Boulevard—7th Floor, Chicago, Illinois 60606–6995).

8:43–1.6 Qualifications of direct care staff

(a) The facility shall exercise good faith and due diligence to ensure that staff providing direct care and resident supervision to residents in the facility:

1. Are in good physical and mental health, emotionally stable, of good moral character, are concerned for the safety and well-being of residents;

2. Have not been convicted of a crime relating adversely to the person's ability to provide resident 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; and

3. Are at least 18 years of age, or have obtained working papers.

8:43–1.7 Qualifications of the director of health maintenance and monitoring services

The director of health maintenance and monitoring services shall be a registered professional nurse.

8:43–1.8 Qualifications of licensed practical nurses

Each licensed practical nurse shall be so licensed by the New Jersey State Board of Nursing.

8:43–1.9 Qualifications of nurse practitioner/clinical nurse specialists (NP/CNS)

Each nurse practitioner/clinical nurse specialist (NP/CNS) shall be so certified by the New Jersey Board of Nursing, in accordance with N.J.A.C. 13:37–7, in one of the following categories of advanced practice: Adult Health, Family, Gerontology, Psychiatric/Mental Health, or Community Health.

8:43–1.10 Qualifications of pharmacists

Each pharmacist shall be so registered by the New Jersey State Board of Pharmacy.

8:43–1.11 Qualifications of physicians

Each physician shall be licensed or authorized by the New Jersey Board of Medical Examiners to practice medicine in the State of New Jersey.

8:43–1.12 Qualifications of registered professional nurses

Each registered professional nurse shall be so licensed by the New Jersey State Board of Nursing.

SUBCHAPTER 2. LICENSURE PROCEDURES

8:43–2.1 Certificate of need

(a) According to N.J.S.A. 26:2H–1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, licensed to operate, or closed except upon application for, and receipt of, a certificate of need issued by the Commissioner.

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

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
CN 360
Trenton, New Jersey 08625
609–292–6552

(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 N.J.S.A. 26:2H–1 et seq., and amendments thereto.

8:43–2.2 Application for licensure

(a) Following receipt of a certificate of need, any person, organization, or corporation desiring to operate a residential health care facility shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from:

Director
Licensing and Certification
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625
609–588–7726

(b) The Department shall charge a nonrefundable fee of $100.00 plus $3.00 per bed for the filing of an application for licensure of a residential health care facility and for the annual renewal of the license.

(c) Each applicant for a license to operate a facility shall make an appointment for a preliminary conference at the Department with the Licensing and Certification Program.

8:43–2.3 Newly constructed or expanded facilities

(a) Any residential health care facility with a construction program, whether a Certificate of Need is required or not, shall submit plans to the Health Facilities Construction Services of the Department for review and approval prior to the initiation of construction.

(b) The licensure application for a newly constructed or expanded facility shall include written approval of final construction of the physical plant by Health Facilities Construction Services, Division of Health Facilities Evaluation and Licensure, New Jersey State Department of Health, in accordance with this chapter.

(c) An on-site inspection of the construction of the physical plant shall be made by representatives of Health Facilities Construction Services to verify that the building has been constructed in accordance with the architectural plans approved by the Department.

8:43–2.4 Surveys and temporary license

(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 Health Facilities Inspection Program of the Department shall be conducted to determine if the facility adheres to the rules in this manual.

1. The facility shall be notified 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 may be issued to a facility when the following conditions are met:

1. A preliminary conference (see N.J.A.C. 8:43–2.2(c)) for review of the conditions for licensure and operation has taken place between the Licensing and Certification Program and representatives of the facility, who will be advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with N.J.S.A. 26:2H–1 et seq., and amendments thereto, and the rules pursuant thereto;

2. The completed licensure application is on file with the Department;

3. The fee for filing of the application has been received by the Department;

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

5. 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;

6. Survey(s) by representatives of the Department indicate the facility adheres to the rules in this manual; and

7. Personnel are employed in accordance with the staffing requirements in this manual.

(c) No facility shall admit residents to the facility until the facility has the written approval and/or license issued by the Licensing and Certification Program of the Department.

(d) 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 resident records and conferences with residents.

(e) A temporary license may be issued to a facility for a period of up to six months and may be renewed as determined by the Department.

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

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

8:43–2.5 Full license

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

(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 or if its ownership changes.

(e) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The facility will receive a request for renewal fee 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.

(f) The license may not be renewed if local rules, regulations and/or requirements are not met.

8:43–2.6 Surrender of license

The facility shall notify each resident, the resident's physician, and any guarantors of payment, the county welfare agency, the Office of the Ombudsman, the Department of Human Services, and the SSI program, Region II office, if residents are SSI recipients, 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 license. In such cases, the license shall be returned to the Licensing and Certification Program of the Department within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

8:43–2.7 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 amendments thereto, and the rules in this manual, waive sections of these rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of residents or the public.

(b) A facility seeking a waiver of these rules shall apply in writing to the Director of the Licensing and Certification Program of the Department.

(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 requested;

2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon adherence;

3. An alternative proposal which would ensure resident safety; and

4. Documentation to support the request for waiver.

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

8:43–2.8 Action against a license

(a) 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.

(b) 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, in accordance with the following:

1. The county welfare agency, the Office of the Ombudsman, and the Department of Human Services shall be notified by the Department at the time the residents are to be removed;

2. The Department shall request county participation in coordination with appropriate service agencies, and make monitoring visits to ensure appropriate care and services to residents during the interim period until relocation takes place;

3. The Department shall notify the SSI program, Region II office, if residents are SSI recipients; and

4. The Department shall cooperate with all agencies and providers of services to relocate residents in the same area if possible.

(c) The provisions of (a) and (b) above shall apply to facilities with a temporary or provisional license and facilities with a full license.

8:43–2.9 Hearings

(a) If the Department proposes to suspend, revoke, deny, assess a monetary penalty, or refuse to renew a license, the licensee or applicant may 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.

(b) Prior to transmittal of any hearing request to the Office of Administrative Law, the Department may schedule a conference to attempt to settle the matter.

8:43–2.10 Special residential health care services

(a) Any existing or new residential health care facility proposing to establish a specialized program where the residents in such a program will constitute a substantial proportion of its census shall submit a plan for provision of services appropriate to the needs of these clients. Such a plan shall be reviewed by the Department and approval shall be received prior to the initiation of such admissions and services. This requirement shall not apply to a facility which is serving residents with special needs (that is, mental illness, diabetes, etc.) as part of its normal admission and retention policies.

(b) The Department may impose operational standards derived from the plan submitted by the facility and from other adopted licensure regulations appropriate to this population as a condition on the issuance of a license. Such conditions are subject to the enforcement actions and procedures specified at N.J.A.C. 8:43–2.8 and 2.9.

SUBCHAPTER 3. PHYSICAL PLANT

8:43–3.1 Scope

(a) Physical plant rules at N.J.A.C. 8:43–3.1 through 3A.11 shall apply to new construction, alterations or renovations of residential health care facilities.

(b) Alterations and renovations shall be evaluated as follows:

1. Alterations exceeding 50 percent: If alterations or repairs are made within any period of 12 months, costing in excess of 50 percent of the current replacement value of the structure, requirements for new structures shall apply to the entire structure, including those portions not altered or repaired;

2. Alterations under 50 percent: If alterations or repairs are made within any period of 12 months, costing between 25 percent and 50 percent of the current replacement value of the structure, only the altered or repaired portions need conform to the requirements for new structures;

3. Alterations under 25 percent: If alterations or repairs are made within any period of 12 months, costing under 25 percent of the current replacement value of the structure, the construction official and appropriate subcode officials shall determine to what degree the portions so altered or repaired shall be made to conform to the requirements for new structures.

(c) Physical plant standards for existing licensed facilities shall be maintained and existing facilities will be inspected according to those codes and standards which were in effect at the time of licensure, unless otherwise required by statute.

(d) Prior to approval of a certificate of need for a transfer of ownership, the Department shall have the option to conduct a physical plant inspection of the facility.

1. If provided, the Department inspection shall assess the facility for compliance with codes and standards in effect at the time of initial licensure, in accordance with (c) above; N.J.A.C. 8:43–3B.1 through 3B.6, codes and standards in effect at the time of inspection;

2. A report of the physical plant inspection shall be provided to the prospective buyer and sellers; and

3. A plan of correction shall be submitted to the Department for all physical plant deficiencies in violation of codes and standards in effect at the time of initial licensure, exclusive of waivers, N.J.A.C. 8:43–3B.1 through 3B.6 and all other standards required by law and applicable to existing facilities.

(e) A request for waiver of any physical plant standards whose correction creates a financial hardship may be submitted by a prospective buyer and will be reviewed by the Department, in accordance with N.J.A.C. 8:43–2.7.

8:43–3.2 Physical plant

Construction of residential health care facilities in new buildings, additions, alterations and renovations to existing buildings shall be in compliance with N.J.A.C. 5:23–, the New Jersey Uniform Construction Code, Use Group I–1. of the Sub–Code, and the BOCA National Building Code as delineated in N.J.A.C. 5:23.

8:43–3.3 Restrictions

Mixed use occupancy shall not be permitted in buildings classified as High Hazard (H), Factory (F) or assembly (A–2) Use Groups.

8:43–3.4 Ventilation

Means of ventilation shall be provided in accordance with BOCA National Building Code, Chapter 12, and BOCA National Mechanical Code, Chapter 16, as required by N.J.A.C. 5:23.

8:43–3.5 Exit access passageways and corridors

The width of passageways, aisles and corridors shall not be less than 44 inches. If an existing building(s) is being converted to a residential health care facility, the authority having jurisdiction may consider an exception which would allow a 36 inch corridor, in accordance with N.J.A.C. 8:43–2.7.

8:43–3.6 Automatic fire alarm system and detectors systems

(a) Smoke detectors shall be provided throughout all facilities, and shall be in accordance with all applicable sections of the BOCA National Building Code, Chapter 9, as reflected in the rules of the Department of Community Affairs.

(b) All alarm systems shall be connected to a full-time fire station or police station or other approved agency. Detectors for self-closing doors, windows and shutters shall be connected to fire alarm systems. Air handling systems shall be provided with smoke detectors. All detectors shall be hardwired and connected to fire alarm system.

8:43–3.7 Fire suppression systems

In new construction, fire suppression systems shall be installed in accordance with all applicable sections of the BOCA Building Code, Chapter 9, as reflected in the rules of the Department of Community Affairs.

8:43–3.8 Interior finish requirement

Interior wall and ceiling finishes shall be installed in accordance with all applicable sections of the BOCA Building Code, Chapter 8, as reflected in the rules of the Department of Community Affairs.

8:43–3.9 Attached structures

Attached structures such as storage sheds or private garages located beneath buildings shall have fire separation assemblies at the walls, floors, and ceilings separating the space from the adjacent interior enclosed space constructed of not less than one-hour fire resistance rating. Attached private garages shall be completely separated from the adjacent interior enclosed spaces and the attic area by means of one-hour rated fire separation assembly applied to the garage side. The sills of all door openings in the garage between garage and building shall be raised not less than four inches above the garage floor. Openings shall be protected in accordance with BOCA, Chapter 7, as reflected in the rules of the Department of Community Affairs.

SUBCHAPTER 3A. PHYSICAL ENVIRONMENT

8:43–3A.1 Resident bedrooms

(a) Sleeping rooms for one resident shall have a minimum of 90 square feet of clear floor area. "Clear floor area" means space exclusive of toilet rooms, fixed closets, fixed wardrobes, alcoves, or vestibules.

(b) Sleeping rooms occupied by more than one resident shall have a minimum of 70 square feet of clear floor area per resident. There shall be three feet of clear space between beds and at the foot of each bed to insure comfort and safety to residents. Space for storage of personal possessions and a non-folding arm chair shall be provided for each bed.

(c) No more than four residents shall be housed in any one room, regardless of room size.

(d) Toilets, bathing facilities, and handwashing sinks shall be available in the following minimum ratios (excluding bedrooms which have private facilities as part of the bed count and excluding facilities of family members and resident employees):

1. Toilets shall be provided so that each resident bedroom shall be adjacent to a toilet room, with no more than four residents served by this toilet.

2. Handwashing sinks shall be provided in every resident bedroom and in every toilet room except in private bedroom(s) where the handwashing sink in the bathroom is sufficient.

3. Tubs or showers shall be provided in a ratio of one per eight residents, with a minimum of one tub per 50 residents, or at least one tub per resident sleeping floor.

4. On floors other than sleeping floors utilized by residents there shall be at least a toilet and a lavatory available and accessible from a common corridor.

(e) Resident bedroom doors may be lockable by the occupant only from the corridor side (outside) by the use of a key. Egress from the room shall be possible at all times by turning the doorknob or pressing a lever. Duplicate keys to resident rooms which are locked shall be carried by designated staff at all times.

8:43–3A.2 Living and recreation rooms

(a) A living room or rooms shall be provided to insure adequate seating for the licensed capacity of the facility. There shall be 15 square feet per resident. The living room(s) shall have ample space for socialization as well as other resident activities such as letter writing, card playing, radio, television, and reading.

(b) Facilities with a licensed capacity of 30 or more residents shall provide two or more separate living or recreation rooms. A quiet sitting room with a minimum of 120 square feet shall be provided on each floor.

8:43–3A.3 Dining room

(a) Twenty-five square feet per resident shall be provided in a dining room or rooms.

(b) The congregate or common dining room shall be a separate area and shall not be a part of any other room. This area may be used for the recreation activities of residents, exclusive of the time required for dining service.

8:43–3A.4 Storage space

(a) Each facility shall provide a minimum of 30 square feet of lighted storage space per resident, in accordance with the following allotments:

1. At least ten square feet of locked personal storage, which may be in a room or common area other than the resident's bedroom; and

2. At least twenty square feet for linens, foods, cleaning and other supplies.

8:43–3A.5 Lighting and electricity

A bedside light shall be available for each bed, in addition to one duplex outlet for each bed and ceiling lights or other fixtures suitable for lighting the entire room.

8:43–3A.6 Laundry equipment

(a) Each facility shall provide at least one non-commercial washer and dryer for residents' personal items.

(b) Where laundry equipment is limited to non-commercial type (ordinary household or residential types), no special fire protective measures shall be required.

(c) When commercial-type laundry equipment is utilized, it shall be installed in a separate laundry room. The remainder of the home shall be protected from the laundry room by fire separation assemblies of at least one-hour fire-resistance rating. Doors to such laundry rooms shall be protected in accordance with BOCA National Building Code, Chapter 7, as reflected in the rules of the Department of Community Affairs.

(d) All dryers shall be vented to the outside of the building.

8:43–3A.7 Kitchens

Kitchen exhaust fans and metal ducts shall be kept free of grease and dirt; metal ducts from such fans shall comply with BOCA National Mechanical Code Article 5, as reflected in the rules of the Department of Community Affairs.

