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FROM: Dr. Solomon Goldberg, Director, Licensing, Certification and Standards

RE: Amendments to the Manual of Standards for Licensure of Long-Term Care Facilities, Manual of Standards for Nursing Homes, and Manual of Standards Intermediate Care Facilities

DATE: June 3, 1982

At the June 3, 1982, meeting, the Health Care Administration Board adopted amendments to N.J.A.C. 8:39 the Manual of Standards for Licensure of Long-Term Care Facilities to delay the effective date of certain standards from July 1, 1982, to June 19, 1983, to delay the expiration of N.J.A.C. 8:30 and N.J.A.C. 8:37 from July 1, 1982, to June 19, 1983, and to apply certain portions of N.J.A.C. 8:30 and N.J.A.C. 8:37 to N.J.A.C. 8:39. These amendments extend until June 19, 1983, the standards that have been in effect for long-term and intermediate care facilities since January 1, 1979. These amendments do not constitute a change in the licensure standards for these facilities. N.J.A.C. 8:39 will expire on June 19, 1983. A copy of the amendments is attached.

SG:MF:jg
Attachment

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AMENDMENTS ON EFFECTIVE DATES OF PORTIONS OF STANDARDS FOR LONG-TERM CARE FACILITIES

NOTE: The purpose of these amendments is to continue the exemption of Standards 6.6.15.1, 6.6.15.5, 8.3, 8.5, 8.12, and 10.7 of the Manual of Standards for Licensure of Long-Term Care Facilities (N.J.A.C. 8:39) from July 1, 1982, to June 19, 1983. In addition, the amendments delay the expiration dates of the Manual of Standards for Nursing Homes (N.J.A.C. 8:30) and the Manual of Standards Intermediate Care Facilities (N.J.A.C. 8:37) to June 19, 1983. The amendments also apply certain standards from N.J.A.C. 8:30 and 8:37 to N.J.A.C. 8:39. These amendments do not constitute a change in the licensure standards that have been in effect since January 1, 1979, for long-term care facilities, nursing homes, and intermediate care facilities.

EXEMPTED STANDARDS OF THE MANUAL OF STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES

N.J.A.C. Citation	Licensure Manual Citation	
8:39-1.14(f)15.i	6.6.15.1	Define the uses of restraints and types of restraints permitted. Restraints shall be applied only by licensed nursing personnel. Restraints shall not be used for punishment or for the convenience of facility personnel
8:39-1.14(f)15.v	6.6.15.5	Specify that a patient placed in restraint be monitored at least every 30 minutes by licensed nursing personnel, with documentation of this, for each shift, in the patient's medical record; and
8:39-1.16(c)	8.3	At least one registered professional nurse, excluding the director of nursing services, shall be assigned to each nursing unit 24 hours a day, seven days a week. A facility having a nursing unit or units of more than 30 skilled and/or ICF-A patients shall have an additional licensed nurse assigned to each such unit on the day and evening shifts
8:39-1.16(e)	8.5	Computation of direct care time shall not include the hours of the director of nursing services except in facilities with 30 or fewer patients.

8:39-1.16(l)	8.12	In facilities with more than 240 patients, a full-time supervisor of nurses shall be appointed who shall serve on the day shift and who shall be directly responsible to the director of nursing services. Computation of direct care time shall not include the hours of the supervisor of nurses. The supervisor shall be responsible for, but not limited to, the following:
8:39-1.18(g)	10.7	The facility shall appoint a dietitian on a full-time, part-time or consultant basis. The dietitian shall provide dietary services in the facility two hours per week for the first 16 patients, and an additional hour for each additional 8 patients. Facilities of 240 patients shall have one full-time dietitian. Additional dietitian time shall be provided in the facility proportionate to the number of patients over 240, at a ratio of one additional hour per eight additional patients. The consultant's hours shall be scheduled for different times on successive visits.

(Please note that a revision of N.J.A.C. 8:39-1.18(g) (standard 10.7) was adopted by the Health Care Administration Board on April 1, 1982, and became effective on May 3, 1982. The revised standard was sent to you in a memo dated April 2, 1982.)

Until the exempted standards become effective, the following rules are to remain in effect and shall apply to the Manual of Standards for Licensure of Long-Term Care Facilities (N.J.A.C. 8:39) until June 19, 1983:

N.J.A.C. Citation	Licensure Manual Citation	
8:30	MANUAL OF STANDARDS FOR NURSING HOMES	
8:30-5.1	501-A	NURSING SERVICE
8:30-5.1(a)2	2.	Of the total nursing personnel, the ratio of registered professional nurse hours to auxiliary nursing hours shall not be less than 1 to 5, with 25 percent credit for licensed practical nurse hours.
8:30-5.1(a)3	3.	Registered or licensed nursing personnel shall be provided around-the-clock on a daily basis. Such personnel shall be currently registered or licensed to practice nursing in New Jersey.
8:30-5.1(a)4	4.	There shall be no less than one registered professional nurse on the day tour of duty, seven days each week.

8:30-5.1(a)5	5.	There shall be available at all times at least two nursing personnel to act effectively in the event of fire or other emergency.
8:30-5.1(a)6	6.	Professional and licensed nurse personnel shall be distributed on each tour of duty in order to insure that the quality of care required by the patient census is provided.
8:30-5.1(a)7	7.	The amount of nursing time provided for direct patient care shall be limited to nursing duties
8:37	MANUAL OF STANDARDS FOR INTERMEDIATE CARE FACILITIES	
8:37-1.1	106.	DIRECTOR OF DIETARY SERVICES A Director of Dietary Services is a person who : 1. A qualified ADA dietitian, or 2. A graduate dietitian, or 3. A person suited by training and experience i foods and nutrition, dietetics, quantity foo service, or institutional management for planning and supervision of menus and preparation of meal services. This individu if requiring further education and preparati should complete the 90-hour course in dietet approved by the Department of Health within nine months after assuming her duties.
8:37-6.1(b)	601.	
Level A	Level A (Upper level-Medical)	
Item IV	IV.	In a Free Standing Facility of less than 50 beds the hours of care of the Director of Nursing may be counted as direct resident care.

Standard 27.3 of the Manual of Standards for Licensure of Long-Term Care Facilities has been amended as follows:

Additions are underlined thus, deletions are in brackets [thus].

N.J.A.C. Citation	Licensure Manual Citation	
8:39-1.35(c)	27.3	For facilities of 45 or fewer beds, the previous manuals, Manual of Standards for Nursing Homes a Manual of Standards Intermediate Care Facilities (N.J.A.C. 8:30 and N.J.A.C. 8:37), shall continu to be the standards for licensure until [July 1, 1982] June 19, 1983.

Initial Adoption by HCAB 4-1-82
Final Adoption by HCAB 6-3-82
Effective 7-1-82

MANUAL OF STANDARDS

INTERMEDIATE CARE FACILITIES

MANUAL OF STANDARDS
INTERMEDIATE CARE FACILITIES

Table of Contents

FORWARD

(1) These standards are set forth as licensing requirements for Intermediate Care Facilities in the State of New Jersey.

(2) Intermediate Care Facilities to which these standards apply are such facilities which provide, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designated to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities such as these.

(3) Intermediate Care Facilities licensed by the Department of Health to deliver this level of care shall maintain at least the standards on a continuing basis. In the event any of these standards are not maintained upon evaluation by the State Department of Health, the facility shall be given a definite time period to set forth a plan of correction to meet these standards. Follow up unannounced visits will be scheduled by the surveyor to assist as well as ascertain if the scheduled progress is being made according to the plan. The Department is responsible for standards of operation, but under Medicaid the single State agency (I & A) Division of Medical Assistance and Health Services will issue time limited contracts for payment of services to residents supported by Federal funds.

(4) Representatives of the Department of Health or of the Department of Institutions and Agencies, having administration of Title XIX Medicaid, shall have reasonable access, at all times, to the premises of the participating Intermediate Care Facility, as well as access to private interviews with recipients of designated services of these facilities.

(5) The Program must provide that any individual eligible for services under the plan may obtain these from any institution, agency, pharmacy or practitioner, including an organization which provides such services or arranges for their availability on a postpayment basis, which is qualified to perform such services. The provision does not prohibit the State agency known as (I & A) Division of Medical Assistance and Health Services from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the plan.or the State agency known as the Department of Health from setting reasonable standards relating to the qualifications of providers of such care.

(6) The Department shall certify to the funding agency that the facility meets the standards set forth in this manual by:

a. On site survey by qualified personnel at least once during the term of a provider agreement, or more frequently if there is a question of compliance.

b. All requirements of contract in Federal and State funding will be determined by the funding agency known as (I & A) Division of Medical Assistance and Health Services.

(7) Institutions which do not qualify under these standards will not be recognized or licensed as Intermediate Care Facilities.

(8) Agreement with State Agency.

The Intermediate Care Facility which makes an agreement for participation in State and Federal funds will have such requirements specified by the funding agency. In the State of New Jersey this would be with the Division of Medical Assistance and Health Services of the Department of Institutions and Agencies. Facilities should acquaint themselves with this agency's contract standards.

(9) Intermediate Care Facility services may include services in a public institution (or distinct part thereof) for individual's determined to be mentally retarded or to have cerebral palsy, epilepsy, or other developmental disabilities. As defined pursuant to Part C of the Developmental Disabilities Services and Facilities Construction Act, "Intermediate Care Facility services" means those items and services furnished by a facility which meets the conditions set forth in this manual.

CHAPTER-I

DEFINITIONS

100. DEFINITIONS

The following definitions are applicable for this Manual.

101. INTERMEDIATE CARE FACILITY

An Intermediate Care Facility is an institution or a distinct part of an institution licensed by the Department; constructed, equipped, maintained and operated in compliance with all applicable State and local laws affecting the health, welfare and safety of the residents.

102. ADMINISTRATOR

An Administrator is a person licensed in New Jersey as a nursing home administrator, with the necessary authority and responsibility for management of the institution and implementation of administrative policies and for responsibilities for qualifications of residents'overall plan of service.

103. CHARGE NURSE (OR HEAD NURSE)

A Charge Nurse or Head Nurse shall be a Registered Professional Nurse or a Practical Nurse licensed other than by waiver in New Jersey who shall be qualified by experience and training to assume responsibility for nursing care and for the activities of staff nurses and nurses' aides in one or more adjacent resident areas. A Charge Nurse shall relieve the Director of Nursing Service when the Director is absent.

104. COMMISSIONER

The term Commissioner refers to the New Jersey State Commissioner of Health.

105. DEPARTMENT

The term Department refers to the New Jersey State Department of Health.

106. DIRECTOR OF DIETARY SERVICES

A Director of Dietary Services is a person who is:

1. A qualified ADA dietitian, or

2. A graduate dietitian, or

3. A person suited by training and experience in foods and nutrition, dietetics, quantity food service, or institutional management for planning and supervision of menus and preparation of meal services. This individual if requiring further education and preparation should complete the 90 hour course in dietetics approved by the State Department of Health within 9 months after assuming her duties.

107. DIRECTOR OF NURSING SERVICE

A. For Level A (upper level medical), a Director of Nursing Service is a Registered Professional Nurse currently licensed to practice in the State of New Jersey, with a minimum of 2 years experience in nursing service administration, nursing supervision, rehabilitation nursing, psychiatric, and/or geriatric nursing.

B. For Level B (lower level non-medical), a Director of Nursing Service is a nurse currently licensed to practice in the State of New Jersey.

108. DISTINCT PART OF AN INSTITUTION

A "Distinct Part" of an Institution is defined as the part of the facility which meets the definition of an Intermediate Care Facility with the following conditions:

1. Identifiable Unit

The "distinct part" of the institution may be an entire unit such as an entire ward or contiguous rooms, wing, floor, or building. It consists of all beds and related facilities in the unit and houses all residents, for whom care is being given.

a. Staff

Appropriate personnel are assigned as defined in this manual and work regularly in the unit. Immediate supervision of staff is provided in the unit at all times by qualified personnel.

b. Shared Facilities and Services

The distinct part may share such central services and facilities as management services, building maintenance and laundry, food, dining, recreation services, etc., with other units.

c. Transfer Between Distinct Parts

In a facility having distinct parts devoted to Skilled Nursing Care and Intermediate Care, which facility has been determined to be organized and staffed to provide services according to individual needs throughout the institution, the foregoing paragraphs shall not be construed to require transfer of an individual within the institution when in the opinion of the individual's physician such transfer might be harmful to the physical or mental health of the individual.

109. HEAD NURSE

See Charge Nurse (103.)

110. LICENSED PRACTICAL NURSE

A Licensed Practical Nurse shall be one of the following:

1. A nurse who is a graduate of a State-approved school of practical nursing or the equivalent as determined by the New Jersey Board of Nursing and who is currently licensed as a Practical Nurse by the New Jersey Board of Nursing. (The license number is preceded by the letter "P".)

2. A nurse who is licensed by Endorsement of the New Jersey Board of Nursing. This category may include those coming from other states who may or may not be eligible to take the examination in New Jersey, including those licensed by waiver in other states. (The license number is preceded by a letter "E".)

3. A nurse who is licensed by waiver of examination in New Jersey and who does not qualify by training and education. (This license number is preceded by the letter "W".)

111. NON-NURSING PERSONNEL

Non-Nursing Personnel are all personnel not assigned to the Department of Nursing Service and, therefore, are responsible for duties other than patient-resident/resident care.

112. NURSES' AIDE

The Nurses' Aide shall be a nonprofessional employee who has had a short formal course of nurses' aide training in a vocational school or hospital, or has received on-the-job training within the facility to assist in giving direct patient care to residents.

113. NURSE SUPERVISOR

A Nurse Supervisor shall be a Registered Professional

Nurse or a Practical Nurse licensed other than by waiver in New Jersey and qualified by experience and training to assume responsibility for nursing personnel and the nursing care in several nursing units, wings, or floors of a large facility as assigned.

114. OCCUPATIONAL THERAPIST

A qualified Occupational Therapist is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

115. PATIENT-RESIDENT

A Patient-Resident is an individual requiring Level A (upper level medical) care in an Intermediate Care Facility as defined in Criteria for Level of Care, Chapter II.

116. PHYSICAL THERAPIST

A qualified Physical Therapist is one who:

1. Has graduated from a physical therapy curriculum approved by The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

2. Prior to January 1, 1966 -

   a. Has been admitted to membership by the American Physical Therapy Association; or

   b. Has been admitted to registration by the American Registry of Physical Therapists; or

   c. Has graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or

3. If he is currently licensed or registered to practice physical therapy persuant to State law, he:

   a. Has two years of appropriate experience as a physical therapist and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the Public Health service; or

b. Was licensed or registered prior to January 1, 1966 and prior to January 1, 1970 had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which he rendered services upon the order of and under the direction of attending and referring physicians; or

4. If trained outside the Unites States -

a. Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

b. Is a member of a member organization of the World Confederation for Physical Therapy; and

c. Has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and

d. Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

117. PHYSICIAN

A Physician means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the State in which he practices.

118. REGISTERED PROFESSIONAL NURSE

A Registered Professional Nurse is a nurse currently registered in the State of New Jersey to practice professional nursing.

119. RESIDENT

A Resident is an individual requiring Level B (lower level non-medical) care in an Intermediate Care Facility as defined in Criteria for Level of Care, Chapter II.

120. SPEECH THERAPIST

A Speech Therapist is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

121. STAFF NURSE

A Staff Nurse shall be a Registered Professional Nurse or a Licensed Practical Nurse who gives direct care to residents.

CHAPTER II

200. Criteria for Level of Care
Intermediate Care Facilities

Level A (Upper level-Medical)

I. Definition of Patient-Resident

A patient-resident at Level IV Medical is a person with physical and/or mental disfunctioning requiring substantial assistance with personal care needs on a daily basis.

II. Quality and Quantity of Care

Regardless of size of the facility, a minimum of 2.5 hours of direct personal care in each 24 hour period, seven days a week, is required. Care provided in each 24 hour period is continuous, under licensed nurse supervision and under the general direction of a registered professional nurse.

III. Requirements for Care

A. Need for Institutional Care

For practical purposes alternate care in the community is not feasible.

Level B (Lower level-Non-medical)

I. Definition of Resident

A resident at Level IV Non-Medical is an ambulant or partially ambulant person with physical and/or mental disfunctioning requiring minimal assistance with personal care needs on a daily basis.

II. Quality and Quantity of Care

Regardless of the size of the facility, a minimum of 1.25 hours of direct resident personal care in each 24 hour period, seven days a week is required. A registered professional nurse or licensed practical nurse shall be on duty for eight hours on the day shift, eight hours on the evening shift, and eight hours on the night shift seven days a week.