8:43–3A.8 Fire extinguisher specifications

(a) There shall be a minimum of two fire extinguishers in the basement, at least one on each floor of the building, and as required in kitchen areas. All fire extinguishers shall bear the seal of the Underwriters Laboratories.

(b) The following types of fire extinguishers shall be provided:

1. In kitchen areas, because of danger of grease fires, extinguishers shall be of the Class B dry chemical type 2–B and a minimum of 5 lbs. The maximum travel distance to an extinguisher shall be 50 feet.

2. In the basement area, extinguisher shall be Class B dry chemical type 2–B and a minimum of 5 lbs., if oil or gas is used as fuel. The maximum travel distance to an extinguisher shall be 50 feet.

3. In all other areas a Class A air-pressurized 2½ gallon water type 2–A extinguisher shall be provided. The maximum travel distance to an extinguisher shall be 75 feet.

8:43–3A.9 Employees' sleeping rooms

In any facilities where 24–hour awake coverage is not required, the employees' sleeping rooms shall be equipped with a four-inch alarm bell connected to the fire alarm system.

8:43–3A.10 Sounding devices

(a) An intercom system with alarm shall be provided on every resident floor and shall ring at an area staffed 24 hours a day and also in the staff sleeping quarters.

(b) Self-locking doors at the main entrance and other entrances opening onto a roof or balcony shall be equipped with a sounding device such as bell, buzzer or chimes, which is in operating condition. The sounding device shall be affixed to the outside of the door or to the adjacent exterior wall, for use in the event that a person is unable to re-enter the building and shall ring at an area staffed 24 hours a day and at staff sleeping quarters.

8:43–3A.11 Ceiling heights

Ceiling heights in corridors, storage rooms, resident rooms, and toilet rooms shall be in accordance with BOCA National Building Code, Chapter 12, as reflected in the rules of the Department of Community Affairs. Ceilings in normally unoccupied spaces may be reduced to at least seven feet.

SUBCHAPTER 3B. EXISTING FACILITIES

8:43–3B.1 Physical plant standards for all existing licensed facilities

Existing licensed facilities shall comply with and shall continue to be inspected according to those codes and standards which were in effect at the time of their initial licensure, and in addition shall comply with N.J.A.C. 8:43–3B.2 through 3B.6.

8:43–3B.2 Fire safety

Smoke detectors, fire suppression systems, and building separations shall be in compliance with the Uniform Fire Code of the State of New Jersey, N.J.A.C. 5:18, Subchapters 3 and 4, as applicable.

8:43–3B.3 Resident bedrooms

(a) Existing licensed facilities shall have 70 square feet of floor area for single rooms and 50 square feet of floor area per resident in multi-bed rooms.

(b) No more than four residents shall be housed in any one room, regardless of room sizes.

8:43–3B.4 Fire extinguishers; specifications

(a) There shall be a minimum of two fire extinguishers in the basement, at least one on each floor of the building, and as required in kitchen areas. All fire extinguishers shall bear the seal of the Underwriters Laboratories. The following types of extinguishers shall be provided:

1. In kitchen areas, because of danger of grease fires, extinguishers shall be of the Class B dry chemical type 2–B and a minimum of 5 lbs. The maximum travel distance to an extinguisher shall be 50 feet;

2. In the basement area, extinguishers shall be Class B dry chemical type 2–B and a minimum of 5 lbs. if oil or gas is used as fuel. The maximum travel distance to an extinguisher shall be 50 feet; and

3. In all other areas, a Class A air-pressurized 2½ gallon water type extinguisher shall be provided. The maximum travel distance to an extinguisher shall be 75 feet.

SUBCHAPTER 4. GENERAL REQUIREMENTS

8:43–4.1 Minimum services and staffing

(a) Each residential health care facility shall provide, at a minimum, personal care, health maintenance and monitoring, pharmacy, dietary, and recreational services.

(b) The facility shall provide at all times at least one employee in each building or structure occupied by residents, in order to provide necessary resident supervision, as follows:

1. In residential health care facilities with 24 or more residents, the facility shall provide sufficient staff for resident supervision 24 hours per day by an employee who is awake on the premises.

2. In residential health care facilities with fewer than 24 licensed beds, the facility shall provide sufficient staff for resident supervision. During the normal sleeping hours of residents, inactive resident supervision shall be provided by an employee who is on duty and available on the premises to provide care and services, but not necessarily awake.

(c) In all residential health care facilities with more than 24 beds, the facility shall have the capacity to provide a sufficient number of on-duty employees (other than residents) to assure a minimum of one hour of resident supervision for each resident during a 24–hour period.

(d) In addition to meeting the requirements of (b) above, all residential health care facilities which have more than one floor shall have a system in place to assure resident safety by providing for immediate notification of staff through an emergency communication system and periodic monitoring of all areas occupied by residents.

(e) The facility shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements.

8:43–4.2 Ownership

(a) The ownership of the facility and the property on which it is located shall be disclosed to the Department. Any proposed change in ownership shall be reported to the Director of the Licensing and Certification Program of the Department in writing at least 30 days prior to the change and in conformance with requirements for Certificate of Need applications.

(b) No facility shall be owned or operated by any person convicted of a crime relating adversely to that person's capability of owning or operating the facility.

(c) The owner or governing authority of the facility shall assume legal responsibility for the management, operation, and financial viability of the facility.

8:43–4.3 Submission and availability of documents

The facility shall, upon request, submit in writing any documents which are required by the rules in this manual to the Director of the Licensing and Certification Program of the Department.

8:43–4.4 Personnel

(a) The facility shall develop written job descriptions and shall ensure that personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions.

(b) All personnel who require licensure, certification, or authorization to provide resident care shall be licensed, certified, or authorized under the appropriate laws and/or rules of the State of New Jersey.

(c) The facility shall maintain and implement written staffing schedules. Actual hours worked by each employee shall be documented.

(d) The facility shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency plans and procedures and the infection prevention and control program.

(e) The staffing ratios of this chapter are minimum only and the residential health care facility shall employ staff in sufficient number and with sufficient ability and training to provide the basic care and resident supervision required in this chapter.

(f) The facility shall have a policy regarding personnel with a reportable communicable disease, infection or exposure to infection, specifying that such an employee shall be excluded from the residential health care facility until that employee has received a physical examination and certification that the condition will not endanger the health of residents or other employees.

8:43–4.5 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following:

1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility;

2. A description of the services provided;

3. Specification of business hours and visiting hours;

4. Policies and procedures for reporting all diagnosed and/or suspected cases of resident abuse or exploitation, as follows:

i. All county welfare agencies shall be notified, in accordance with N.J.S.A. 40:69A–60.5, P.L.1979, c.469, The Rooming and Boarding House Act of 1979, as amended; and

ii. If the resident is 60 years of age or older, the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly shall also be notified, in compliance with N.J.S.A. 52:27G–7.1 et seq.;

5. Policies and procedures for maintaining confidentiality of resident records, including policies and procedures for examination of resident records by the resident and other authorized persons and for release of the resident's records to any individual outside the facility, as consented to by the resident or as required by law or third party payor;

6. Policies and procedures for the maintenance and confidentiality of personnel records for each employee, including at least the employee's name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, prior criminal records, records of physical examinations, job description, and evaluations of job performance; and

7. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and persons providing direct resident care services in the facility through contractual arrangements or written agreement.

(b) The facility shall make all policy and procedure manuals available to residents, guardians, designated responsible persons, prospective applicants, and referring agencies during normal business hours or by prior arrangement.

8:43–4.6 Resident transportation

(a) The facility shall ensure that resident transportation will be provided, either directly or by arrangement, which may include an arrangement with a family member or other responsible person, to and from health care services provided outside the facility. The facility shall have policies and procedures addressing reasonable plans for security and accountability for the resident and his or her personal possessions, as well as transfer of resident information to and from the provider of the service.

(b) The facility shall assist the resident in arranging for transportation to activities of social, religious, and community groups in which the resident chooses to participate.

8:43–4.7 Written agreements

The facility shall have a written agreement or its equivalent, or a linkage for services not provided directly by the facility. If the facility provides care to residents with psychiatric disorders, the facility shall also have a written agreement with one or more community mental health centers specifying which services will be provided by the mental health center. The written agreements shall require that services be provided in accordance with the rules in this chapter.

8:43–4.8 Reportable events

(a) The facility shall notify the Department immediately by telephone at 609–588–7725 (609–392–2020 after business hours), followed within 72 hours by written confirmation, of the following:

1. Interruption for three or more hours of basic physical plant services;

2. Termination of employment of the administrator, and the name and qualifications of his or her replacement;

3. Occurrence of epidemic disease in the facility;

4. All fires, all disasters, all residents who are missing for 24 hours, and all deaths resulting from accidents or incidents in the facility or related to facility services. The written confirmation shall contain information about injuries to residents and/or personnel, disruption of services, and extent of damages;

5. Any major occurrence or incident shall be reported promptly to the Department by telephone, and shall be confirmed in writing to the Department as soon as possible thereafter;

6. All alleged or suspected crimes which are serious crimes committed by or against residents, which have also been reported at the time of occurrence to the local police department; and

7. All suspected cases of resident abuse or exploitation which have been reported to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly and/or to the county welfare agencies.

8:43–4.9 Notices

(a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public:

1. All waivers granted by the Department;

2. A list of deficiencies from the last annual licensure inspection survey report and the list of deficiencies from any valid complaint investigation during the past 12 months;

3. Policies and procedures regarding resident rights;

4. Visiting hours (including at least the time between the hours of 8:00 A.M. and 8:00 P.M. daily) and business hours of the facility, including the policies of the facility regarding limitations and activities during these times;

5. The toll-free hot line number of the Department; telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman; and

6. The names of, and a means to formally contact, the owner and/or members of the governing authority.

8:43–4.10 Information reportable to State Board of Medical Examiners

(a) In accordance with the Professional Medical Conduct Reform Act, P.L.1989, c.300, as amended, the facility shall notify the New Jersey Board of Medical Examiners of all actions which result in reduction or restriction of staff privileges of any practitioner who is employed by or who is under contract to the facility. The information to be reported shall include, but not be limited to, the following:

1. A disciplinary proceeding or action taken by the facility against any practitioner licensed by the Board when the proceeding or action results in a practitioner's reduction or suspension of privileges or removal or resignation from the facility's medical staff; and

2. A medical malpractice liability insurance claim settlement, judgment or arbitration award in which the facility is involved.

(b) For purposes of (a) above, "practitioner" means physician, medical resident or intern, or podiatrist.

(c) Notifications shall be provided within seven days of the reported event, on forms provided by the Department of Health for that purpose. Forms shall be submitted to the New Jersey State Board of Medical Examiners, 28 West State Street, Trenton, New Jersey 08608. (Questions may be directed to the Board Office at (609) 292–4843.)

8:43–4.11 Maintenance of records

(a) The facility shall maintain an annual chronological listing of residents admitted and discharged, including the destination of residents who are discharged; and

(b) Statistical data, such as resident census and facility characteristics, shall be forwarded on request, in a format provided by the Department.

8:43–4.12 Admission and retention of residents

(a) The administrator or the administrator's designee shall conduct an interview with the resident and, if available, the resident's family, guardian, or interested agency, prior to or at the time of the resident's admission. The interview shall include at least orientation to the facility's policies, business hours, fee schedule, services provided, resident rights, and criteria for admission and discharge. Documentation of the resident interview shall be included in the resident's record.

(b) At the initial interview prior to or at the time of admission of each resident, the administrator or the administrator's designee shall be provided with the name, address, and telephone number of a family member, guardian, responsible person or designated community agency who can be notified in the event of the resident's illness, incident, or other emergency.

(c) A physician shall certify for each resident that he or she has seen the resident within 30 days prior to admission and that the resident does not have needs which exceed the level of care provided by the facility, is free from communicable disease, is not in need of skilled nursing care, is mobile under his or her own power with or without assistive devices, and, if incontinence is suspected, has received a medical and nursing evaluation to determine whether the facility can provide an appropriate level of services to the resident.

(d) For emergency admissions, the physician's certification shall be received within 72 hours of admission.

(e) 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 the attending physician or the physician on call shall evaluate the resident to determine whether the resident is appropriately placed in that facility and to locate a new placement if necessary. The mental health screening process, as defined in Title 30 of New Jersey Statutes Annotated, may be initiated by the health maintenance and monitoring nurse, or by the administrator after consultation with the physician or nurse. The facility's health maintenance and monitoring nurse is also authorized to decide whether to initiate the mental health screening process when circumstances warrant immediate action to protect the health, safety and welfare of the resident or other residents of the facility.

(f) If the facility is not of fire-resistive construction, residents who are blind or who can walk independently assisted by crutches or other assistive devices shall be housed on a floor with direct grade level access.

(g) The facility may admit residents who require wheelchairs if the following conditions are met:

1. The resident is able to propel the wheelchair independently;

2. The resident's living unit shall be located on a floor at grade level, or if not at grade level, on a floor with handicap access to grade level;

3. The corridor on which the resident's living unit is located shall be at least 44 inches wide;

4. Each door through which the resident must travel to exit shall be at least 32 inches wide; and

5. The facility shall be in full compliance with uniform fire safety codes.

(h) If any condition listed in (g) above is not met, the facility may request approval from the Department to admit the resident. These conditions shall not apply to a resident who uses a wheelchair for convenience, but who is capable of ambulating independently without a wheelchair. The Department's determination will be made on a case-by-case basis.

(i) If an applicant, after applying in writing, is denied admission to the facility, the applicant and/or his or her family, guardian, or designated community agency shall, upon written request, be given the reason for such denial in writing, signed by the administrator, within 15 days of the receipt of the written request.

(j) Each resident shall be admitted or retained only upon his or her own volition.

8:43–4.13 Involuntary discharge

(a) Written notification by the administrator or the administrator's designee shall be provided to a resident and/or his or her family, guardian, designated responsible person, and county welfare agencies of a decision to involuntarily discharge the resident from the facility. Such involuntary discharge shall only be upon grounds contained in the facility's policies and procedures and shall occur only if the resident has been notified and informed of such policies in advance of admission. The notice of discharge shall be given at least 30 days in advance of the involuntary discharge and shall include the reason for discharge and the resident's right to appeal. A copy of the notice shall be entered in the resident's record.

(b) The resident shall have the right to appeal to the administrator any involuntary discharge from the facility. The appeal shall be in writing and a copy shall be included in the resident's record with the disposition or resolution of the appeal. The resident shall have the right to retain legal counsel to appeal.

(c) In an emergency situation, as stated in N.J.A.C. 8:43–4.12(e), for the protection of the life and safety of the resident or others, the facility may discharge the resident without 30 days notice. The Department and county welfare agencies shall be notified in the event of such discharge.

8:43–4.14 Notification requirements

(a) The resident's family, guardian, and/or responsible person or community agency, the county welfare agency and any other agency in which the client is a participating program member or under treatment, shall be notified, promptly after the occurrence, in the event of the following:

1. Any significant change in the resident's physical or mental status;

2. Any serious accident, criminal act or incident occurs which involves the resident and results in serious harm or injury or results in the resident's arrest or detention.