III. Requirements for Care

A. Need for Institutional Care

For practical purposes alternate care in the community is not feasible.

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
B. Physical Needs	B. Physical Needs
1. Disease symptoms are moderate to mild. (e.g. recently compensated cardiopulmonary states in the process of further stabilization; CVA after early restoration and now in process of continuing restoration and/or maintenance stabilization. Controlled diabetes with occasional mild complications; post traumatic neurological condition after early restoration and now in process of continuing restoration and/or maintenance stabilization.	1. Disease symptoms are mild to minimal (e.g. stabilized and compensated cardiopulmonary states; CVA with high functional level; controlled diabetes; post traumatic-neurological condition with minimal and stabilized residual).
2. Convalescent care (e.g. post-operative states where patient-resident no longer requires skilled nursing care but requires basic nursing care).	2. Convalescent care (e.g. post operative states where resident no longer needs basic nursing care but may need assistance and/or supervision with personal care).
3. Chronic diseases not requiring skilled nursing care but requiring basic nursing care (e.g. late multiple sclerosis in remission but with residual disability).	3. Chronic diseases not requiring basic nursing care but requiring personal care (e.g. early multiple sclerosis in remission with minimal residual disability).
4. Terminal illness in stages where skilled nursing care is not needed but basic nursing care is required (e.g. brain malignancy causing unsteadiness of gait, double vision, etc.).	

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
C. Psycho-Social Needs	C. Psycho-Social Needs
1. Mental Status Impairment - requiring moderate treatment, observation, and/or instruction (e.g. usually or generally confused and/or disoriented in 1, 2, or 3 spheres (time, place and/or person), moderate loss of memory, continuing judgmental defect, etc. which precludes responsibility for such things as medication schedules, continued and proper use of prosthetic devices, etc.	1. Mental Status Impairment - requiring minimal treatment, observation, and/or instruction (e.g. occasionally confused and/or disoriented in one or more spheres (time, place and/or person), mild memory loss, beginning judgmental defect, etc. which preclude self-administration of medications, requires occasional supervision and/or support in continued use of prosthetic devices, etc.
2. Personal and Social Care Requirements	2. Personal and Social Care Requirements
a. Personal Care Continuing restorative and/or maintenance in A.D.L. (e.g. grooming, personal hygiene, eating, etc.)	a. Personal Care Continuing restorative or maintenance in A.D.L. (e.g. in grooming, personal hygiene, eating, etc.)
b. Social Care Individualized social therapies for restoration of social interaction skills and social activities stimulation (e.g. programming for progression from 1 to 1 to	b. Social Care Individualized social therapies for continuing restoration and maintenance of social interaction skills and social activities stimulation (e.g. pro-

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
complex social relationships and from observation of activities to full participation in facility activities and increasingly in community activities as necessary.	gramming for progressive social interaction as necessary and for progressive social activities participation and outreach into community).
D. Plan of Treatment	D. Plan of Treatment
1. A combined plan for medical, personal, and social care with emphasis on medical and personal rehabilitation and beginning emphasis on social activities.	1. A combined plan for medical, personal, and social care with primary emphasis on social rehabilitation.
IV. Services Provided	IV. Services Provided
(not meant to be all inclusive)	
1. Medical care (physician evaluation and plan of treatment reviewed every 30 days).	1. Medical care (as required but plan of treatment reviewed at least every 60 days).
2. Continuing* physical, occupational, speech or inhalation therapies to meet predetermined goal.	2. Continuing* physical, occupational, speech or inhalation therapies to meet predetermined goals. (At this level special therapies could be provided through OPD services in the community).

*Continuing means continued from a higher level of care and does not mean continuing ad infinitum.

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
3. Restorative nursing techniques such as:	3. Restorative nursing techniques such as:
(a) Proper positioning of patient resident in bed, wheelchair, or other accommodation to prevent deformity and decubitus ulcers;	(a) Reminders regarding good body alignment;
(b) Reinforcement in training and assistance in transfer activities (bed to wheelchair, wheelchair to commode etc.);	(b) Reinforcement in training and activities leading to independence in activities of daily living (e.g. dressing self, eating with help of devices, etc.);
(c) Continuing range of motion exercises as part of preventive and maintenance care;	(c) Maintenance of bowel and bladder continence through supervision of toileting habits, diet, and regular exercise.
(d) Assistance with casts, braces, splints, or other appliances and other self-help devices;	(d) Reminders regarding proper use of braces, prostheses, etc.

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
(e) Assisting in the continuing*restoration of bowel and bladder continence following restoration at a higher level of care;	(e) Activity programs using physical methods (e.g. games, dancing, walking, etc.)
(f) Individualized social interaction programming and social activities;	(f) Maintenance of muscle tone and strength through daily activity program (e.g. may be managed through group exercise sessions).
(g) Supervision and/or assistance with IPPB (intermittent positive pressure breathing) equipment and nebulizers, oxygen administration in emergencies;	(g) Activity programs planned for social interaction (birthdays, parties, etc.)
(h) Training and assistance in activities of daily living such as dressing, eating, personal hygiene, communication, and exercise;	(h) Minimal supervision of self-administered IPPB equipment;
(i) Continuing*restoration and instruction in the care of colostomy;	(i) Supervision and minimal assistance in activities of daily living such as dressing, eating, personal hygiene, communication, and exercise;

*Continuing means continuing from a higher level of care and does not mean ad infinitum.

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
(j) Based on individual need, provision of frequent reality communication (following Reality Orientation at a higher level of care), Remotivation (continuing* restorative or maintenance), Attitude Therapy (continuing*restorative or maintenance), behavior modification (continuing* restorative or maintenance), resocialization techniques (continuing* restorative or maintenance). These therapies shall be provided with professional supervision.	(j) Minimal supervision in self-care of colostomy;
	(k) Frequent reality communication, Remotivation, Attitude Therapy, behavior modification, resocialization techniques, all as continued restorative or maintenance, modified for provision by non-professional staff without professional supervision. These therapies are planned to meet individual residents' needs.

*Continuing means continuing from a higher level of care and does not mean ad infinitum.

CHAPTER III

ADMISSION, TRANSFER AND DISCHARGE POLICIES

300. ADMISSION POLICIES

301. GENERAL REQUIREMENTS

A. The individual or officers responsible for the institution shall develop written procedures for the general care policies to govern admissions and discharge of all patient-resident/residents. These written procedures shall be formulated with the advice of one or more physicians and one or more Registered Professional Nurse(s) and/or Licensed Practical Nurse(s), and shall be available at the facility for review by authorized State personnel.

B. All patient-resident/residents admitted to an Intermediate Care Facility shall be admitted to the appropriate level of care only on orders of a licensed physician who shall provide or shall make provision for the adequate medical care of the resident.

302. MEDICAL/SOCIAL INFORMATION

The facility shall be responsible for obtaining, prior to or at the time of admission, patient-resident/resident information including history of medical services, current medical findings, diagnoses, and orders from a licensed physician for the continuing care of the patient-resident/resident. If the referring physician is not the physician chosen to be the treating physician, the patient-resident/resident shall be seen by the treating or attending physician within 48 hours after admission.

303. INFORMATION FURNISHED TO RESIDENT BY THE FACILITY PRIOR TO ADMISSION

Prior to admission the administrator or his designee shall acquaint the prospective patient-resident/resident and/or his sponsors with the facility and its services, and thereby provide a basis for individual adjustment to any change in living arrangements. The prospective patient-resident/resident and/or his sponsors shall be informed of the type of care for which the facility is licensed and to advise that a change in the patient-resident/resident's condition could necessitate the need for transfer to another unit or facility.

The administrator or his designee shall fully acquaint the patient-resident/resident with the staff, other

patient-resident/residents, and with the rights, privileges and obligations assumed by patient-resident/residents.

304. INFORMATION FURNISHED TO PERSON(S) LEGALLY RESPONSIBILE FOR A PATIENT-RESIDENT/RESIDENT

The patient-resident/resident and/or guardian, person or agency placing a patient-resident/resident in the facility shall be furnished a written copy of the admission and general operating policies of the intermediate care facility at the time of admission. The policies shall include, but not be limited to, responsibility for medical care and medication, type of care, charges for services and refund policies.

305. PATIENT-RESIDENT/RESIDENT PREFERENCE

Insofar as possible, each patient-resident/resident shall have his wishes respected concerning with whom a room is shared. When a patient-resident/resident is moved within the home, the patient-resident/resident, his sponsor and/or guardian and attending physician shall be advised of the necessity or reason for the move. The intent of the foregoing is to preserve the patient-resident/resident maximum right of self-determination, insofar as space consideration will permit, in matters relating to his personal comfort and happiness. This principle recognizes that residents are happiest and most likely to respond to therapy when in congenial surroundings.