3. The transfer of the resident from the facility; or

4. The death of the resident.

(b) The Department shall also be notified of the events in (a)2 above.

(c) The notification required in (a) above shall be given at the time of occurrence, and then documented in the resident's record.

8:43–4.15 Policies and procedures for dispute resolution; forum for discussion of advance directives

(a) 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 appli-

cation 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 make clinical and ethical judgements.

(b) The facility's policies 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.

8:43–4.16 Policies and procedures for advance directives

(a) For purposes of this Chapter, "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, and instruction directive, or both.

(b) 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 shall be documented in the resident's 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.

(c) 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 into the resident's record when received.

(d) The facility shall have procedures to provide each adult resident upon admission and, where the resident is unable to respond, the family or other representative of the resident, with a written statement of his or her rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive. Such a statement shall be issued by the Commissioner. Appropriate 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.

(e) 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 that can promptly advise and/or assist the resident.

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

(g) 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 in the instance of private, religiously affiliated health care institutions who establish policies defining circumstances in which they will decline to participate in the implementation of advance directives. Such institutions must provide notice of their policies to residents or their families or health care representatives prior to or upon admission. 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 and the receiving health care facility before transferring the resident.

(h) At least one education training program each year shall be held for all administrative staff and employees providing resident supervision and/or personal care on the rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H–53 et seq., P.L. 1991, c.201, and internal facility policies and procedures which implement this law.

8:43–4.17 Building occupancy

(a) A facility licensed as a residential health care facility shall not be used for any other purpose, with the following exception: the facility may be used for housing quarters of the owner, the administrator, or other staff members, if prior approval by the Department is obtained.

(b) Resident occupancy shall be limited to floors at or above the grade level, with the following exceptions:

1. Basement occupancy may be permitted if no more than one-half the height of the room or rooms to be occupied is below grade level and if there are no other conditions which might jeopardize the health, safety or welfare of the resident;

2. Any resident who requires assistance from staff to ambulate stairs shall be housed on a floor with grade level access; and

3. Any resident with a walker, crutch(es) or leg brace(es) shall be assessed before being placed on a floor other than a grade level floor in order to ensure that the resident is able to evacuate the building safely.

8:43–4.18 Resident bedrooms

(a) Each resident's personal living unit shall have direct access to corridors and toilet facilities without passing through the rooms of other residents, kitchen or dining areas, or other occupied rooms.

(b) No more than four residents shall be housed in one bedroom.

8:43–4.19 Interpretation services

The facility shall demonstrate the ability to provide a means to communicate with any resident admitted who is non-English-speaking and/or has a communication disability, using available community services.

SUBCHAPTER 5. ADMINISTRATION

8:43–5.1 Appointment of administrator

An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available on the premises of the facility at all times.

8:43–5.2 Administrator's responsibilities

(a) The administrator shall be responsible for, but not limited to, the following:

1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;

2. Planning for, and administration of, the managerial, operational, fiscal, and reporting components of the facility;

3. Ensuring that all personnel are assigned duties based upon their ability and competency to perform the job and in accordance with job descriptions;

4. Ensuring the provision of staff orientation and staff education; and

5. Establishing and maintaining liaison relationships and communication with facility staff and services and with residents and their families.

SUBCHAPTER 6. RESIDENT CARE POLICIES

8:43–6.1 Resident care policies and procedures

(a) Written resident care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, policies and procedures regarding the following:

1. Resident rights;

2. The determination of staffing levels to ensure a minimum of one hour of resident supervision for each resident of the facility during each 24–hour period. Supervision may be provided by on-duty employees who are engaged in the direct supervision and care of residents, and also by those providing basic services such as food service, housekeeping, laundry and general maintenance, who, by reason of their availability on the premises, provide care and supervision as needed;

3. The referral of residents to health care providers in order to provide a continuum of resident care;

4. Emergency medical and dental care of residents, including notification of the resident's family, guardian, or designated community agency, and care of residents during periods of acute illness;

5. Obtaining written informed consent for any medical procedures performed at the facility which require informed consent by law, and the circumstances under which written informed consent shall be obtained;

6. The control of smoking in the facility in accordance with N.J.S.A. 26:3D–1 et seq. and N.J.S.A. 26:3D–7 et seq. as follows:

i. Residents shall not be permitted to smoke in their rooms and in other secluded areas;

ii. Restricted smoking areas shall be designated and rules governing such smoking specified 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;

iii. A facility may continue to enforce a smoke-free policy in effect on the implementation date of these rules and shall set forth this policy in its admission agreement;

iv. At the facility's option, it may institute a smoke-free policy after the implementation date of these rules. 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 resident smokers by providing a designated area with adequate outside ventilation for controlled smoking. If inside, the designated smoking room shall be adequate-

ly ventilated to prevent recirculation of smoke to other areas of the facility. If outside, the designated area shall provide reasonable protection from inclement weather;

7. Discharge, termination by the facility, transfer, and readmission of residents, including criteria for each;

8. The care and control of pets, if the facility permits pets in the facility or on its premises (see recommendations set forth in Appendix E);

9. A system to monitor residents leaving the facility or its premises, which shall include a policy to determine those circumstances where the resident's absence shall be investigated; and

10. Care of deceased residents, including, but not limited to, policies and procedures regarding the following:

i. Pronouncement of death: The resident's family, guardian, or designated community agency shall be notified at the time of death. The deceased shall not be removed from the facility until pronounced dead and the death is documented in the resident's medical record; and

ii. Transportation of the deceased in the facility, and removal from the facility, in a dignified manner.

8:43–6.2 Financial arrangements

(a) The facility shall:

1. Inform residents of any and all fees for services provided and charges for supplies routinely utilized. The resident shall also be informed of costs of supplies which are specially ordered;

2. Maintain a written record of all financial arrangements with the resident and/or his or her family, guardian, or designated community agency, with copies furnished to the resident and, upon request, to the person or agency with whom the arrangements were made;

3. Assess no additional charges, expenses, or other financial liabilities in excess of the daily, weekly, or monthly rate included in the admission agreement, except:

i. Upon written approval and authority of the resident and/or his or her family, guardian, or designated community agency, who shall be given a copy of the written approval; or

ii. Upon written orders of the resident's physician, stipulating specific services not included in the admission agreement; or

iii. Upon 30 days' prior written notice to the resident and/or his or her family of charges, expenses, or other financial liabilities that are in addition to the agreed daily, weekly, or monthly 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; and

4. Provide the resident with information regarding financial assistance available from third-party payors and/or other payors and referral systems for residents' financial assistance.

8:43–6.3 Personal needs allowance

(a) The administrator or his or her representative shall reserve for each resident who receives Supplementary Security Income (SSI) or General Public Assistance a monthly personal needs allowance of at least the amount specified by the Division of Youth and Family Services of the New Jersey State Department of Human Services pursuant to N.J.S.A. 44:7–87(h) and N.J.A.C. 10:123–3, and under the following conditions:

1. The resident shall not be required to provide the owner, administrator, employee or their representative(s) with any portion of the personal needs allowance.

2. No owner, administrator, employee or their representative(s) shall coerce, intimidate, or exploit residents into providing them with any portion of the personal needs allowance.

3. Each resident shall receive his or her personal needs allowance within three working days of the receipt of the check by the administrator.

(b) Every administrator to whom a resident's personal funds are entrusted shall maintain written records, such as a ledger, including the date each payment was received, the amount of payment, the date of each disbursement, the amount of each disbursement, the reason for each disbursement and to whom each disbursement was made.

(c) The resident shall sign to acknowledge receipt of funds, goods or services purchased with such funds at the time of disbursement.

(d) Residents' funds received in trust or on deposit with the facility shall be kept in a separate bank account(s) and not commingled with the facility's general funds. If residents' funds are kept in an interest bearing account, all interest earned shall be credited to the resident after bank charges, if any, are deducted.

SUBCHAPTER 7. PERSONAL CARE SERVICES

8:43–7.1 Provision of personal care services

Each resident shall be provided with personal care services (bathing, oral hygiene, hair care, manicuring and pedicuring, and shaving) as needed to maintain acceptable personal hygiene.

8:43–7.2 Resident clothing

(a) The administrator or the administrator's designee shall assist residents in obtaining clothing which is suitable for the climate and weather conditions, of proper size, and in sufficient amounts for necessary changes.

(b) Clothing shall be laundered as frequently as necessary to maintain cleanliness, in accordance with N.J.A.C. 8:43–15.8.

8:43–7.3 Facilities and furnishings

(a) The administrator shall ensure that each resident has, within his or her sleeping area, the following items, which shall at all times be clean and comfortable and in good repair:

1. Beds:

i. A standard bed not less than 36 inches in width;

ii. A bedspring which is in good condition;

iii. A mattress not less than four inches in thickness that fits the bed.

iv. Beds shall not be located under windows, against radiators or air conditioners, or in alcoves unless a resident has chosen to place his or her bed in such a location and the administrator has determined that such placement poses no safety risk to the resident.

v. Roll-away beds, day beds, cots and latex foam mattresses shall be prohibited. (Day beds may be permitted, if the resident so requests.)

2. Pillows: At least one standard size pillow. Extra pillows available to meet the needs of the resident. Latex foam pillows shall be prohibited.

3. Chairs: At least one chair.

4. Reading light: A reading light and/or a bed light.

5. Storage:

i. A closet in the resident's room;

ii. A dresser or chest for personal possessions;

iii. A night table.

6. Bed linen:

i. A moisture-proof mattress or a moisture-proof mattress cover or pad which can be removed for cleaning or laundering;

ii. A pillowcase for each pillow;

iii. At least two sheets or two sheet blankets or a combination thereof; sheets and pillowcases shall be changed at least weekly and more often if necessary;

iv. A washable blanket and such additional blankets as are necessary for the resident's comfort;

v. A bedspread.

7. Personal linen: A washcloth and a bath towel which shall be changed when soiled.

8. Windows: Shades, curtains, drapes, or blinds shall be provided for all windows, to ensure privacy.

SUBCHAPTER 8. DIETARY SERVICES

8:43–8.1 Provision of meals

The residential health care facility shall provide dietary services to meet the daily nutritional needs of residents.

8:43–8.2 Requirements for dietary services

(a) The facility shall establish and implement written policies and procedures for the provision of dietary services.

(b) Beginning January 1, 1994, or subsequent date as determined by the Commissioner, the facility shall designate a consultant dietitian to be responsible for the direction, provision, and quality of the dietary service, when the Commissioner determines that adequate funds are available to implement the requirements, based upon a financial analysis conducted subsequent to:

1. An increase in Supplemental Security (S.S.I.) income by the State of New Jersey (see N.J.S.A. 44:7–85 et seq.);

2. Additional third party insurance coverage of residential health care facility services; or

3. A finding that the majority of providers have adequate revenues in excess of expenses.

(c) Notice of the operative date of (b) above shall be provided in the New Jersey Register by the Commissioner.

(d) The dietitian required in (b) above shall be responsible for, but not limited to, the following:

1. Participating in developing and implementing written objectives, policies, a procedure manual, an organization plan, and a quality assurance program for the dietary service;

2. Participating in planning and budgeting for the dietary service;

3. Ensuring that dietary services are provided to meet the dietary needs of residents;

4. Assisting in developing and maintaining written job descriptions for dietary personnel, and assigning duties based upon education, training, competencies, and job descriptions;

5. Participating in staff education activities and providing consultation to facility personnel; and

6. Providing nutritional counseling.

(e) If the facility fails to substantially comply with the requirements of this subchapter, or if residents of the facility have significant nutritional deficiencies, the Department may require a consultant dietitian to be retained by the facility to assist in correcting the deficiencies in dietary services cited by the Department, in addition to other enforcement actions. The facility shall retain the consultant dietitian until all deficiencies have been corrected.

(f) The facility shall provide:

1. Policies and procedures for planning, preparing, and serving meals, purchasing food, supervising residents at mealtime, and providing therapeutic diets in accordance with admission policy of the facility and as prescribed by the resident's physician. "Therapeutic diet" means a diet prescribed by a physician, and may include modifications in nutrient content, caloric value, consistency, methods of food preparation, content of specific foods, or a combination of these modifications;

2. Nutrients and calories for each resident, in accordance with current recommended dietary allowance of the Food and Nutrition Board of the Nation Academy of Sciences, National Research Council, adjusted for age, sex, weight, and physical activity, therapeutic needs of the resident if therapeutic diets are provided, and Appendix A, A Daily Food Guide;

3. A current diet manual;

4. Diets served to residents that are consistent with the diet manual;

5. Written menu plans for all meals and snacks;

6. For each resident at each meal, a place setting consisting of at least a dish(es), a glass and/or cup, fork, spoon, and napkin, and a knife or additional utensils as required or requested by the resident; and

7. For each resident's use, in the dining room at each meal, salt, pepper, sugar or sugar substitute, dairy or nondairy additives for beverages, and condiments, unless contraindicated by the resident's physician.

(g) All meals shall be served in the dining room. Exceptions may be made if the resident is ill, or requests that his or her meal be served in another location.

(h) All meals shall be attractive when served to residents.

(i) The facility and personnel shall comply with the provisions of Chapter XII of the New Jersey Sanitary Code, N.J.A.C. 8:24 (see Appendix C).

8:43–8.3 Administrator's responsibilities

(a) The administrator or the administrator's designee shall ensure that the dietary service:

1. Selects foods and beverages, which include fresh and seasonal foods, and prepares menus with regard for the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal food preferences of residents;

2. Has written and dated menus for all meals and snacks, planned at least seven days in advance for all diets. The same menu shall not be used more than once in any continuous seven day period. The facility shall offer substitute food and drink of equivalent nutritional value, if requested by a resident at least 24 hours in advance;

3. Posts current menus, with portion sizes, in the food preparation area and in a conspicuous place in residents' area, or provides a copy of the menu to each resident. Any changes or substitutes in menus shall be posted or provided in writing to each resident. Menus, with changes or substitutes, shall be kept on file in the facility for at least 30 days;

4. Prepares and serves daily to residents at least three meals;

5. Complies with written policies regarding meal hours. No more than 15 hours shall elapse between an evening meal and breakfast the next morning, and the first meal shall not be served before 7:00 A.M.;

6. Provides evening snacks and beverages;

7. Prepares food by cutting, chopping, grinding, or blending to meet the needs of each resident;

8. Provides self-help feeding devices as required by residents;

9. Maintains a file of recipes for menu items that require a recipe, adjusted to yield, which shall be used in preparing foods listed on the posted menus;

10. Maintains thermometers in refrigerators and freezers;

11. Adheres to written policies and procedures for the selection, storage, use, and disposition of nondisposable and disposable items. Disposable items shall not be reused;

12. Prepares work schedules for the dietary service so as to allow residents to eat at their own pace;

13. Maintains at least a three-day supply of nonperishable food on the premises; and

14. Develops a written schedule of cleaning operations for the kitchen, including daily, weekly, monthly, or annual tasks.

8:43–8.4 Commercial food management services

If a commercial food management firm provides dietary services, it shall be required to conform to the standards of this subchapter.

SUBCHAPTER 9. HEALTH SERVICES

8:43–9.1 Health maintenance and monitoring services

(a) The residential health care facility shall provide health maintenance and monitoring services under the direction of a registered professional nurse.

(b) The facility shall have at least one registered professional nurse available at all times. Available, in this instance, shall mean on call and capable of being reached by telephone.

(c) A registered professional nurse shall be designated in writing as the director of health maintenance and monitoring services and shall be responsible for the direction, provision and quality of health maintenance and monitoring services. The director shall be responsible, in coordination with the administrator, for developing and implementing written objectives, standards of practice, policies and procedures and an organization plan for the health maintenance and monitoring service. The director may be employed directly by the facility or on a contractual basis.

(d) Written policies and procedures shall include, but not be limited to the following:

1. Assessing the health service needs of all residents in the facility;

2. Monitoring the conditions of the residents on a continuing basis;

3. Notification of the administrator if there are significant changes in a resident's condition;

4. Assessing the resident's need for referral to a physician or community agencies as appropriate;

5. Maintaining records as required by the facility; and

6. Serving as a resource person and health educator to the residents and to the administrator of the facility.

(e) The facility shall provide health maintenance and monitoring services according to the following schedule:

1. The facility shall provide a minimum of 0.25 hours of nursing care from a registered professional nurse per resident per week. Facilities having an average resident census, over a 12–month period, of greater than 75 percent or more residents whose source of income is SSI, Municipal Assistance or Interim Assistance shall be exempted and shall provide a minimum of 0.20 hours of nursing care from a resident professional nurse per resident per week. A facility claiming that 75 percent or more of its residents are SSI, Municipal Assistance, or Interim Assistance recipients shall provide documentation to the Department and receive approval prior to reducing health monitoring and maintenance staffing to the level of 0.20 hours of nursing care. So long as the total minimum hourly requirement is met, the registered professional nurse shall determine whether visits to an individual resident shall be weekly, biweekly, or according to a schedule based on the individual resident's needs, as determined by the nurse's assessment.

2. Beginning January 1, 1994, or subsequent date as determined by the Commissioner, if the Commissioner determines that adequate funds are available to implement these requirements, based upon a financial analysis conducted subsequent to an increase in SSI funding by the State of New Jersey; or additional third party insurance coverage is available; or that the Commissioner has issued a finding that the majority of providers have adequate revenues in excess of expenses, the facility shall provide a minimum of 0.33 hours (20 minutes) of nursing care from a registered professional nurse per resident per week, of which a maximum of 0.13 hours (8 minutes) of each 0.33 hours (20 minutes) of nursing care may be delegated to a licensed practical nurse. Notice of the operative date in this paragraph shall be provided in the New Jersey Register by the Commissioner.

8:43–9.2 Provision of health services

(a) The facility shall arrange for health services to be provided to residents as needed.

(b) At the time of admission, arrangements shall be made between the administrator and the resident, guardian, or designated community agency regarding the physician and dentist to be called in case of illness, or the person to be called for a resident who, because of religious affiliation, is opposed to medical treatment.

(c) Beginning January 1, 1994, or subsequent date published in the New Jersey Register in accordance with N.J.A.C. 8:43–9.1(e)2, each resident shall be screened by a licensed professional nurse at least monthly. Screening shall be done every 60 days, until the time monthly screening begins. "Screening" means a personal evaluation of the resident which includes a review of the resident's physical and mental status, progress in response to nursing interventions, and education of the resident to new nursing interventions. The licensed professional nurse shall document each resident's monthly screening in the resident record.

(d) The registered professional nurse shall notify the resident's physician of any significant change in the resident's physical or psychological condition.

(e) Each resident shall receive an initial nursing assessment, and, beginning January 1, 1994, or upon the operative

date of N.J.A.C. 8:43–9.1(e)2 above, whichever is later, a quarterly nursing assessment from the registered professional nurse. Until quarterly screening begins, each resident shall receive a semiannual nursing assessment from the registered professional nurse. The nursing assessment shall include, at a minimum, evaluation of the following:

1. Cognitive patterns;
2. Communication/hearing patterns;
3. Vision patterns;
4. Physical functioning and structural problems;
5. Continence;
6. Psychosocial well-being;
7. Mood and behavior patterns;
8. Activity pursuit patterns;
9. Disease diagnoses;
10. Health conditions;
11. Oral/nutritional status;
12. Oral/dental status;
13. Skin condition;
14. Medication use; and
15. Special treatment and procedures.

(f) Notice of the operative dates in (c) and (e) above shall be provided in the New Jersey Register by the Commissioner.

(g) The nursing assessment required by (e) above shall be documented on the minimum data set for resident assessment and care screening (MDS), which is included in Appendix B, or on an equivalent assessment instrument which has been developed by the facility and approved by the Department prior to its use.

(h) The registered professional nurse or a physician shall be called at the onset of illness of any resident to arrange for assessment of the resident's nursing care needs of medical needs and for the needed nursing care intervention or medical care.

(i) A resident with a temporary illness may be cared for in a residential health care facility for a period not to exceed one week. If a resident needs bed care for a more extended period, arrangements shall be made for his or her prompt transfer to an appropriate health care facility.

(j) Each resident shall have an annual physical examination by a physician, which shall be documented in the resident's record. The physician shall certify annually that the resident does not have needs which exceed the care provided by the residential health care facility. A collaborating physician may delegate responsibility for the physical examination to a nurse practitioner/clinical nurse specialist, in accordance with N.J.A.C. 13:37–7.

(k) Residents shall be permitted free choice of a physician.

(*l*) The administrator shall arrange for a physician to be available for emergencies, including injuries or accidents to residents, or when required by a resident's condition.

(m) If the physician determines the need for a transfer to another health care facility because the residential health care facility cannot meet the resident's needs, such transfers shall be initiated promptly. The registered professional nurse shall be notified to ensure that the resident is receiving appropriate care during the transfer period. If the resident is not transferred within seven days, the Department shall be notified and assistance shall be requested from the Department to arrange for transfer of the resident.

SUBCHAPTER 10. MEDICATIONS

8:43–10.1 Self-administration of medications

(a) A designated employee shall provide resident supervision and/or assistance during self-administration of medications in accordance with physicians' orders, or orders from a nurse practitioner/clinical nurse practitioner who has written joint protocols with a collaborating physician, in accordance with N.J.A.C. 13:37. Any employee who has been designated to provide resident supervision or assistance during self-administration of medications shall have received training from the health maintenance and monitoring nurse, the provider pharmacist, or the consultant pharmacist.

1. The facility shall document the provision of training to each employee who has been designated to provide resident supervision and/or assistance with self-administration of medications; and
2. The facility shall document any observed instance where medications are not taken in accordance with physician's orders.

(b) Self-administration of medications by residents shall be performed as follows:

1. By removing a dose from a previously dispensed, properly labeled container (including a unit dose container);
2. By verifying it with the directions on the label; and

3. By taking orally, injecting, inserting, or otherwise administering the medication.

8:43–10:2 Designation of a consultant pharmacist

(a) The facility shall designate a consultant pharmacist who shall be responsible for the direction, provision, and quality of pharmaceutical services. The consultant pharmacist may be the director of pharmaceutical services or pharmacist provider. The consultant pharmacist shall be responsible for, but not limited to, the following:

1. Training of employees;

2. Educating staff and residents regarding medications;

3. Establishing policies and procedures which ensure safe and appropriate self-administration of medications;

4. Drug regimen review; and

5. Inspecting all areas in the facility where medications are stored and maintaining records of such inspections.

(b) The consultant pharmacist shall be present in the facility at least quarterly and shall provide written reports to the administrator and to the health maintenance and monitoring nurse.

(c) If the facility fails to substantially comply with the requirements of this subchapter the Department may require a pharmacist be retained by the facility to assist in correcting the deficiencies in pharmaceutical services cited by the Department, in addition to the requirements at (b) above, and in addition to other enforcement actions. The facility shall retain the pharmacist until all deficiencies have been corrected.

8:43–10.3 Storage of medications

(a) The facility shall provide a medication storage area of sufficient size for the storage of all medications of residents, and shall assure that:

1. The storage area shall be conveniently located and adequately lighted;

2. The storage area shall be kept locked when not in use;

3. The storage area shall be used only for storage of medications and medical supplies;

4. The key to the storage area shall be kept on the person on duty responsible for resident supervision; and

5. Each resident's medications shall be kept separated in the storage area, with the exception of large volume medications which may be labeled and stored together in the storage area.

(b) If a resident is authorized through a written physician's order, or order from a nurse practitioner/clinical nurse practitioner who has written joint protocols with a collaborating physician, in accordance with N.J.A.C. 13:37 to store medications in such resident's room, the facility shall provide a secure locked area for storage of such medications which complies with the requirements for medication storage areas stated in (a)1 and 2 above. Exceptions for emergency medications to remain unlocked in the resident's room may be made with the approval of the consultant pharmacist.

(c) Medications shall be stored in accordance with manufacturer's instructions.

(d) Medications which require refrigeration shall be properly maintained. The refrigerator shall have a thermometer to indicate temperature in conformance with U.S.P. (United States Pharmacopeia) requirements. If medications are stored in a refrigerator in common with food, medications shall be stored in a container which is securely fastened to the refrigerator and locked.

(e) All medications shall be kept in their original containers and shall be properly labeled and identified.

1. The label of each resident's prescription medication container shall be permanently affixed and contain the resident's full name, physician's name, prescription number, name and strength of drug, directions for use, lot number, date of issue, expiration date, manufacturer's name if generic, and cautionary and/or accessory labels. If a generic substitute is used, the drug shall be labeled according to the Drug Utilization Review Council Formulary, N.J.A.C. 8:71 and N.J.S.A. 24:6E–1 et seq. Required information appearing on individually packaged drugs or within an alternate medication delivery system need not be repeated on the label.

2. All over-the-counter (OTC) medications repackaged by the pharmacy shall be labeled with an expiration date, name and strength of the drug, lot number, date of issue, manufacturer's name if generic, and cautionary and/or accessory labels. Original manufacturer's containers shall be labeled with at least the resident's name, and the name label shall not obstruct any of the aforementioned information.

3. If a unit dose drug distribution system is used, each dose of medication shall be individually packaged in a hermetically sealed, tamper-proof container, and shall carry full manufacturer's disclosure information on each discrete dose. Disclosure information shall include, but not be limited to, the following: product name and strength, directions for use, lot number, expiration date, and manufacturer's or distributor's name. ("Bingo" or punch card systems are not required to have each discrete dose labeled.)

(f) Single use and disposable items shall not be reused.

(g) No stock supply of prescription medications shall be maintained.

(h) Discontinued or expired medications shall be destroyed within 30 days, in the facility. All medication destruction in the facility shall be witnessed by two persons, each of whom shall be either the administrator, the licensed nurse or the consultant pharmacist.

SUBCHAPTER 11. RECREATIONAL SERVICES

8:43–11.1 Provision of recreational services

(a) A planned, diversified program of recreational activities shall be offered at least 6 days a week, including individual and/or group activities, on-site or off-site, to meet the needs of residents.

(b) A diversity of programs shall be available to maintain residents' sense of usefulness and self-respect, including at a minimum, on a monthly basis, the following:

1. Social, such as parties, club meetings, picnics, and other special events;

2. Physical, such as exercise, sports, dancing, and swimming;

3. Creative, educational and cultural, such as crafts, poetry, drama, music, art, gardening, discussion groups, and guest speaker programs;

4. Spiritual, such as religious services;

5. Awareness, including, for example, cognitive and sensory individual and group stimulation for residents; and

6. Community-integrating, such as 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.

(c) If the facility requires an exception from any of the categories of activities listed at (b)1 through 6 above, reasons for the exception, such as impracticability or lack of appropriateness or interest on the part of residents, shall be documented.

(d) Indoor and outdoor recreational activities shall be provided.

(e) Residents shall have the opportunity to organize and participate in a resident council that presents the resident's concerns to the administrator of the facility.

8:43–11.2 Administrator's responsibility for recreational services

(a) The administrator or the administrator's designee shall be responsible for the direction, provision, and quality of the recreational service. The administrator shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual and an organizational plan for the recreational service;

2. Ensuring that recreational services are provided and are coordinated with other resident care services to provide a continuum of care for the resident;

3. Assisting in developing and maintaining written job descriptions for recreational service personnel, and assigning duties based upon education, training, competencies, and job descriptions; and

4. Posting a current weekly recreational activities schedule where it can be read by residents and staff.

SUBCHAPTER 12. EMERGENCY SERVICES AND PROCEDURES

8:43–12.1 Emergency medical services

(a) The facility shall have a procedure to access all available emergency medical services.

(b) The facility shall have a written plan for arranging for emergency transportation of residents to another health care facility for care and returning them to the residential health care facility.

(c) The facility shall maintain first aid supplies to meet the emergency needs of the residents. The supplies shall be approved by the physician who is available for resident emergencies and reviewed by the provider pharmacist.

8:43–12.2 Emergency plans and procedures

(a) The facility shall develop written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of medical emergencies, power failures, fire, or natural disasters. The emergency plans shall be filed with the Department of Health and the Department shall be notified when the plans are changed. Copies of emergency plans shall also be forwarded to both municipal and county emergency management officials for their review.

(b) The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter.

(c) Procedures for emergencies shall specify persons to be notified, process of notification and verification of notification, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating residents, procedures for reentry and recovery, frequency of fire drills, tasks and responsibilities assigned to all personnel, and shall specify medications and records to be taken from the facility upon evacuation and to be returned following the emergency.

8:43–12.3 Drills and tests

(a) The facility shall conduct at least one drill of the emergency plans every month, of which at least one annually shall take place during every working shift. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall be assigned to participate in at least one drill annually, and selected residents may participate in drills.

(b) The facility shall request of the local fire department that at least one joint fire drill be conducted annually. Upon scheduling a joint fire drill, the facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills.

(c) The facility shall test at least one manual pull alarm each month of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

(d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

SUBCHAPTER 13. RESIDENT RECORDS

8:43–13.1 Maintenance of resident records

(a) A current, complete record shall be maintained for each resident.

(b) Records and information regarding the individual resident shall be considered confidential and the resident shall have the opportunity to examine such records, in accordance with facility policies. The written consent of the resident shall be obtained for release of his or her records to any individual not associated with the facility, except in the case of the resident's transfer to another health care facility, or as required by law, third-party payor, or authorized government agencies.

(c) All resident records shall be maintained for a period of 10 years after the discharge of a resident from the home.