306. OBSERVANCE OF RELIGIOUS BELIEFS

A. No patient-resident/resident shall be compelled to undergo any medical screening, examination, diagnosis or treatment, or to accept any other health care or service if the patient-resident/resident and/or parent or guardian objects to such on religious grounds, except for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health.

B. The Intermediate Care Facility shall respect, insofar as practical, the religious beliefs of all residents.

307. TRANSFER POLICIES

308. DISCHARGE OF PATIENT-RESIDENT/RESIDENT

A. Each intermediate care facility shall have a written agreement(s) with one or more general hospitals within reasonable proximity to the facility, under which such hospital or hospitals will provide needed diagnostic

and other services to patient-resident/residents of the intermediate care facility and under which the hospital(s) agree to timely admission of acutely ill patient-resident/residents of the facility who are in need of hospital care. A copy of this written agreement(s) and any subsequent changes thereto, shall be on file to be examined by representatives of the Department.

B. The written agreement(s) with a hospital(s) shall provide a basis for effective working relationship under which in-patient hospital care shall be available promptly to the intermediate care facility patient-resident/resident, when needed, and shall include, as a minimum:

1. Procedures for transfer of acutely ill patient-residents/residents to the hospital, ensuring timely admission;

2. Provisions for continuity in the care of the patient-resident/resident and for the transfer of pertinent medical and other information between the intermediate care facility and the hospital. Transfer information shall include, as a minimum, current medical findings; medications; diagnosis; summary of course of treatment; rehabilitation potential and the applicable nursing, dietary and restorative aspects of care;

3. Provisions for the prompt availability of diagnostic and other medical services;

4. Establishment of responsibility for the prompt exchange of patient-resident/resident information to enable each institution to determine its ability to provide the required care and services to the patient-resident/resident;

5. Provision for the transfer of any or all personal effects and pertinent information relating to such items.

6. If the intermediate care facility is a distinct part of a skilled nursing home which has an agreement with hospital(s) this shall suffice for both levels of care.

C. Each Intermediate Care Facility shall have a written agreement(s) with one or more skilled nursing facilities to provide for timely acceptance of patient-resident/residents whose status has changed their need for skilled nursing care.

309. IN-HOUSE TRANSFER

The requirement for room assignments and transfers of patient-resident/resident within an Intermediate Care Facility

is covered under the Chapter on Civil Rights in the manual.

310. RESPONSIBILITY FOR PATIENT-RESIDENT/RESIDENT TRANSFERS

When a patient-resident/resident's condition changes and indicates the need for transfer from a higher to a lower level of care (skilled nursing to intermediate care), proper notification of such a change must be made to the funding agency who shall advise the facility of the procedure to be followed. In the case of a private patient-resident/resident the agency need not be notified, but the patient-resident/resident and/or the guardian should be fully informed.

311. DISCHARGE POLICIES

312.. DISCHARGE OF THE PATIENT-RESIDENT/RESIDENT

The intermediate care facility from which the patient-resident/resident is discharged shall have available all pertinent and relevant information necessary for continuing care of the patient-resident/resident, and shall make such information available to the physician or facility who assumes responsibility for such continuing care.

313. PATIENT-RESIDENT/RESIDENT DISCHARGE AND/OR TRANSFER REQUIREMENT

No patient-resident/resident shall be discharged or transferred from an intermediate care facility except on written order from the attending physician or a physician acting for the attending physician, with prior notification of the next of kin or sponsor. An exception would be when a mentally competent patient-resident/resident signs himself out of the facility.

CHAPTER IV

ADMINISTRATION AND ORGANIZATION

400. **GOVERNING BODY**

There shall be a governing body which shall assume full legal responsibility for the overall operation of the Intermediate Care Facility. The governing body shall be held responsible for compliance with all applicable Federal, State and local laws, regulations and standards. If an organized body is not available, the individual owner(s) or partners of the facility shall be held legally responsible for the conduct of the facility and compliance with applicable laws, regulations and standards.

401. OWNERSHIP

A. Facilities that are in compliance with the requirements applicable to Intermediate Care Facilities may participate in the Program and receive payments under Title XIX regardless of their ownership category, i.e. proprietary, voluntary non-profit, or Government. Each facility, however, shall supply to the Department, full and complete information as to the identity:

1. Of each person having (directly or indirectly) an ownership interest of 10 percent or more in such Intermediate Care Facility;

2. Of each officer and director of the corporation if the Intermediate Care Facility is organized as a corporation;

3. Of each partner if the Intermediate Care Facility is organized as a partnership.

B. Each facility shall promptly report to the Department within 48 hours any changes of ownership which would affect the current accuracy of the information required.

C. No facility shall be owned and/or operated by a person convicted of a misdemeanor or a high misdemeanor relating adversely to his/her capability of owning or operating that facility, unless that person is considered rehabilitated, as stipulated in the Rehabilitated Convicted Offenders Act, N.J.S.A. 2A:168A-1 et seq.*

402. ORGANIZATION AS A DISTINCT PART

An Intermediate Care Facility may be a free-standing, separate institution, qualifying and serving in its entirety as an Intermediate Care Facility, or it may be a distinct part of a larger institution. If the facility is operated as a distinct part of a larger institution (a unit attached to a general hospital, the nursing unit of a home for the aged or one unit of some other institution), the distinct part serving as the Intermediate Care Facility shall meet the following conditions:

*Effective as amended 6-9-77

1. Is a distinct identifiable unit;

2. Is noted on its license and is formally approved as an Intermediate Care Facility.

403. ADMINISTRATION

Every facility providing intermediate care services under the multiple occupancy provisions of this manual, (skilled nursing and intermediate level of care), whether a free-standing structure or a part of a structure, shall be operated under the supervision of an Administrator who is licensed as a nursing home administrator in the State of New Jersey.

The administrative policies shall provide that:

1. An individual on the professional staff of the facility is designated and is assigned responsibility for the coordination and monitoring of the patient-resident/residents' overall plan of service;

2. The numbers and categories of personnel are determined by the number of patient-resident/residents and their particular needs in accordance with accepted policies of effective institutional care.

3. Written policies and procedures shall be developed by the administrator with the assistance of a licensed nurse and/or key personnel;

4. There are written policies which preserve the dignity of patient-resident/resident, which prohibit mistreatment, neglect, or abuse of patient-resident/residents, and which provide for the registration of patient-resident/resident complaints without threat of discharge or other reprisals;

5. A written account is maintained on a current basis for each patient-resident/resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all expenditures and disbursements made by or in behalf of the resident;

6. There are written procedures for personnel to follow in an emergency including care of the patient-resident/resident notification of the attending physician and other persons responsible for the patient-resident/ resident, arrangements for transportation, for hospitalization, or other appropriate services;

7. There is an orientation program for all new employees which includes review of all facility policies, patient-resident/resident care policies, and emergency and disaster instructions:

8. An inservice education program is planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the population served by the facility. Records are maintained which indicate the content of, and participation in, all staff development programs;

9. There is available to staff, patient-resident/residents, consumer groups, and the interested public all policies of the facility including a written outline of its objectives and statement of the rights of its patient-resident/residents;

10. The admission, transfer, and discharge of patient-resident/residents of the facility are conducted in accordance with written policies as set forth in Chapter III.

404. PERSONNEL HEALTH PROGRAM

A. All regular paid personnel shall have a pre-employment physical examination including a chest x-ray or Tine test, serology, and stool examinations if a history of typhoid fever and/or parasites is elicited.

B. A physical examination, including chest x-ray or Tine test, shall be repeated annually on all regular paid personnel.

C. Personnel who show signs of respiratory infections, skin lesions, diarrhea, venereal disease and other communicable diseases shall be excluded from work, to return only after approval by a physician.

D. Personnel absent from duty because of any reportable communicable disease, infection or exposure thereto, shall be excluded from the facility until examined by a physician and certified by him to the Administrator as not suffering from any condition that may endanger the health of the patient-resident/residents or employees. For this purpose, the sections on "Reportable Diseases" and "Regulations Concerning Isolation of Persons Ill or Infected with a Communicable Disease and Restrictions of Contacts with Such Communicable Disease", State Sanitary Code, New Jersey State Department of Health, January 1, 1966 or as amended, shall be used as a reference.

E. All personnel health records shall be on file and available for examination by representatives of the Department of Health.

405. PATIENT-RESIDENT/RESIDENT CARE POLICIES

A. Policies shall be developed by the Policy Committee, which is a group of professional personnel, including the administrator, at least one or more physicians, the Director of Nursing, Recreational Director or Dietary Director, Consultant Pharmacist, and any other which may be designated by the facility. The committee shall be formulated by members who:

1. Meet regularly or at least annually at scheduled intervals and minutes of each meeting are recorded and kept on file;

2. Who attend at least 60 percent of the scheduled meetings.

B. It shall be the duty of this committee to write the policies that shall govern the care and services to patient-resident/residents of the Intermediate Care Facility. These policies shall describe at least admission, transfer, discharge planning, patient-resident/residents accepted and not accepted at facility, protection provided for patient-resident/residents' personal and property rights, the patient-resident/resident care plan, restorative nursing, rehabilitation, dietary regulations, activity programs, records, procedures for patient-resident/residents indicating illness beyond scope of the facility, mentally or emotionally disturbed, requiring isolation, and any other subject related to the welfare of the patient-resident/resident.

C. The policies shall be implemented at the direction of the Administrator by the Director of Nursing who is given regular scheduled medical guidance by a member of the medical staff. A periodic medical review of the patient-resident/residents shall examine the effectiveness of the policies. Each physician shall be acquainted with the requirements of the patient-resident/resident care policies. Medical records and minutes of committee meetings shall reflect that the patient-resident/residents' care is being given in accordance with the written policies. Minutes of all meetings of the Policy Committee shall be kept of file and available for review by the Department's Representative.

CHAPTER V

PHYSICIAN SERVICES AND TREATMENT

500. ACTIVE TREATMENT IN AN INTERMEDIATE CARE FACILITY MEANS:

Daily participation, in accordance with an individual plan of care and service, in activities, experiences, or therapies which are part of a professionally developed and supervised program of health, social or rehabilitative services offered by or procured by the institution for its residents;

1. An individual plan of care and service which is a comprehensive written plan developed for each patient resident/resident by an appropriate interdisciplinary professional team setting forth measurable goals or behaviorally stated objectives for which the patient-resident/resident is presently or potentially capable.

Level A (upper level medical)	Level B (lower level non-medical)
Plan of treatment shall be:	Plan of treatment shall be:
A combined plan for medical, personal, and social care with emphasis on medical and personal rehabilitation and beginning emphasis on social activities.	A combined plan for medical, personal, and social care with primary emphasis on social rehabilitation.

501. GENERAL REQUIREMENTS

A. The Intermediate Care Facility maintains policies and procedures to assure that each resident's health care is under the continuing supervision of a physician in compliance with the following standard:

Level A (upper level medical)	Level B (lower level non-medical)
1. Medical care (physician evaluation and plan of treatment reviewed every 30 days).	1. Medical care (as required but plan of treatment reviewed at least every 60 days).

2. Continuing*physical, occupational, speech or inhalation therapies to meet predetermined goal.	2. Continuing*physical, occupational, speech or inhalation therapies to meet predetermined goals. (at this level speci therapies could be provided through OPD services in the community).

B. All patient-resident/residents shall be admitted only on orders of a licensed physician who will be responsible for prescribing for the adequate care of the patient-resident/resident.

C. Each patient-resident/resident's care shall be under the supervision of the attending physician or, in the absence of an attending physician, a physician who accepts responsibility for the adequate care of the resident and is so recorded in each resident's clinical record.

D. The facility shall have a licensed physician or physicians who shall be available to furnish necessary medical care in case of an emergency if the physician responsible for the care of a patient-resident/resident is not immediately available. There shall be established procedures to be followed in an emergency which covers the immediate care of the patient-resident/resident, persons to be notified and reports to be prepared. Such procedures shall be available to surveyors from the Department.

502. PHYSICIANS' SERVICES

Physicians' services are "those services provided within the scope of practice of his profession as defined by State law, by or under the direct personal supervision of an individual licensed under State law to practice medicine or osteopathy". "Under the direct personal supervision of" is the actual physical presence of the physician in the immediate area where a given service is rendered in order to oversee its accurate implementation where such service is considered to be within the scope of his practice.

503. MEDICAL FINDINGS AND PHYSICIANS' ORDERS (ADMISSION PERIOD)

At the time of admission, the facility shall be responsible for obtaining patient-resident/resident information which includes current medical findings, diagnoses, re-

*Continuing means continued from a higher level of care and does not mean continuing ad infinitum.

habilitation potential, a summary of the course of treatment followed in the hospital, and orders from a physician for the immediate care of the patient-resident/resident.

A. If the above information is not available in writing in the facility upon admission of the patient-resident/resident, it shall be obtained by the facility within 48 hours after admission.

B. If medical orders for the immediate care of a patient-resident/resident are unobtainable at the time of admission, the physician with responsibility for emergency care shall give temporary orders.

C. A current hospital or skilled nursing facility discharge summary containing the above information is acceptable.

504. PHYSICIAN RESPONSIBILITY FOR CONTINUING CARE

A. Based on an evaluation of the patient-resident/resident's immediate and long term needs, the attending physician shall prescribe a planned regimen of medical care under the following headings:

1. Indicated medications
2. Restorative services
3. Diet
4. Special procedures
5. Activities
6. Plans for continuing care
7. Discharge

B. The medical evaluation of the patient-resident/resident shall be based on a history and physical examination done within 48 hours of admission.

C. The Director of Nursing and other appropriate personnel involved in the care of the patient-resident/resident shall assist in planning the total program of care.

D. Orders concerning medications and treatment shall be in effect for the specified numbers of days indicated by the physician but in no case exceed a period of 30 days in level A (upper level medical) and 60 days in level B (lower level non-medical).

E. Telephone orders shall be accepted only when necessary and only by licensed nurses. Telephone orders are to be written into the appropriate clinical record by the nurse receiving them and countersigned by the physician within 48 hours.

EMERGENCIES: In the event of an emergency telephone order where the life of the patient-resident/resident may be endangered or his clinical status may be compromised, such order must be countersigned by the physician within 48 hours from the time the order was given.

F. There shall be evidence in the clinical record of the physician's visits to the patient-resident/resident at each visit which shall include pertinent facts concerning the patient-resident/resident's current status, relevant findings and significant changes observed. In level A (upper level medical) medical orders and progress notes shall be updated at least every 30 days. In level B (lower level non-medical) medical orders and progress notes shall be updated at least every 60 days.

G. Upon discharge, there shall be available for each patient-resident/resident, a summary which shall include diagnoses, medication, disposition of resident, plan of treatment, condition and recommendations for future care.

505. TRANSFER TO ANOTHER FACILITY

In the event of an accident or illness requiring care beyond the capabilities of the facility, the patient-resident/resident shall be transferred on orders of the attending physician to a facility where required services are available. The personnel of the Intermediate Care Facility shall have the authority, within their capabilities, to execute emergency procedures as prescribed by the attending physician.

CHAPTER VI

Nursing Services
Patient Activities and Social Service

600. GENERAL REQUIREMENTS

A. There shall be written policies and procedures to govern the nursing care, related medical services, residents'activities, social services if available and other services provided in the facility in accordance with the requirements set forth in this manual, which shall reflect awareness of and provisions for meeting the total needs of the patient-resident/resident.

601. The nursing staffing pattern in an Intermediate Care Facility shall comply with the following chart:

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
I. A minimum of 2.5 hours of direct patient-resident care in each 24 hour period, seven days a week, is required.	I. A minimum of 1.25 hours of direct resident personal care in each 24 hour period, seven days a week is required.
II. A registered professional nurse shall be employed for a minimum of 40 hours a week as Director of Nursing.	II. One licensed nurse shall be designated as Director of Nursing.
III. Registered professional nurses shall be on duty 8 hours daily (56 hours a week). There shall be a ratio of registered nurses to other staff of 1 to 5, with 25% credit for licensed practical nurses. A licensed nurse and at least one nurse's aide shall be on duty each 8 hour shift, 24 hours a day, seven days a week.	III. A licensed nurse and at least one nurse's aide shall be on duty each 8 hour shift, 24 hours a day, seven days a week.