(d) The following records shall be maintained and shall be kept available on the premises for review at any time by representatives of the Department of Health:

1. A register which contains a current census of all residents, along with other pertinent information shall be maintained by each residential health care facility. The following standards for maintaining the register shall apply:

i. The administrator or the administrator's designee shall make all entries in the register and shall be responsible for its maintenance and safe-keeping;

ii. The register shall be kept up-to-date at all times. Admissions, discharges and discharge destination, and other changes shall be recorded within 24 hours;

iii. The register, which is a permanent record, shall be kept in a safe place, in a fire-resistant container; and

iv. All entries into the register shall be clear, legible, and written in ink or typed.

2. Each resident's record shall include at least the following:

i. The resident's completed admission application and all records forwarded to the facility;

ii. The resident's name, last address, date of birth, name and address of sponsor or interested agency, date of admission, date of discharge (and discharge destination) or death, the name, address and telephone number of physician to be called, and the name and address of nearest relative, guardian, responsible person, or interested agency, documentation of the existence or nonexistence of an advance directive and the facility's inquiry of the resident concerning this, together with any other information the resident wishes to have recorded;

iii. A statement by a physician of the individual's suitability for admission to the facility, as specified in N.J.A.C. 8:43–4.12(c). The administrator or the administrator's designee shall be responsible for having the certification properly completed and signed by a physician. When first contact is made regarding the placement of an individual in the facility, the administrator or the administrator's designee shall inform the individual making the inquiry that the medical certification must be completed before admission;

iv. Whenever a resident dies in the residential health care facility, the administrator or the administrator's designee shall include written documentation from the physician of the date and time of death, the name of the person who pronounced the death, disposition of the body, and a record of notification of the family;

v. A complete record of physicians' or nurse practitioner/certified nurse specialist visits, as known by the facility, including dates and physician's or NP/CNS comments if applicable; and

vi. Annual nursing assessments and nurse's health monitoring and maintenance notes, entered in accordance with N.J.A.C. 8:43–9.2 or more frequently based on individual resident's needs.

SUBCHAPTER 14. RESIDENT RIGHTS

8:43–14.1 Policies and procedures regarding resident rights

(a) The facility shall establish and implement written policies regarding the rights and responsibilities of residents, and shall be responsible for developing and adhering to procedures implementing such policies. These policies and procedures and a copy of N.J.S.A. 55:13B–17 et seq. shall be given to residents and their next of kin and/or sponsors and/or guardians, and to each member of the facility's staff. These policies and procedures and N.J.S.A. 55:13B–17 et seq. shall also be conspicuously posted in the facility.

(b) Each employee of the facility, upon employment, shall receive inservice education concerning the implementation of policies and procedures regarding resident rights.

(c) The facility shall comply with all applicable State and Federal statutes, rules, and regulations concerning resident rights, including N.J.S.A. 52:27G–7.1 et seq. and Chapter 500, P.L. 1979, N.J.S.A. 55:13B–17 et seq.

(d) Any suspected case of resident abuse or exploitation shall be reported to the county welfare agency, in accordance with P.L. 1979, c.469, the Rooming and Boarding House Act of 1979. If the resident is 60 years of age or older, the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly shall also be notified, pursuant to N.J.S.A. 52:27G–7.1 et seq.

8:43–14.2 Rights of each resident

(a) Resident rights, policies, and procedures shall ensure that, as a minimum, each resident admitted to the facility:

1. Is informed of these rights, as evidenced by his or her written acknowledgment, and is given a statement of these rights and the facility's rules and regulations, and an explanation of the resident's responsibility to adhere to all regulations of the facility and to respect the personal rights and private property of other residents;

2. Is informed, and is given a written statement prior to or at the time of admission and during stay, as documented in the resident's record, of services available in the facility and of all charges including room, board, laundry, and personal services, and is given written notification at least 30 days prior to any change in charges. This statement shall include the payment, fee, deposit, and refund policy of the facility;

3. Is allowed to retain the services of his or her personal physician at his or her own expense or under a third-party payment system; is assured of assistance in obtaining medical care, may refuse medication and treatment, after being informed of the effects of such actions; and may refuse to participate in research projects (but if the resident chooses to participate, his or her informed written consent shall be obtained);

4. Is, except in the case of an emergency, transferred or discharged only for medical reasons or for his/her welfare or that of other residents upon the written order of the resident's physician, who shall document the reason for the transfer or discharge in the resident's record, or for nonpayment for the resident's stay, or for repeated violations of the facility's written rules and regulations after being advised of them in writing, if required by the Department, or 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., as specified in N.J.A.C. 8:43–4.16;

i. If a transfer or discharge on a non-emergency basis is requested by the facility, the resident or, in the case of an adjudicated mentally incompetent resident, the next of kin and/or sponsor and/or guardian, shall be given at least 30 days advance notice in writing of such transfer or discharge;

5. Is encouraged and assisted, throughout the period of stay, to exercise rights as a resident and as a citizen, and to this end may voice grievance on behalf of himself or herself or others, initiate action for damages or other relief for deprivations or infringements of the right to treatment and care established by any applicable statute, rule, regulation, or contract, and recommend changes in policies and services to facility personnel and/or to outside representatives of the resident's choice, free from restraint, interference, coercion, discrimination, or reprisal.

i. The administrator shall provide all residents and/or next of kin and/or sponsors and/or guardians with the following names, addresses, and telephone numbers where complaints may be lodged:

Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, N.J. 08625
Telephone: (800) 792–9770 and
State of New Jersey
Office of the Ombudsman for the Institutionalized Elderly
CN 808
Trenton, N.J. 08625
Telephone: (800) 624–4262

ii. These telephone numbers shall be conspicuously posted in the facility at every public telephone and on all bulletin boards used for posting public notices. The facility shall also conspicuously post the name, address, and telephone number of the county welfare agency and the county office on aging.

6. Is free from mental and physical abuse, free from exploitation, in accordance with N.J.S.A. 52:27G–7.1, and free from chemical and physical restraints. Drugs and other medication shall not be used for punishment, for convenience of facility personnel, or in quantities that interfere with a resident's living activities;

7. Is allowed to keep and use his or her personal property, including at least clothing and personal possessions used on a daily basis, unless this would be unsafe, impractical, or an infringement on the rights of other residents. The residential health care facility must provide reasonable protection of the resident's personal possessions from theft, loss, and misplacement;

8. Is assured confidential treatment of his or her personal and health and social records and has the opportunity to examine such records. The written consent of the resident shall be obtained for release of his or her records to any individual outside the facility, except in the case of the resident's transfer to another health care facility, or as required by law or third-party payor;

9. Is treated with consideration, respect, and full recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, privacy concerning his or her treatment and condition and the care of his or her personal needs. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance;

10. Is not required to perform services for the facility. If the resident volunteers to perform services for the facility, the resident shall receive supervision;

11. May associate and communicate privately with persons of his or her choice, may have reasonable opportunities for private and intimate physical and social interaction with other people, may join with other residents or individuals within or outside the facility to work for improvements in resident care, may send and receive personal mail unopened, and upon his or her request, shall be given assistance in the reading and writing of correspondence;

i. The facility shall, with the consent of the resident being visited, permit visitors, legal services representatives, employees of the Department of the Public Advocate, employees and volunteers of the Office of the Ombudsman for the Institutionalized Elderly in the Department of Community Affairs, representatives of governmental welfare and social agencies, and all governmental representatives full and free access at a reasonable hour to the facility in order to visit with, and make personal, social and legal services available to all residents;

12. May participate in facility activities, and meet with, and participate in activities of social, religious, and community groups at his/her discretion; and has the opportunity for physical exercise and the opportunity to be outdoors;

13. Is allowed to leave the facility. If the resident's absence is medically contraindicated, the physician or other appropriate person(s) shall be notified in the event that the resident leaves the facility;

14. May retain and use personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except where the facility can demonstrate that such would be unsafe, impractical to do so, infringes upon the rights of others and that mere convenience is not the facility's motive to restrict this right. If the resident has property on deposit with the facility, he or she shall have daily access to such property during specific periods established by the facility, and at a reasonable hour;

15. Has the right to unrestricted communication, including personal visitation with any person of his or her choice during visiting hours, which must be set at reasonable times and for no less than 12 hours per day. The facility shall develop policies specifying times when visits are allowed and shall conspicuously post its visiting hours;

16. The facility shall develop policies and procedures so that the resident is allowed visits from his or her next of kin and/or sponsor and/or guardian at any time, if ill. Members of the clergy shall be notified by the facility at the resident's request, and shall be admitted at the request of the resident and/or next of kin and/or sponsor and/or guardian at any time. Privacy shall be ensured for visits with his or her family, friends, clergy, social workers, attorney, counselor, advocates, or for professional or business purposes;

17. Is allowed unaccompanied access to telephones, in the facility, at a reasonable hour, both to make and to receive confidential calls, and has the right to a private telephone at his or her expense. If the facility provides telephones which are not coin-operated, the resident shall be charged no more than the actual cost of the call, except that an access fee no greater than the charge for a local call on a coin-operated telephone may be charged;

18. Is not required to go to bed and has the right to be outside his or her bedroom;

19. Is allowed, or his or her next of kin and/or sponsor and/or guardian and/or conservator, as defined in N.J.S.A. 3B:13A–1 through 13A–36, Laws of 1983, Chapter 192, is allowed, to manage the resident's personal financial affairs, or is given at least a quarterly written statement of financial transactions made on his or her behalf, should

the facility accept his or her written delegation of this responsibility.

i. The written delegation of responsibility shall be witnessed by a person who is unconnected with the facility, its operations, and its personnel, and shall be included in the resident's record;

ii. The financial statement shall account for all the resident's property on deposit at the beginning of the quarter, all deposits and withdrawals transacted during the quarter (substantiated by receipts given to the resident or his or her next of kin and/or sponsor and/or guardian), and the property on deposit at the end of the quarter;

iii. The facility shall maintain a monthly written record for each resident who receives Social Security Administration (SSA) and/or Supplemental Security Income (SSI) checks. The written record shall include the resident's name, the date and amount of each check, the date and amount of each disbursement, the reasons for each disbursement, and to whom each disbursement was made;

iv. Each resident residing in a residential health care facility who receives benefits generated from the Home Energy Assistance Program shall not be required to provide the owner, operator, employee, or their representative with any portion of monies provided through the Home Energy Assistance Program. No owner, operator, employee, or representative of the facility shall coerce, intimidate, or exploit residents into providing them with any portion of their home energy assistance checks;

20. Is assured of exercising civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any resident or facility. Knowledge of available choices shall not be infringed upon and the facility shall encourage and assist in the exercise of these rights. Arrangements shall be made, at the resident's expense, for attendance at religious services of his or her choice when requested;

21. Is not the object of discrimination with respect to participation in recreational activities, meals, or other social functions. The resident's participation may be restricted or prohibited if recommended by the resident's physician in the resident's record, and consented to by the resident;

22. Is not deprived of any constitutional, civil, and/or legal rights solely by reason of admission to the facility. Such rights shall include, but not be limited to, the right to gainful employment, to move to a different living arrangement, to wear his or her own clothing, and to determine his or her own dress, hair style, and other personal choices according to individual preference; and

23. Is allowed to discharge himself or herself from the facility upon presentation of a written notice to the administrator and, in the case of an adjudicated mentally incompetent resident, upon the written consent of his or her next of kin and/or sponsor and/or guardian.

SUBCHAPTER 15. HOUSEKEEPING, SANITATION, SAFETY AND MAINTENANCE

8:43–15.1 Provision of housekeeping, sanitation, safety and maintenance

(a) The facility shall provide and maintain a sanitary and safe environment for residents, in accordance with the requirements of Chapter 12 of the New Jersey Sanitary Code, N.J.A.C. 8:24.

(b) The facility shall provide housekeeping, laundry, pest control, and maintenance services.

(c) Written objectives, policies, a procedure manual, and an organizational plan for housekeeping, sanitation, safety, laundry and maintenance services shall be developed and implemented.

8:43–15.2 Housekeeping

(a) A written work plan for housekeeping operations shall be established and implemented, with categorization of cleaning assignments as daily, weekly, monthly, or annually within each area of the facility.

(b) Procedures shall be developed for selection and use of housekeeping and cleaning products and equipment.

(c) Housekeeping personnel shall be trained in cleaning procedures within the scope of their responsibility, including the use, cleaning and care of equipment.

8:43–15.3 Resident environment

(a) The following housekeeping and sanitation conditions shall be met:

1. The facility and its contents, including all environmental surfaces, shall be clean to sight and touch and free of dirt and debris;

2. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors;

3. All resident areas shall be free of noxious odors;

4. All facility furnishings shall be clean and in good repair, and facility mechanical equipment shall be in working order. Broken or worn items shall be repaired, replaced, or removed promptly;

5. All equipment and materials necessary for cleaning, disinfecting, sanitizing, and sterilizing (if applicable) shall be provided;

6. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration, in accordance with Chapter 12 of the New Jersey Sanitary Code, N.J.A.C. 8:24;

7. Sufficient and adequately lighted storage space shall be provided in the facility for the proper storage of residents' clothing, linens, drugs, food, cleaning and other supplies;

8. Articles in storage shall be elevated from the floor and away from walls (if moisture is present), ceilings, and air vents;

9. Unobstructed aisles shall be provided in storage areas;

10. Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility. The premises shall be kept in such condition as to prevent the breeding, harborage, or feeding of vermin. All openings to the outer air shall be effectively protected against the entrance of insects;

11. Items that come in contact with open skin or mucous membranes shall be sterilized or, at a minimum, receive high level disinfection;

12. Items that come in contact with intact skin, such as bedpans, toilets and sinks, shall be disinfected, using a process for disinfection established by the facility as specified above, at N.J.A.C. 8:43–15.2; and

13. Toilet tissue, soap, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times. Residents' personal cloth towels may be used in private or semi-private bathrooms. A self-draining dish or device shall be provided for storage of bar soap, if bar soap is used.

(b) The following safety conditions shall be met:

1. Scatter rugs shall not be permitted, except that residents may have the option to use scatter rugs which have non-skid backing in individual resident bedrooms. The facility shall ensure that scatter rugs are only used in a manner that does not jeopardize resident safety. Floors shall be coated with slip-resistant floor finish. Carpeting shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled;

2. Pesticides shall be applied in accordance with N.J.A.C. 7:30;

3. All household, cleaning and personal care products in the facility shall be identified and labeled. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room. The facility shall ensure that all household and cleaning products in a resident's possession are stored in the resident's locked room or other secure location. The telephone number of the poison control center shall be conspicuously posted in the facility;

4. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater;

5. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in accordance with fire safety requirements specified at Table 313.1.4.1 of BOCA National Building Code;

6. Wastebaskets and ashtrays shall be made of non-combustible materials;

7. If pets are allowed in the facility, the facility shall provide safeguards to prevent interference in the lives of residents as required by N.J.A.C. 8:43–6.1(a), and the facility should comply with guidelines for pet facilitated therapy issued by the Veterinary Public Health Program of the New Jersey State Department of Health; (Appendix E)

8. The use of open fireplaces shall be restricted to the living and recreation rooms of the building;

i. When a fireplace is in use it shall be protected by a metal screen or glass enclosure;

ii. When a fireplace is in use it shall be under the supervision of a responsible employee;

iii. All ashes shall be kept in metal containers;

9. A licensed electrician or an independent inspection agency approved by the State of New Jersey shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory and in safe condition;

i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are U.L. approved;

ii. The written statement shall be forwarded annually to the New Jersey Department of Health, Division of Health Facilities Evaluation; and

10. All partitions in the basement shall be constructed of non-combustible material.

8:43–15.4 Waste removal

(a) All solid or liquid waste which is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health. Solid waste shall be stored in insectproof, rodentproof, fireproof, nonabsorbent, watertight containers with tightfitting covers and collected from storage areas regularly so as to prevent nuisances such

as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24.