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
Appendix A indicates the required hours of nursing staffing by census and category of nursing staff.	
IV. In a Free Standing Facility of less than 50 beds, the hours of care of the Director of Nursing may be counted as direct resident care.	IV. In a Free Standing Facility of less than 50 beds, the hours of care by the Director of Nursing may be counted as direct resident care. In a Free Standing Facility 50 beds or more, the hours of care of the Director of Nursing may not be counted as direct resident care nor may they be included in satisfying requirements of Item 5.
	V. In a facility which is part of a facility providing a higher level of care, the minimal registered nurse coverage may be counted entirely as direct care.
	VI. In every facility there shall be sufficient licensed nurses on duty to provide 20% of the minimum hours in each 24 hour period. Nurses' aides may provide 80% of the minimum required hours of care.

602. Basic Nursing Care Services shall be in conformity with the following chart:

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
I. Observation of vital signs and recording of findings in medical record;	I. Vital signs as necessary in temporary illness;
II. Skin care using preventive techniques as well as care of small superficial lesions or irritations (e.g. stage 1 and 2 decubitus ulcers, etc.)	II. Supervision, assistance and support for maintenance of self-care at highest functioning level possible;
III. Dressing changes for routine, chronic, non-infected skin conditions;	III. Dressing changes for superficial wound supervision and observation to prevent or detect infection;
IV. Use of protective restraints, bed rails, binders and supports if ordered by physician and provided in accordance with written patient-resident care policies and procedures.	IV. Care of occasional or beginning incontinence of bowel and bladder;
V. Care of incontinency of bowel and bladder in stages of restoration or terminal care;	V. Emergency clysis pending transfer to higher level of care;
VI. Administration and/or supervision of clyses;	VI. Gastrostomy supervision after stabilization;
VII. Gastrostomy care after stabilization at a higher level of care;	VII. Tracheostomy supervision after stabilization;
VIII. Tracheostomy care after stabilization at a higher level of care;	VIII. Administration of simple medications and teaching self-administration for discharge if ordered by physician;

Level A (Upper level-Medical)	Level B (Lower level-Non-medical)
IX. Bladder irrigation for indwelling catheter; (catheterization only according to Nurse Practice Act of N.J.);	IX. Programming for social interaction and social activities according to individual needs;
X. Intensive terminal care (including spoon feeding, care of skin, personal hygiene etc.)	X. Observation and supervision for preventive and maintenance of current health and social status.
XI. Administration of medications and treatments as ordered by physician to include instruction of patient-resident in self-administration where indicated;	
XII. Observation and supervision of all aspects of patient-resident care including social interaction and social activities (preventive, restorative, and maintenance);	
XIII. Instruction for independence in all activities of daily living and basic health care and maintenance;	

603. NURSING SERVICES PERSONNEL

Nursing services personnel are sufficient in numbers and qualifications so that:

1. There is on duty, awake and fully dressed, a sufficient number of responsible staff members at all times, immediately accessible to all residents and qualified by training and experience, to assure prompt, appropriate action in cases of injury, illness, fire, or other emergencies;

2. In the presence of minor illness and for temporary periods, bedside care under the direction of the patient-resident/resident's physician is available from or supervised by a registered nurse or licensed practical nurse; and

3. All resident health needs are met and each patient-resident/resident receives treatments, medications, diet and other health services as prescribed and planned, all hours of each day and all days of each week.

4. Nursing staff are distributed throughout each tour of duty and throughout the week according to the services and activities to be provided on certain days and times of day.

5. There shall be a job description on file for each nursing title used in the facility (e.g. Director of Nursing Service, Assistant Director of Nursing Service, Nurse Supervisor, Head Nurse, Staff Nurse) as well as general responsibilities for each category of nursing personnel (e.g. registered professional nurse, licensed practical nurse, nurses' aide).

6. Time sheets and payroll sheets for all nursing personnel shall be made available to authorized personnel of the New Jersey State Department of Health to show compliance with the standards for minimal and qualified nurse coverage.

604. STAFF DEVELOPMENT

A. An inservice ongoing educational program for all personnel shall be developed.

B. Regularly planned staff meetings shall be conducted by the Administrator and the Director of Nursing Services, with the participation of nursing and other staff.

605. NURSING STAFF REQUIRED

A. Director of Nursing Services

In a separate intermediate care facility or in a multiple occupancy facility which includes intermediate care the Director of the Department of Nursing Service shall be the Director of Nursing Service and shall be a registered professional nurse with a minimum of two years experience in nursing service administration, nursing supervision, with knowledge of rehabilitation nursing, psychiatric, and/or geriatric nursing.

1. A licensed nurse shall relieve the Director on a regular basis whenever the Director is not in the facility.

B. The Director of Nursing has the following responsibilities:

1. The development and implementation of a written health care plan for each patient-resident/resident in accordance with instructions of the attending physician. For level A (upper level medical), the nursing-social care plan shall be based on the medical plan of treatment and expanded to include nursing-social therapies individualized for each patient-resident/resident to meet his needs. For level B (lower level non-medical) the nursing-social care plan shall be based on the medical and social status of the resident to meet his needs;

2. General supervision, guidance and assistance for each patient-resident/resident in carrying out his personal health program to assure that preventive measures, treatments and medications prescribed by the attending physician are properly carried out and recorded; and

3. The review and revision of patient-resident/resident health care plans, as needed, but not less than 30 days for level A (upper level medical) or 60 days for level B (lower level non-medical).

C. Nurse Supervisors and Head Nurses

There shall be sufficient nurse supervisors and head nurses to meet the needs of the facility in relation to its size and complexity and to the quantity and quality of other nursing staff employed.

D. Staff Nurses

There shall be a sufficient number of staff nurses, nurses' aides and other nursing personnel to provide the required quantity and quality of direct nursing care.

E. Charge Nurse (if applicable)

606. ADMINISTRATION OF MEDICATIONS

All medications shall be administered to patient-resident/residents upon written order of the attending physician by a registered professional nurse or a licensed practical nurse in accordance with the Nurse Practice Act of New Jersey, the regulations of the New Jersey Board of Nursing, and the standards set forth in the sections on Physicians and on Pharmaceutical Services. Telephone orders shall be accepted only when necessary and only by licensed nurses. Telephone orders shall be written into the appropriate clinical record by the nurse receiving them and countersigned by the physician within 48 hours.

607. EQUIPMENT AND NURSING SUPPLIES

The following equipment and supplies shall be made available by the facility:

1. Equipment necessary in each unit for providing proper care and treatment to all patient-resident/residents.

2. Equipment necessary for the proper storage and administration of medications (See Pharmaceutical Services).

3. First aid supplies and equipment with a breakable seal, kept at or near the nurses' station.

4. Provision for sterilization by autoclave or chemicals after each use of reusable equipment, in accordance with accepted hospital techniques.

608. NURSES' NOTES

A. There shall be nursing notes which comply with the following standards:

Level A (Upper level - medical)	Level B (Lower level - non-medical)
Nursing notes as necessary but at least a summary once every two weeks directly related to the progress of the nursing-social plan of care.	Nursing notes as necessary but at least a monthly summary directly related to the nursing-social plan of care. Social activity record at least monthly.

B. Temporary illness or sudden change in condition of patient-resident/resident shall be cause for keeping a clinical record on all 3 tours of duty each 24 hour day or until the patient-resident/ resident's physician determines transfer to a hospital or skilled nursing facility.

C. Daily Activities Records shall be kept on each patient-resident/resident at least monthly and more often as necessary, The records shall be maintained more frequently when special progress toward a goal, or when obvious deterioration shows need for new approaches and/or new goals.

D. Restraint orders by the physician shall be recorded indicating type, date, shift, number of hours of each use, unless recorded on the Medication Sheet.

609. ACCIDENT REPORTS AND INCIDENT REPORTS

Special reports on designated forms shall be filed by nursing personnel involved in or witness to accidents and incidents which may involve a question of patient-resident/resident safety or be possible cause for subsequent question as to the adequacy of nursing-social care or supervision. These forms shall be used in cases of known injury from unknown cause, in medication errors, in patient-resident/ resident physical altercations with each other, or with nursing staff. A copy of the accident report form shall be attached to the patient-resident/ resident's record, a copy retained by the administrator, and a copy sent to the Department.

610. ORIENTATION OF NEW PERSONNEL AND CONTINUED INSERVICE EDUCATION

Under the supervision of the Director of Nursing Services the following are required.

1. Established procedure and recorded content for the orientation of all new nursing and social personnel to the particular health care facility and its philosophy of care, and to the specific functions and duties to be performed;

2. Continuing inservice education for all nursing perpersonnel to include:

   a. Current theory appropriate to each level of nursing staff in medical, geriatric, psychiatric, and restorative nursing and social care.

b. **Instruction in planning and conducting individual and group social and recreational activities and in adaptation of environmental factors to meet the physical and psychosocial needs of the residents.**

611. ANCILLARY SERVICES *

The Activities Program shall provide programming with the patient-resident/resident's participation designed to encourage restoration to self-care and maintenance of normal activities through physical exercise, intellectual and sensory stimulation and social interaction which assures that:

1. An initial evaluation of patient-resident/resident needs and interests shall be conducted and recorded in the patient-resident/resident's individual record within 14 days of the date of admission ;

2. A current written outline for group and independent activities of sufficient variety to meet the needs of the various types of patient-resident/residents in the facility is maintained under the direction and supervision of a staff member qualified by experience and/or training in directing group activity or who has available consultation from a qualified recreational therapist, occupational therapist, occupational therapy consultant or social worker;

3. Independent and group activities shall be planned for each patient-resident/resident as a matter of record and provided in accordance with his/her needs and interests. Each patient-resident/resident's activity plan shall be reviewed, in conjunction with the patient-resident/resident, at least quarterly and a written evaluation of the patient-resident/resident's progress, identification of needs, and establishment of goals for the next quarter made;

4. Adequate indoor and outdoor recreation areas shall be provided with sufficient equipment and materials available to support independent and group activities;

5. Opportunities, as available, shall be provided for the patient-resident/resident's participation in activities of interest outside the facility through community, educational, social, recreational, and religious resources ; and

6. All activities, both independent and group, in which the patient-resident/resident participates shall be reflected in the quarterly review. Individual patient-resident/resident progress and the value of the activities in which the patient-resident/resident participates shall be recorded in the clinical record.

*Effective 8-20-76

CHAPTER VII

PHARMACEUTICAL SERVICES

700. GENERAL REQUIREMENTS

The facility shall maintain policies and procedures relating to drugs and biologicals.

A. If the facility maintains a pharmacy department, it shall employ a licensed pharmacist;

B. If the facility does not have a pharmacy, it shall have a formal arrangement with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and recordkeeping of drugs and biologicals;

C. All medications shall be ordered in writing by the patient-resident/resident's attending physician;

D. Medications not limited as to time or number of doses when ordered shall be automatically stopped in accordance with written policies of the facility, and the attending physician shall be notified;

E. Self-administration of medications shall be allowed only with the written permission of the attending physician;

F. The Director of Nursing Services shall review monthly each patient-resident/resident's medications;

G. Medication orders shall be reviewed at least every 30 days for level A (upper level-medical) and every 60 days for level B (lower level-non-medical) by the attending physician;

H. All medications ahll be administered by medical and nursing personnel in accordance with the Medical and Nurse Practice Acts of the State;

I. The facility shall comply with the Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics, those drugs subject to the Drug Abuse Control Amendment of 1965 and other legend drugs;

J. The use of unit dose drugs shall be optional with the facility;

K. All drugs and medications shall be prescribed, handled, stored, and administered in accordance with the requirements of this manual and all other applicable State and Federal regulations.

701. STANDARDS FOR PHARMACEUTICAL SERVICES

The facility shall have written policies covering the pharmaceutical services which are developed with the advice of members of the medical staff, pharmacist and Director of Nursing. The policies shall be reviewed at least annually. Pharmacy policies and procedures including obtaining, dispensing, and administering drugs and biologicals shall be developed by the medical staff, pharmacist, and Director of Nursing Services serving as the Pharmacy and Therapeutics Committee or any other designated committee used by the facility.

702. SPECIFIC REQUIREMENTS

The services of a consultant pharmacist shall be provided and such consultant may be the provider of services to the facility.

1. The consultant pharmacist shall visit the facility as required, but at least quarterly and shall provide the Administrator with a written report of his findings.

703. EMERGENCY KIT

A. An emergency kit approved and listed by the Pharmacy and Therapeutics Committee shall be located at each nurses' station. Any policy changes made by other designated committees shall be recorded in the minutes of the designated committee. The emergency kit shall have a breakable seal placed in such a manner that it will readily indicate when the kit has been opened. This kit shall be maintained, restocked and resealed by the consultant pharmacist as needed, but at least quarterly. All medications shall be injectables (unit packaged) with the exception of aromatic ammonia spirits and nitroglycerine tablets. Telephone orders should be confirmed in writing by the physician. Emergency drugs may be administered only by a licensed nurse.

B. Emergency drugs are defined as those drugs the prompt use and immediate availability of which are generally regarded by physicians as essential in the proper treatment of sudden and unforeseen adverse changes in a patient-resident/resident's condition. These changes are a threat to the patient-resident/resident's life or well-being and the medications included should be primarily for the treatment of cardiac arrest, circulatory collapse, allergic reactions, convulsions and bronchial spasms. The emergency drug kit should be a source for "stat" drug orders.

704. CONFORMANCE WITH PHYSICIAN'S ORDERS

A. All medications administered to patient-resident/residents shall be ordered, in writing, on the patient-resident/resident's chart by the attending physician and shall be in effect for the number of days specified by the physician, but in no case to exceed 30 days in level A (upper level medical) or 60 days in level B (lower level-non-medical).

B. Oral orders shall be given only to a registered professional nurse or licensed practical nurse, and shall be immediately reduced to writing, signed by the nurse and countersigned by the physician within 48 hours.

C. Medications not specifically limited as to time or number of doses, when ordered, shall be automatically stopped in accordance with written policy approved by physician or physicians responsible for advising the facility on its medical administrative policies.

705. STOP ORDER POLICY

A. The patient-resident/resident's attending physician shall be notified of stop order policies by the Pharmacy and Therapeutics Committee or any other designated committee and contacted promptly by the head nurse for renewal of such orders prior to expiration of such order so that continuity of the patient-resident/resident's therapeutic regimen is not interrupted.

B. The following shall be considered a guideline for a stop order policy in level A (upper level medical) or in level B (lower level non-medical) when necessary. However in level B (lower level non-medical) the stop order should not exceed 60 days.

Analgesics	-2 weeks
Antianemia	-1 month
Antibiotics	-5 days

Anticoagulants	-Automatic
Antiemetics	-3 days
Antihistamines	-2 weeks
Antineoplastics	-1 week
Barbiturates	-1 month
Cardiovascular Drugs	-1 month
Cathartics	-1 month
Cold Preparations	-5 days
Cough Preparations	-5 days
Dermatologicals	-1 week (except emollients)
Diuretics	-1 month
Hormones	-1 month
Hypnotics	-1 month
Narcotics	-5 days
Psychotherapeutics	-1 month
Sedatives	-1 month
Spasmolytics	-2 weeks
Sulfonamides	-5 days
Vitamins	-1 month

706. ADMINISTRATION OF MEDICATIONS

All medications shall be administered by licensed medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of New Jersey. Each dose administered shall be properly recorded on patient-resident/resident's clinical record in accordance with the following criteria:

1. The nursing station(s) shall have readily available items necessary for the proper administration of medication.

2. Medications shall be administered by nursing personnel in accordance with the requirements in Chapter V on Nursing Services.

3. Self-administration of medications by patient-resident/residents shall be permitted by order of the patient-resident/resident's physician.

4. Medication errors and drug reactions shall be immediately reported to the patient-resident/resident's physician and an entry thereof made in the clinical record as well as on an incident report, and signed by the attending physician.

5. Up-to-date medication reference texts and sources of information shall be provided. Any one of the following texts shall be considered acceptable as a minimum:

American Hospital Formulary Service

American Drug Index

Facts and Comparisons

Modern Drug Encyclopedia and Therapeutic Index

Pharm Index (Bi-Monthly Supplements)

Physician's Desk Reference

6. Medications shall be administered and properly recorded on the patient-resident/resident's clinical record by the nurse who administered the medication. The record shall include each dosage given, method of administration, time and initials. The full signature for identification purposes shall be elsewhere in the facility records.

707. RECEIPT OF MEDICATION FROM PHARMACY PROVIDER

There shall be assigned a responsible person(s) by the facility whose initials on the pharmacy provider's claim form will attest to receipt of any medications supplied to the facility.

708. LABELING AND STORING

Patient-resident/resident's medications shall be properly labeled and stored in a locked cabinet or room at the nurses' station in accordance with the following criteria:

1. The label of each patient-resident/resident's individual medication container shall clearly indicate the patient-resident/resident's full name; physician's name; prescription number; name, strength and quantity of drugs; directions for drug use; name, address and telephone number of pharmacy issuing the drug.