(b) Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system.

(c) Plastic bags shall be used for solid waste removal. Plastic bags used for solid waste removal 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.

8:43–15.5 Heating and air conditioning

(a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. When the heating system is used, the temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) during the day ("day" means the time between sunrise and sunset) and 68 degrees Fahrenheit (20 degrees Celsius) at night, when residents are in the facility.

1. Filters for heaters and air conditioners shall be provided and maintained in accordance with manufacturer's specifications.

2. Tanks for all new installations of oil furnaces or other equipment shall be located outside the building. Previously installed oil storage tanks shall have the vent pipe and fill pipe located outside the building.

3. An identifiable electrical emergency shut-off switch shall be provided, on the first floor, for any oil burner.

4. Portable heaters shall not be permitted.

(b) During warm weather conditions, the temperature of the facility shall not exceed 82 degrees Fahrenheit.

1. 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. The facility shall provide for and operate adequate ventilation in all areas used by residents.

2. Beginning January 1, 1994, or subsequent date as determined by the Commissioner, if the conditions of N.J.S.A. 26:2H–14.3 are met, 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. Notice of the operative date in this paragraph shall be provided in the New Jersey Register by the Commissioner.

8:43–15.6 Water supply

(a) The water supply used for drinking or culinary purposes shall be adequate in quantity, of a safe and 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 Potable Water, CN 209, Trenton, New Jersey 08625.

(b) There shall be no back-siphonage conditions present.

(c) 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.

(d) The temperature of the hot water used for bathing and handwashing shall be maintained between 95 degrees and 110 degrees Fahrenheit (35 to 43 degrees Celsius).

(e) Equipment requiring drainage, such as ice machines, shall be drained to a sanitary connection.

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

Case Notes

The Department of Health was authorized to assess penalty against residential health care facility; maximum hot water temperature regulation violated. Health Care Facilities Evaluation v. The Montclair Plaza. 92 N.J.A.R.2d (HLT) 17.

8:43–15.7 Building and grounds maintenance

(a) The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to residents' health and safety.

(b) A written work schedule for building and grounds maintenance operations shall be established and implemented, with categorization of maintenance assignments as daily, weekly, monthly, or annually within each area of the facility and the grounds.

8:43–15.8 Laundry services

(a) Written policies and procedures shall be established and implemented for the facility's laundry services, including, but not limited to, policies and procedures regarding the following:

1. The storage and transportation of laundry;

2. Collection and storage of soiled laundry in a ventilated area;

3. Protection of clean laundry from contamination during processing, transporting, and storage; and

4. Handling and laundering of residents' clothing and personal items separately from other laundry.

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

(c) All soiled laundry from resident rooms and other service areas 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.

(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. An established procedure shall be followed to reduce the number of bacteria in the fabrics. Equipment or surfaces such as tables that come into contact with soiled laundry shall be sanitized after use.

(f) Residents who choose to launder their personal items shall be provided with in-house assistance and resident supervision, as required, in accordance with a schedule developed by the facility which will allow such residents access at a reasonable hour.

(g) If the facility provides an on-premises laundry in lieu of using a commercial laundry service, it shall provide a receiving, holding, and sorting area with hand-washing facilities in close proximity. The walls, floors, and ceilings of the area shall be clean and in good repair. Ventilation shall be adequate to prevent heat and odor buildup. If a structural change is required by this rule, the facility shall demonstrate an alternate system to meet the intended requirements of all subsections of this rule.

SUBCHAPTER 16. INFECTION PREVENTION AND CONTROL SERVICES

8:43–16.1 Infection control program

(a) The facility shall develop and implement an infection prevention and control program.

(b) The health maintenance and monitoring nurse, in coordination with the administrator, shall be responsible for the direction, provision, and quality of infection prevention and control services. The health maintenance and monitoring nurse, in coordination with the administrator, shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, and an organizational plan for the infection prevention and control service.

8:43–16.2 Development of infection control policies and procedures

(a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications:

1. Guideline for Handwashing and Hospital Environmental Control; and

2. Infection control practices, including universal precautions, in accordance with the Occupational Safety and Health Administration (OSHA) rule, 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne pathogens.

NOTE: Centers for Disease Control 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

8:43–16.3 General infection control policies and procedures

(a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following:

1. In accordance with Chapter II, New Jersey State Sanitary Code, N.J.A.C. 8:57, a system for investigating, reporting and evaluating the occurrence of all infections or diseases which are reportable or conditions which may be related to activities and procedures of the facility, and maintaining records for all residents or personnel having these infections, diseases, or conditions (see Appendix D);

2. Infection control and isolation, in accordance with the Occupational Safety and Health Administration (OSHA) rule 29, CFR part 1910.1030, Occupational Exposure to Bloodborne Pathogens;

3. Exclusion from work, and authorization to return to work, for personnel with communicable diseases;

4. Surveillance techniques to minimize sources and transmission of infection;

5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident;

6. Protocols for identification of residents with communicable diseases and education of residents regarding prevention and spread of communicable diseases;

7. Where applicable, cleaning, sterilization and disinfection practices and techniques used in the facility, including, but not limited to, the following:

i. Care of utensils, instruments, solutions, dressings, articles, and surfaces;

ii. Selection, storage, use, and disposition of disposable and nondisposable resident care items. Disposable items shall not be reused;

iii. Methods to ensure that sterilized materials are packaged, labeled, processed, transported, and stored to maintain sterility and to permit identification of expiration dates; and

iv. Care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices and equipment that provide a portal of entry for pathogenic microorganisms; and

(b) High-level disinfection techniques approved by the New Jersey State Department of Health shall be used for all reusable respiratory therapy equipment and instruments that touch mucous membranes.

(c) Disinfection procedures for items that come in contact with bedpans, sinks, and toilets shall conform with established protocols for cleaning and disinfection.

(d) Personnel who have had contact with resident excretions, secretions, or blood, whether directly or indirectly, in activities such as performing a physical examination, providing catheter care, and emptying bedpans, shall wash their hands with soap and warm water for between 10 and 30 seconds or use other effective hand sanitation techniques immediately after such contact.

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

(f) Needles and syringes used by residents as part of home self-care shall be destroyed in accordance with N.J.S.A. 2A:170–25.17, and amendments thereto, and shall then be placed in a puncture-resistive container prior to disposal.

8:43–16.4 Employee health and resident policies and procedures for infection prevention and control

(a) 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 tuberculin 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 and shall be excluded from work until the physician provides written approval to return.

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

(c) The facility shall assure that all current employees who have not received the Mantoux test upon employment, except those exempted by (a) above, shall receive a test within three months of the effective date of this rule. The facility shall act on the results of tests of current employees in the same manner as prescribed in (a) above.

(d) The facility shall report annually the results of all tuberculin testing of personnel, on forms provided by the Department of Health, Division of Epidemiology, Tuberculosis Program, in accordance with N.J.A.C. 8:57, Communicable Diseases.

(e) 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.

(f) If a communicable disease prevents the employee from working for a period of more than three days, a physician's statement approving the employee's return shall be required prior to the employee's return to work.

(g) 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.

(h) The facility shall maintain records documenting contagious diseases contracted by employees during employment.

(i) The facility shall maintain listings of all residents and personnel who have infections, diseases, or conditions which are reportable to the Department pursuant to Chapter II, New Jersey State Sanitary Code, N.J.A.C. 8:57, unless prohibited by Federal or state law.

(j) 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.

(k) The health maintenance and monitoring nurse shall perform at least monthly checks of handwashing practices throughout the facility.

8:43–16.5 Staff education and training for infection prevention and control

All employees shall be informed about the facility's infection control procedures, including personal hygiene requirements.

8:43–16.6 Regulated medical waste

(a) Regulated medical waste shall be collected, stored, handled, and disposed of in accordance with applicable Federal and State laws and regulations.

(b) 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.

APPENDIX A

A Daily Food Guide

MEAT GROUP

Foods included: Beef; veal; lamb; pork; variety meats, such as liver, heart, kidney. Poultry and eggs. Fish and shellfish. As alternates—dry beans, dry peas, lentils, nuts, peanuts, peanut butter.

Amounts Recommended: Choose 2 or more servings every day. Count as a serving: 2 to 3 ounces of lean cooked meat, poultry or fish—all without bone; 1 egg, ½ cup cooked dry beans, dry peas, or lentils; 2 tablespoons peanut butter may replace one-half serving of meat.

VEGETABLE–FRUIT GROUP

Foods Included: All vegetables and fruits. This guide emphasizes those that are valuable as sources of vitamin C and vitamin A.

Sources of Vitamin C: Good sources—Grapefruit or grapefruit juice; orange or orange juice; cantaloupe; guava; mango; papaya; raw strawberries; broccoli; Brussels sprouts; green pepper; sweet red pepper. Fair sources—Honeydew melon; lemon; tangerine or tangerine juice; watermelon; asparagus tips; raw cabbage; collards; garden cress; kale; kohlrabi; mustard greens; potatoes and sweet potatoes cooked in the jacket; spinach; tomatoes or tomato juice; turnip greens.

Sources of Vitamin A: Dark-green and deep-yellow vegetables and a few fruits, namely: Apricots, broccoli, cantaloupe, carrots, chard, collards, cress, kale, mango, persimmon, pumpkin, spinach, sweet potatoes, turnip greens and other dark-green leaves, winter squash.

Amounts Recommended: Choose 4 or more servings each day, including: 1 serving of a good source of vitamin C or 2 servings of a fair source. 1 serving, at least every other day, of a good source of vitamin A. If the food for chosen vitamin C is also a good source of vitamin A, the additional serving of a Vitamin A food may be omitted.

The remaining 1 to 3 or more servings may be of any vegetable or fruit, including those that are valuable for vitamin C and for vitamin A.

Count as 1 serving: ½ cup of vegetable or fruit; or a portion as ordinarily served, such as 1 medium apple, banana, orange, or potato, half a medium grapefruit or cantaloupe, or the juice of 1 lemon.

MILK GROUP

Foods Included: Milk—fluid whole, evaporated, skim, dry, buttermilk. Cheese—cottage; cream; Cheddar-type, natural or process. Ice cream.

Amounts Recommended: Some milk every day for everyone.

Recommended amounts are given below in terms of 8–ounce cups of whole fluid milk:

Children under 9	2 or 3
Children 9 to 12	3 or more
Teenagers	4 or more
Adults	2 or more
Pregnant women	3 or more
Nursing mothers	4 or more

Part or all of the milk may be fluid skim milk, buttermilk, evaporated milk, or dry milk.

Cheese and ice cream may replace part of the milk. The amount of either it will take to replace a given amount of milk is figured on the basis of calcium content. Common portions of cheese and of ice cream and their milk equivalents in calcium are:

1–inch cube Cheddar-type cheese	½ cup milk

½ cup cottage cheese	⅛ cup milk
2 tablespoons cream cheese	1 tablespoon milk
½ cup ice cream	¼ cup milk

BREAD–CEREAL GROUP

Foods Included: All breads and cereals that are whole grain, enriched, or restored; check labels to be sure. Specifically, this group includes: Breads; cooked cereals; ready-to-eat cereals; cornmeal; crackers; flour; grits; macaroni and spaghetti; noodles; rice; rolled oats; and quick breads and other baked goods if made with whole-grain or enriched flour. Bulgur and par-boiled rice and wheat also may be included in this group.

Amounts Recommended: Choose 4 servings or more daily. Or, if no cereals are chosen, have an extra serving of breads or baked goods, which will make at least 5 servings from this group daily.

Count as 1 serving: 1 slice of bread; 1 ounce ready-to-eat cereal; ½ to ¾ cup cooked cereal, cornmeal, grits, macaroni, noodles, rice or spaghetti.

OTHER FOODS

To round out meals and meet energy needs, almost everyone will use some foods not specified in the four food groups. Such foods include: unenriched, refined breads, cereals, flours; sugars; butter, margarine, other fats. These often are ingredients in a recipe or added to other foods during preparation or at the table.

Try to include some vegetable oil among the fats used.

INTRODUCTION

Food alone cannot make anyone healthy. Good health also depends on heredity, environment, and health care, that is, exercise, habits, smoking, etc. affect health status. Lifestyle is also important to health. But a diet based on these guidelines can help promote good health.

When planning your facility's menu incorporate the following Dietary Guidelines for Americans.

1. Serve a variety of foods.

2. Prepare a diet moderately low in fat, saturated fat and cholesterol.

3. Offer a diet with plenty of vegetables, fruits and whole grain products.

4. Use salt and sodium in moderation when preparing foods.

5. Offer foods high in sugars in moderation.

#1 EAT A VARIETY OF FOODS

These guidelines call for moderation avoiding extremes in diet. More than 40 different nutrients are essential for good health. Essential nutrients include vitamins, minerals, amino acids from protein, certain fatty acids from fat, and sources of calories (protein, carbohydrates, and fat). These nutrients should come from a variety of foods, not from a few highly fortified foods or supplements. Any food that supplies calories and nutrients can be part of a nutritious diet. The content of the total diet over a day or more is what counts.

Many foods are good sources of several nutrients. For example, vegetables and fruits are important for Vitamins A and C, folic acid, minerals, and fiber. Breads and cereals supply B vitamins, iron, and protein; whole-grain types are also good sources of fiber. Milk provides protein, B vitamins, vitamins A and D, calcium, and phosphorus. Meat, poultry, and fish provide protein, B vitamins, iron and zinc.

No single food can supply all nutrients in the amounts needed. For example, milk supplies calcium but little iron; meat supplies iron but little calcium. Diets should be adjusted to meet individual factors and needs such as healthy weight, cholesterol and blood pressure levels, etc. For a nutritious diet, consume a variety of foods.

#2 CHOOSE A DIET LOW IN FAT, SATURATED FAT AND CHOLESTEROL

Most health authorities recommend an American diet with less fat, saturated fat, and cholesterol. Populations like ours with diets high in fat have more obesity and certain types of cancer. The higher levels of saturated fat and cholesterol in our diets are linked to our increased risk for heart disease.

A diet low in fat makes it easier to include the variety of foods you need for nutrients without exceeding calorie needs because fat contains over twice the calories of an equal amount of carbohydrates or protein. A diet low in saturated fat and cholesterol can help maintain a desirable level of blood cholesterol. For adults this level is below 200 mg/dl. As blood cholesterol increases above this level, greater risk for heart disease occurs. Risk can also be increased by high blood pressure, cigarette smoking, diabetes, a family history of premature heart disease, obesity, and being a male.

The way diet affects blood cholesterol varies among individuals. However, blood cholesterol does increase in most people when they eat a diet high in saturated fat and cholesterol and excessive in calories. Of these, dietary saturated fat has the greatest effect; dietary cholesterol has less.

Total fat. An amount that provides 30 percent or less of calories is suggested. Thus, the upper limit on the grams of fat in the diet depends on the calories needed. For example, at 2,000 calories per day, your suggested upper limit is 600 calories from fat (2,000 x .30). This is equal to 67 grams of fat (600–9, the number of calories each gram of fat provides).

Saturated fat. An amount that provides less than 10 percent of calories (less than 22 grams at 2,000 calories per day) is suggested. All fats contain both saturated and unsaturated fat (fatty acids). The fats in animal products are the main sources of saturated fat in most diets, with tropical oils (coconut, palm kernel, and palm oils) and hydrogenated fats providing smaller amounts.

Cholesterol. Animal products are the source of all dietary cholesterol. Eating less fat from animal sources will help lower cholesterol as well as total fat and saturated fat in your diet.

FOR A DIET LOW IN FAT, SATURATED FAT, AND CHOLESTEROL

- Use fats and oils sparingly in cooking.

- Use small amounts of salad dressings and spreads, such as butter, margarine, and mayonnaise. One tablespoon of most of these spreads provides 10 to 11 grams of fat.

- Choose liquid vegetable oils most often because they are lower in saturated fat.

- Check labels on foods to see how much fat and saturated fat are in a serving.

- Choose lean meat, poultry, fish, dry beans, and eggs as protein sources.

CHOOSE A DIET WITH PLENTY OF VEGETABLES, FRUITS AND GRAIN PRODUCTS

This guideline recommends that adults eat at least three servings of vegetables and two servings of fruits daily. It recommends at least six servings of grain products, such as breads, cereals, pasta, and rice, with an emphasis on whole grains.

Vegetables, fruits and grain products are emphasized in this guideline especially for their complex carbohydrates, dietary fiber, and other food components linked to good health.

These foods are generally low in fats. By choosing the suggested amounts of them, you are likely to increase carbohydrates and dietary fiber and decrease fat in the diet, as health authorities suggest.

Complex carbohydrates, such as starches, are in breads, cereals, pasta, rice, dry beans and peas, and other vegetables, such as potatoes and corn. Dietary fiber—a part of plant foods—is in whole-grain breads and cereals, dry beans and peas, vegetables, and fruits. It is best to eat a variety of these fiber-rich foods because they differ in the kinds of fiber they contain.

Eating foods with fiber is important for proper bowel function and can reduce symptoms of chronic constipation, diverticular disease, and hemorrhoids. Populations like ours with diets low in dietary fiber and complex carbohydrates and high in fat, especially saturated fat, tend to have more heart disease, obesity, and some cancers. Just how dietary fiber is involved is not yet clear.

Some of the benefit from a higher fiber diet may be from the food that provides the fiber, not from fiber alone. For this reason, it's best to get fiber from foods rather than from supplements. In addition, excessive use of fiber supplements is associated with greater risk for intestinal problems and lower absorption of some minerals.

Advice for today: Eat more vegetables, including dry beans and peas; fruits; and breads, cereals, pasta, and rice. Increase your fiber intake by eating more of a variety of foods that contain fiber naturally.

USE SALT AND SODIUM ONLY IN MODERATION

Table salt contains sodium and chloride—both are essential in the diet. However, most Americans eat more salt and sodium than they need. Food and beverages containing salt provide most of the sodium in our diets, much of it added during processing and manufacturing.

In populations with diets low in salt, high blood pressure is less common than in populations with diets high in salt. Other factors that affect blood pressure are heredity, obesity, and excessive drinking of alcoholic beverages.

In the United States, about one in three adults has high blood pressure. If these people restrict their salt and sodium, usually their blood pressure will fall.

- Use salt sparingly, if at all, in cooking and at the table.

- When planning meals, consider that:

—fresh and plain frozen vegetables prepared without salt are lower in sodium than canned ones.

—cereals, pasta, and rice cooked without salt are lower in sodium than ready-to-eat cereals.

—milk and yogurt are lower in sodium than most cheeses.

—fresh meat, poultry, and fish are lower in sodium than most canned and processed ones.

—most frozen dinners and combination dishes, packaged mixes, canned soups, and salad dressings contain a considerable amount of sodium.

—so do condiments, such as soy and other sauces, pickles, olives, catsup, and mustard.

● Use salted snacks, such as chips, crackers, pretzels, and nuts, sparingly.

● Check labels for the amount of sodium in foods. Choose those lower in sodium most of the time.

USE SUGARS ONLY IN MODERATION

Americans eat sugars in many forms. Sugars provide calories and most people like their taste. Some serve as natural preservatives, thickeners, and baking aids in foods. This guideline cautions about eating sugars in large amounts and about frequent snacks of foods containing sugars and starches.

Sugars and many foods that contain them in large amounts supply calories but are limited in nutrients. Thus, they should be used in moderation by most healthy people and sparingly by people with low calorie needs. Both sugars and starches—which break down into sugars—can contribute to tooth decay. Sugars and starches are in many foods that also supply nutrients—milk; fruits; some vegetables; and breads, cereals, and other foods with sugars and starches as ingredients.

Adapted from Nutrition and Your Health: Dietary Guidelines for Americans; Third Edition, 1990: U.S. Department of Agriculture, U.S. Department of Health and Human Services.

ACKNOWLEDGMENTS

The U.S. Department of Agriculture and the U.S. Department of Health and Human Services acknowledge the recommendations of the Dietary Guidelines Advisory Committee—the basis for this edition. The Committee consisted of Malden C. Nesheim, Ph.D. (chairman); Lewis A. Barness, M.D.; Peggy R. Borum, Ph.D.; C. Wayne Callaway, M.D.; John C. LaRosa, M.D.; Charles S. Lieber, M.D.; John A. Milner, Ph.D.; Rebecca M. Mullis, Ph.D.; and Barbara O. Schneeman, Ph.D.

APPENDIX B. Resident Assessment

Resident Assessment

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
BACKGROUND INFORMATION/INTAKE AT ADMISSION

I. IDENTIFICATION INFORMATION

1	RESIDENT NAME	(First) (Middle Initial) (Last)
2	DATE OF CURRENT ADMISSION	Month Day Year
3	MEDICARE NO. (SOC. SEC or Comparable No. if no Medicare No.)	
4	FACILITY PROVIDER NO.	Federal No.
5	GENDER	1 Male 2. Female
6	RACE/ ETHNICITY	1. American Indian/Alaska Native 2 Asian/Pacific Islander 3. Black, not of Hispanic origin 4 Hispanic 5. White, not of Hispanic origin
7	BIRTHDATE	Month Day Year
8	LIFETIME OCCUPATION	
9	PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes _____ (Specify)
10	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during 5 years prior to admission)* Prior stay at this nursing home a. Other nursing home/residential facility b. MH/psychiatric setting c. MR/DD setting d. *NONE OF ABOVE* e.
11	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1 Yes
12	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status, that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to Item 13) a. MR/DD with Organic Condition Cerebral palsy b. Down's syndrome c. Autism d. Epilepsy e. Other organic condition related to MR/DD f. MR/DD with no organic condition g. Unknown h.
13	MARITAL STATUS	1. Never Married 3. Widowed 5. Divorced 2. Married 4. Separated
14	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing home 4. Other
15	LIVED ALONE	0. No 1. Yes 2. In other facility
16	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier a. Observation revealed additional information b. Resident unstable at admission c.

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1	DATE OF CURRENT READMISSION	Month Day Year
2	MARITAL STATUS	1. Never Married 3. Widowed 5. Divorced 2. Married 4. Separated
3	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing home 4. Other
4	LIVED ALONE	0. No 1. Yes 2. In other facility
5	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier a. Observation revealed additional information b. Resident unstable at admission c.

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

1	CUSTOMARY ROUTINE (Year prior to first admission to a nursing home)	*(Check all that apply. If all information UNKNOWN, check last box only.)* CYCLE OF DAILY EVENTS Stays up late at night (e.g., after 9 pm) a. Naps regularly during day (at least 1 hour) b. Goes out 1+ days a week c. Stays busy with hobbies, reading, or fixed daily routine d. Spends most time alone or watching TV e. Moves independently indoors (with appliances, if used) f. *NONE OF ABOVE* g. EATING PATTERNS Distinct food preferences h. Eats between meals all or most days i. Use of alcoholic beverage(s) at least weekly j. *NONE OF ABOVE* k. ADL PATTERNS In bed/clothes much of day l. Wakens to toilet all or most nights m. Has irregular bowel movement pattern n. Prefers showers for bathing o. *NONE OF ABOVE* p. INVOLVEMENT PATTERNS Daily contact with relatives/close friends q. Usually attends church, temple, synagogue (etc.) r. Finds strength in faith s. Daily animal companion/presence t. Involved in group activities u. *NONE OF ABOVE* v. UNKNOWN—Resident/family unable to provide information w.

END

Signature of RN Assessment Coordinator: _____

Signatures of Others Who Completed Part of the Assessment

_____ _____ _____

_____ _____ _____

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	ASSESSMENT DATE	Month — Day — Year
2.	RESIDENT NAME	(First) (Middle Initial) (Last)
3.	SOCIAL SECURITY NO.	
4.	MEDICAID NO. (If applicable)	
5.	MEDICAL RECORD NO.	
6.	REASON FOR ASSESSMENT	1. Initial admission assess. 2. Hosp/Medicare reassess. 3. Readmission assessment 4. Annual assessment 5. Significant change in status 6. Other (e.g., UR)
7.	CURRENT PAYMENT SOURCE(S) FOR N.H. STAY	(Billing Office to indicate; check all that apply) Medicaid a. Medicare b. CHAMPUS c. VA d. Self pay/Private insurance e. Other f.
8.	RESPONSIBILITY/ LEGAL GUARDIAN	(Check all that apply) Legal guardian a. Other legal oversight b. Durable power attny./ health care proxy c. Family member responsible d. Resident responsible e. NONE OF ABOVE f.
9.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will a. Do not resuscitate b. Do not hospitalize c. Organ donation d. Autopsy request e. Feeding restrictions f. Medication restrictions g. Other treatment restrictions h. NONE OF ABOVE i.
10.	DISCHARGE PLANNED WITHIN 3 MOS.	(Does not include discharge due to death) 0. No 1. Yes 2. Unknown/uncertain
11.	PARTICIPATE IN ASSESSMENT	a. Resident 0. No 1. Yes b. Family 0. No 1. Yes 2. No family
12.	SIGNATURES	Signature of RN Assessment Coordinator Signatures of Others Who Completed Part of the Assessment

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to SECTION E)
2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes: 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past: 0. Memory OK 1. Memory problem
3.	MEMORY/ RECALL ABILITY	(Check all that resident normally able to recall during last 7 days) Current season a. Location of own room b. Staff names/faces c. That he/she is in a nursing home d. NONE OF ABOVE are recalled e.

[ ] = Code the appropriate response ☐ = Check all the responses that apply

4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. Independent—decisions consistent/reasonable 1. Modified Independence—some difficulty in new situations only 2. Moderately Impaired—decisions poor; cues/supervision required 3. Severely Impaired—never/rarely made decisions
5.	INDICATORS OF DELIRIUM —PERIODIC DISORDERED THINKING/ AWARENESS	(Check if condition over last 7 days appears different from usual functioning) Less alert, easily distracted a. Changing awareness of environment b. Episodes of incoherent speech c. Periods of motor restlessness or lethargy d. Cognitive ability varies over course of day e. NONE OF ABOVE f.
6.	CHANGE IN COGNITIVE STATUS	Change in resident's cognitive status, skills, or abilities in last 90 days 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(With hearing appliance, if used) 0. Hears adequately—normal talk, TV, phone 1. Minimal difficulty when not in quiet setting 2. Hears in special situations only—speaker has to adjust tone/ quality and speak distinctly 3. Highly impaired/absence of useful hearing
2.	COMMUNICATION DEVICES/ TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used a. Hearing aid, present and not used b. Other receptive comm. techniques used (e.g., lip read) c. NONE OF ABOVE d.
3.	MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech a. Writing messages to express or clarify needs b. Signs/gestures/sounds c. Communication board d. Other e. NONE OF ABOVE f.
4.	MAKING SELF UNDERSTOOD	(Express information content—however able) 0. Understood 1. Usually Understood—difficulty finding words or finishing thoughts 2. Sometimes Understood—ability is limited to making concrete requests 3. Rarely/Never Understood
5.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. Understands 1. Usually Understands—may miss some part/intent of message 2. Sometimes Understands—responds adequately to simple, direct communication 3. Rarely/Never Understands
6.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand or hear information has changed over last 90 days 0. No change 1. Improved 2. Deteriorated

SECTION D. VISION PATTERNS

1.	VISION	(Ability to see in adequate light and with glasses if used) 0. Adequate—sees fine detail, including regular print in newspapers/books 1. Impaired—sees large print, but not regular print in newspapers/books 2. Highly Impaired—limited vision; not able to see newspaper headlines; appears to follow objects with eyes 3. Severely Impaired—no vision or appears to see only light, colors, or shapes
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) a. Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes b. NONE OF ABOVE c.
3.	VISUAL APPLIANCES	Glasses; contact lenses, lens implant; magnifying glass 0. No 1. Yes

SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE — *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0 *INDEPENDENT* — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days

1 *SUPERVISION* — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus physical assistance provided only 1 or 2 times during last 7 days

2. *LIMITED ASSISTANCE* — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times — OR — More help provided only 1 or 2 times during last 7 days

3. *EXTENSIVE ASSISTANCE* — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days

4. *TOTAL DEPENDENCE* — Full staff performance of activity during entire 7 days

2. ADL SUPPORT PROVIDED — *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1 Setup help only
2 One-person physical assist
3 Two+ persons physical assist

			(1) SELF PERF	(2) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c	LOCO-MOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prostheses		
e	EATING	How resident eats and drinks (regardless of skill)		
f	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
3	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. *Code for most dependent in self-performance and support.* Bathing Self-Performance codes appear below)		
		0. Independent—No help provided	a.	b.
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		

4. BODY CONTROL PROBLEMS *(Check all that apply during last 7 days)*

- Balance—partial or total loss of ability to balance self while standing [a.]
- Bedfast all or most of the time [b.]
- Contracture to arms, legs, shoulders, or hands [c.]
- Hemiplegia/hemiparesis [d.]
- Quadriplegia [e.]
- Arm—partial or total loss of voluntary movement [f.]
- Hand—lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) [g.]
- Leg—partial or total loss of voluntary movement [h.]
- Leg—unsteady gait [i.]
- Trunk—partial or total loss of ability to position, balance, or turn body [j.]
- Amputation [k.]
- *NONE OF ABOVE* [l.]

5 MOBILITY APPLIANCES/ DEVICES *(Check all that apply during last 7 days)*

- Cane/walker [a.]
- Brace/prosthesis [b.]
- Wheeled self [c.]
- Other person wheeled [d.]
- Lifted (manually/ mechanically) [e.]
- *NONE OF ABOVE* [f.]

6. TASK SEGMENTATION — Resident requires that some or all of ADL activities be broken into a series of subtasks so that resident can perform them
0. No 1. Yes

7. ADL FUNCTIONAL REHABILITATION POTENTIAL

- Resident believes he/she capable of increased independence in at least some ADLs [a.]
- Direct care staff believe resident capable of increased independence in at least some ADLs [b.]
- Resident able to perform tasks/activity but is very slow [c.]
- Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) [d.]
- *NONE OF ABOVE* [e.]

8. CHANGE IN ADL FUNCTION — Change in ADL self-performance in last 90 days
0. No change 1. Improved 2. Deteriorated

SECTION F. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident performance over all shifts)*

0. CONTINENT — Complete control
1. USUALLY CONTINENT — BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT — BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT — BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. INCONTINENT — Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a. BOWEL CONTINENCE — Control of bowel movement, with appliance or bowel continence programs, if employed

b. BLADDER CONTINENCE — Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

2. INCONTINENCE RELATED TESTING *(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)*

- Resident has been tested for a urinary tract infection [a.]
- Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination [b.]
- *NONE OF ABOVE* [c.]

3. APPLIANCES AND PROGRAMS Any scheduled toileting plan

- External (condom) catheter [a.]
- Indwelling catheter [b.]
- Intermittent catheter [c.]
- Did not use toilet room/ commode/urinal [d.]
- Pads/briefs used [e.]
- Enemas/irrigation [f.]
- Ostomy [g.]
- *NONE OF ABOVE* [h.]

4. CHANGE IN URINARY CONTINENCE — Change in urinary continence/appliances and programs in last 90 days
0. No change 1. Improved 2. Deteriorated

SECTION G. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVEMENT

- At ease interacting with others [a.]
- At ease doing planned or structural activities [b.]
- At ease doing self-initiated activities [c.]
- Establishes own goals [d.]
- Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) [e.]
- Accepts invitations into most group activities [f.]
- *NONE OF ABOVE* [g.]

2. UNSETTLED RELATIONSHIPS

- Covert/open conflict with and/or repeated criticism of staff [a.]
- Unhappy with roommate [b.]
- Unhappy with residents other than roommate [c.]
- Openly expresses conflict/anger with family or friends [d.]
- Absence of personal contact with family/friends [e.]
- Recent loss of close family member/friend [f.]
- *NONE OF ABOVE* [g.]

3. PAST ROLES

- Strong identification with past roles and life status [a.]
- Expresses sadness/anger/empty feeling over lost roles/status [b.]
- *NONE OF ABOVE* [c.]

SECTION H. MOOD AND BEHAVIOR PATTERNS

1	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)*	
		VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS	
		— Tearfulness, emotional groaning, sighing, breathlessness	b.
		— Motor agitation such as pacing, handwringing or picking	c.
		— Failure to eat or take medications, withdrawal from self-care or leisure activities	d.
		— Pervasive concern with health	e.
		— Recurrent thoughts of death—e.g., believes he/she about to die, have a heart attack	f.
		— Suicidal thoughts/actions	g.
		NONE OF ABOVE	h.
2	MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up" 0. No 1. Yes	
3	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	a.
		VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	b.
		PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	c.
		SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	d.
4	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)*	
		Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		NONE OF ABOVE	c.
5	BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints or psychotropic medications in this category) 0 No behavior problem 1 Yes, addressed 2 No, not addressed	
6	CHANGE IN MOOD	Change in mood in last 90 days 0. No change 1. Improved 2. Deteriorated	
7	CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days 0. No change 1 Improved 2. Deteriorated	

SECTION I. ACTIVITY PURSUIT PATTERNS

1	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	*NONE OF ABOVE*	d.
2	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—1/3 to 2/3 of time 3. None			
3	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.	Outside facility	d.
		Day/activity room	b.	*NONE OF ABOVE*	e.
		Inside NH/off unit	c.		

4	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*			
		Cards/other games	a.	Spiritual/religious activities	f.
		Crafts/arts	b.	Trips/shopping	g.
		Exercise/sports	c.	Walking/wheeling outdoors	h.
		Music	d.	Watch TV	i.
		Readings	e.	*NONE OF ABOVE*	j.
5	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses/indicates preference for other activities/ choices 0. No 1. Yes			

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/inactive diagnoses.)

1	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		HEART/CIRCULATION		**PSYCHIATRIC/MOOD**	
		Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
		Cardiac dysrhythmias	b.	Depression	q.
		Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
		Hypertension	d.	**SENSORY**	
		Hypotension	e.	Cataracts	s.
		Peripheral vascular disease	f.	Glaucoma	t.
		Other cardiovascular disease	g.	**OTHER**	
		NEUROLOGICAL		Allergies	u.
		Alzheimer's	h.	Anemia	v.
		Dementia other than Alzheimer's	i.	Arthritis	w.
		Aphasia	j.	Cancer	x.
		Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
		Multiple sclerosis	l.	Explicit terminal prognosis	z.
		Parkinson's disease	m.	Hypothyroidism	aa.
		PULMONARY		Osteoporosis	bb.
		Emphysema/Asthma/ COPD	n.	Seizure disorder	cc.
		Pneumonia	o.	Septicemia	dd.
				Urinary tract infection—in last 30 days	ee.
				NONE OF ABOVE	ff.
2	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	a. _____			
		b. _____			
		c. _____			
		d. _____			
		e. _____			
		f. _____			

SECTION K. HEALTH CONDITIONS

1	PROBLEM CONDITIONS	*(Check all problems that are present in last 7 days unless other time frame indicated)*			
		Constipation	a.	Pain—resident complains or shows evidence of pain daily or almost daily	j.
		Diarrhea	b.		
		Dizziness/vertigo	c.	Recurrent lung aspirations in last 90 days	k.
		Edema	d.		
		Fecal impaction	e.	Shortness of breath	l.
		Fever	f.	Syncope (fainting)	m.
		Hallucinations/ delusions	g.	Vomiting	n.
		Internal bleeding	h.	*NONE OF ABOVE*	o.
		Joint pain	i.		
2	ACCIDENTS	Fall in past 30 days	a.	Hip fracture in last 180 days	c.
		Fall in past 31-180 days	b.	*NONE OF ABOVE*	d.

3.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating	a.
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem	b.
		NONE OF ABOVE	c.

SECTION L. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d.
2.	HEIGHT AND WEIGHT	*Record height (a.) in inches and weight (b.) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* HT (in) a. WT (lb.) b.	
		c. Weight loss (i.e., 5%+ in last 30 days; or 10% in last 180 days) 0. No 1. Yes	c.
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods a.	
		Insufficient fluid; dehydrated b.	
		Did NOT consume all/almost all liquids provided during last 3 days c.	
		Regular complaint of hunger	d.
		Leaves 25%+ food uneaten at most meals	e.
		NONE OF ABOVE	f.
4.	NUTRITIONAL APPROACHES	Parenteral/IV a.	
		Feeding tube b.	
		Mechanically altered diet c.	
		Syringe (oral feeding) d.	
		Therapeutic diet e.	
		Dietary supplement between meals	f.
		Plate guard, stabilized built-up utensil, etc.	g.
		NONE OF ABOVE	h.

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures and/or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingivs); swollen or bleeding gums; oral abscesses, ulcers or rashes	e.
		Daily cleaning of teeth/dentures	f.
		NONE OF ABOVE	g.

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(open lesion caused by poor venous circulation to lower extremities) 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers	
		1. Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved	
		2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater	
		3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue	
		4. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone	
3.	HISTORY OF RESOLVED/ CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1. Yes	

4.	SKIN PROBLEMS/ CARE	Open lesions other than stasis or pressure ulcers (e.g., cuts)	a.
		Skin desensitized to pain, pressure, discomfort	b.
		Protective/preventive skin care	c.
		Turning/repositioning program	d.
		Pressure relieving beds, bed/chair pads (e.g., egg crate pads)	e.
		Wound care/treatment (e.g., pressure ulcer care, surgical wound)	f.
		Other skin care/treatment	g.
		NONE OF ABOVE	h.

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1. Yes	
3.	INJECTIONS	*(Record the number of days injections of any type received during the last 7 days)*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of days during last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly)* Antipsychotics	a.
		Antianxiety/hypnotics	b.
		Antidepressants	c.
5.	PREVIOUS MEDICATION RESULTS	*(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics—otherwise code correct response for last 90 days)* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. SPECIAL TREATMENT AND PROCEDURES

1.	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE—*Check treatments received during the last 14 days*	
		Chemotherapy a.	
		Radiation b.	
		Dialysis c.	
		Suctioning d.	
		Trach. care e.	
		IV meds	f.
		Transfusions	g.
		O_2	h.
		Other _____	i.
		NONE OF ABOVE	j.
		THERAPIES—*Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days:*	
		Speech—language pathology and audiology services	k.
		Occupational therapy	l.
		Physical therapy	m.
		Psychological therapy (any licensed professional)	n.
		Respiratory therapy	o.
2.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90-days? 0. No 1. Yes 2. No tests performed	
3.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	a.
		Trunk restraint	b.
		Limb restraint	c.
		Chair prevents rising	d.

SECTION Q: Resident Classification

1.	Payment Source	Private	
		Medicare	
		Medicaid	
		Other	
2.	Requires Basic Nursing Services (NJAC 10:63-1.3)		
3.	Requires Additional Nursing Services (NJAC 10:63(f)4) as below:		
	Trachestomy		a
	Use of Respirator		b
	Head Trauma Stimulation/ advanced neuromuscular/ orthopedic care		c
	Intravenous Therapy		d
	Wound Care		e
	Oxygen Therapy		f
	Nasogastric tube feeding and/or Gastrostomy		g

Signature of RN Coordinator _____ License Number _____ Date _____

Signatures of Others Who Completed Part of the Assessment:

Name _____ Title _____

Name _____ Title _____

Resident's Name:	Medical Record No.:

Signature of RN Assessment Coordinator: _____

RESIDENT ASSESSMENT PROTOCOL SUMMARY

1. For each RAP area triggered, show whether you are proceeding with a care plan intervention.
2. Document problems, complications, and risk factors; the need for referral to appropriate health professionals; and the reasons for deciding to proceed or not to proceed to care planning. Documentation may appear anywhere the facility routinely keeps such information, such as problem sheets or nurses' progress notes.
3. Show location of this information.

RAP Problem Area	Care Planning Decision		Location of Information
	Proceed	Not Proceed	
DELIRIUM	☐	☐	
COGNITIVE LOSS/DEMENTIA	☐	☐	
VISUAL FUNCTION	☐	☐	
COMMUNICATION	☐	☐	
ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐	☐	
URINARY INCONTINENCE AND INDWELLING CATHETER	☐	☐	
PSYCHOSOCIAL WELL-BEING	☐	☐	
MOOD STATE	☐	☐	
BEHAVIOR PROBLEM	☐	☐	
ACTIVITIES	☐	☐	
FALLS	☐	☐	
NUTRITIONAL STATUS	☐	☐	
FEEDING TUBES	☐	☐	
DEHYDRATION/FLUID MAINTENANCE	☐	☐	
DENTAL CARE	☐	☐	
PRESSURE ULCERS	☐	☐	
PSYCHOTROPIC DRUG USE	☐	☐	
PHYSICAL RESTRAINTS	☐	☐	

August 15, 1990

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND

LEGEND:
● Automatic Trigger—Go directly to RAP Instructions
▲ Potential Trigger—Go to RAP instructions for more detailed trigger definitions

Instructions: Match MDS item codes with trigger codes below. Proceed to RAP instructions as indicated by symbol. Circle all RAPs that are "triggered," based on your review.

MDS Item	Code	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Functional/Rehabilitation Potential	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavior Problem	Activities	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
B2 a or b	1		▲																
B3 a.b.c.d	fewer than 3 ✓		▲																
B4	0.1.2			▲															
	1.2.3		▲																
B5 a.b.c.d.e	any ✓	●																	
B6	2	●												▲					
C4	2.3			▲															
C5	1.2.3		▲																
	2.3			▲	▲														
C6	2	●																	
D1	1.2.3			●															
D2 a	✓			●															
E1 a.b.c.d.e.f	3.4				▲														
E3 a	3.4				▲														
E4 a.b.d.e.h.j	any ✓										▲								
E7 a.b	any ✓				▲														
E8	2													▲					
F1 b	2.3.4					▲													
F3 b.c.d.f	any ✓					▲													
G2 a.b.c.d	any ✓						●												
G3 b	✓						●												
H1 a.b.c.d.e.f.g	any ✓							●											
H1 d	✓													▲					
H2	1							●											
H3 a.b.c or d	1.2								●										
H6	2	▲																	
H7	2	●																	
I2	0.2.3									▲									
I5	1									●									
J1 ee	✓													▲					
J2	260, 261, 262											●							
	263, 263.0, 263.1											●							
	263.2, 263.8, 263.9											●							
	276.5													▲					
	291.0, 292.81	●																	
	293.0, 293.1	●																	
K1 b.c.f.h.n	any ✓													▲					
K2 a.b	any ✓										●								
L1 c	✓														●				
L2 c	1											●		▲					
L3 a.d.e	any ✓											●							
L3 b	✓													●					
L3 c.e	✓													▲					
L4 a.b	any ✓													▲					
L4 a.c.d.e	any ✓											●							
L4 b	✓												●						
M1 a.c.d.e	any ✓														●				
M1 f	not ✓														●				
N2	1.2.3.4											●				●			
N4 c.d.e.f.g	none ✓															▲			
O4 a.b.c	1-7								▲		▲						▲		
P2 b.c or d	1.2								▲										●

APPENDIX E

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.

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 should be effectively housebroken and provisions must be 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 should be promptly notified by telephone of any pet which dies on the premises.

1. If the diseased 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 of 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 should 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 which 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, rhinothracheitis, calcivirus, chlamydia, and rabies. Proof of vaccination should be included on a health certificate which is signed by a licensed veterinarian and kept on file at the facility.

2. Determined not to 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 which 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 prevention 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.

n. Be regularly groomed and receive a bath whenever indicated.

2. Residential birds:

a. Should be treated by a licensed veterinarian with an approved chlortetracyline 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.

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.