2. Medication containers having soiled, damaged, incomplete or makeshift labels shall be returned to the issuing pharmacy for relabeling. Medication in containers having no labels or illegible labels or medications no longer in use, or medications whose expiration date is past, shall be destroyed in accordance with State and Federal laws.

3. The medications of each patient-resident/resident shall be stored in their original containers. Transferring between containers is forbidden.

4. Separately locked, securely fastened boxes (or drawers) within the medicine cabinet shall be provided for storage of narcotics, barbiturates, amphetamines and other dangerous drugs as provided for Schedule II Drugs under the Controlled Substances Act of 1970. Narcotic drugs, Schedules III, IV and V Drugs as indicated by the Controlled Substances Act shall be retained under double lock at all times.

5. Cabinets shall be well lighted and of sufficient size to permit storage without crowding.

6. Medications requiring refrigeration shall be kept in a separate, locked box within a refrigerator at or near the nursing station, or in a locked drug room where the refrigerator is located.

7. Poisons and medications for "external use only" shall be kept in a locked cabinet, separate from other medications and properly labeled.

8. Only supplies of non-legend drugs may be maintained as stock and shall be administered by individual order of the patient-resident/resident's physicians. Non-legend drugs may be administered by a registered professional nurse or a licensed practical nurse directly from a stock supply.

709. CONTROL OF DRUGS SUBJECT TO CONTROLLED SUBSTANCE ACT OF 1970

A. Narcotics

1. The facility shall comply with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics and those drugs subject to the Controlled Substances Act of 1970.

2. A narcotic record shall be maintained, listing on separate sheets for each type and strength of narcotic the following information: Date, time administered, route of administration, name of patient-resident/resident, dose, prescribing physician's name, signature of person administering dose and balance of the medication remaining.

B. Other Drugs

1. There shall be full compliance with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of all medications subject to the Controlled Substances Act of 1970.

2. An individual record shall be maintained for each type and strength of medication subject to the aforementioned Act. The following information shall be recorded: Date, time administered, name of patient-resident/resident, dose, route of administration, physician's name, signature of the person administering the dose and the balance of the medication remaining.

3. A record of the verification of inventories of the controlled medications shall be made by both nurses (incoming and outgoing) at the time of each tour change. Provision shall be made for established procedures to be followed in the event that the inventories cannot be verified. A report of all such incidents shall be written and signed by both nurses and further investigation shall be made by the pharmacist and Administrator with subsequent written report to the appropriate Federal agency.

4. Suitable provisions shall be established for procedures to be instituted for controlled medications which may be lost, contaminated or destroyed. Such incidents shall be documented by the nurse involved and by witnesses if present at the time, with a follow-up investigation to be made by the consultant pharmacist and Administrator, and subsequent written report to the appropriate agency.

C. The key to the medication room or cabinet shall be kept on the person of the registered professional nurse or licensed practical nurse authorized to administer medications.

D. The supply of needles and syringes used to administer medications to residents shall be stored in a locked area. Disposable needles and syringes shall be destroyed after use in such a manner that they can not again be used.

CHAPTER VIII

DIETARY SERVICES

800. GENERAL REQUIREMENTS

The Intermediate Care Facility shall provide for professional planning and supervision of menus and meal service of both regular and special diets so that:

1. A current diet manual recommended by the Department is readily available to food service and health service personnel;

2. There is a sufficient number of food service personnel to meet the dietary needs of the patient-resident/residents;

3. Procedures are established and regularly followed which assure that the serving of meals to patient-resident/residents for whom special or restricted diets have been medically prescribed is supervised and their acceptance by the patient-resident/residents is observed and recorded in the patient-resident/resident's record;

4. At least three meals or their equivalent are served daily, at regular times with not more than 14 hours between the evening meal and breakfast;

5. Menus are planned at least 2 weeks in advance and sufficient food to meet the nutritional needs of patient-resident/residents is prepared as planned for each meal. When changes in the menu are necessary, substitutions provide equal nutritive value. Records of menus as actually served are retained for 30 days;

6. Individuals needing special equipment, implements or utensils to assist them when eating have such items provided;

7. All food is procured, stored, prepared, distributed and served under sanitary conditions.

801. DIRECTOR OF DIETARY SERVICES

A. The dietary services shall be under the full-time direction of a director. (See Page 1 Definitions)

B. The detail functions of the Director of Dietary Services shall consist of the following as a minimum:

1. The development, maintenance and evaluation of all dietary policies and procedures,

2. The orientation, direction and supervision of all dietary personnel,

3. The provision of nutrition consultation and in-service education for the nursing and other related staff;

4. The participation in conferences when necessary with the Administrator or the physician and Director of Nursing Service regarding dietary services for the patient-resident/resident;

5. The making of recommendations and participation in the purchase, quantity and quality control of foods and equipment for the dietary service.

C. If dietary services are provided under contract with an outside food management company, the company shall have a dietitian in accordance with Section 801-A who shall maintain standards as listed herein and shall provide for continuing liaison with the medical and nursing staff of the facility for recommendations on dietetic policies affecting resident care.

802 DIETARY STAFF

A. The number of food service personnel, in addition to the Director, shall be determined by the size and needs of the facility.

B. Food service personnel shall be on duty for a period of 12 hours or more daily to meet the dietary requirements of the patient-resident/resident.

C. During the absence of the Dietary Services Director, a member of the dietary staff who the administrator considers qualified shall be assigned to be in charge of the dietary services.

D. In the event dietary employees are assigned duties outside the dietary department, these duties shall not interfere with the sanitation, safety, or time required for dietary work assignments.

E. Written job descriptions and qualifications of dietary employees shall be available at the facility for review by the Department of Health.

803. WRITTEN POLICIES AND PROCEDURES

Written policies and procedures to include, but not be limited to the following, shall be available at the facility for review by the Department of Health representatives.

A. Work Assignments and duty schedules of all dietary personnel shall be posted

B. Food service personnel shall be in good health, practice hygienic food handling techniques, and shall meet the following requirements, as a minimum:

1. Food service personnel shall wear clean, washable garments, hair nets or clean caps, and keep their hands and fingernails clean at all times;

2. Routine health examinations shall meet local, State or Federal codes for food service personnel;

3. Food handlers' permits shall be current where required;

4. Personnel having symptoms of communicable diseases or open infected wounds shall not be permitted to work.

C. The food and nutritional needs of residents shall be met in accordance with physicians' orders.

D. Therapeutic diets ordered by physicians shall be planned and prepared according to the diet manual, and shall be served under direction as specified in Section 801-1.

NOTE: Each individual patient-resident/resident's reaction and other pertinent information related to the therapeutic diet, shall be recorded in the patient-resident/resident's medical record by the nursing staff.

E. A current New Jersey Diet Manual shall be maintained in the facility and be readily available to all dietary and nursing personnel.

F. At least three meals, or their equivalent, shall be served daily at regular times, with no more than a 14 hour span between the evening meal and breakfast. Between-meal or bedtime snacks of nourishing quality shall be offered. If the "four or five meal a day" plan is in effect, meals and snacks shall provide equivalent nutritional value.

G. Menus shall be planned at least two weeks in advance and food sufficient to meet the nutrition needs of residents shall be prepared as planned for each meal and when changes in the menu are necessary, substitutions shall provide equal nutritive value and so recorded on the menu.

H. The current menu shall be posted in one or more accessible places in the dietary department for easy use by workers purchasing, preparing and serving foods.

I. Menus shall provide a sufficient variety of foods served in adequate amounts at each meal, with different menus for the same days of each week adjusted for seasonal changes.

J. Records of menus served shall be filed and maintained for 30 days.

K. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two day period shall be maintained on the premises properly stored.

L. Records of food purchases shall be kept on file.

M. Foods shall be prepared by methods that conserve nutritive value, flavor, appearance, and shall be attractively served at the proper temperatures and in a form to meet individual needs.

N. A file shall be maintained of tested recipes, adjusted to appropriate yield; food shall be cut, chopped or ground to meet individual needs and substitutes shall be offered to residents who refuse foods served.

O. Effective equipment shall be provided and procedures established to maintain at proper temperature during serving.

P. Dining room service shall be provided for all residents who can and will eat at a table.

Q. Trays provided for bedfast residents shall rest on firm supports such as overbed tables. Sturdy tray stands of proper height shall be provided residents able to be out of bed.

R. Sanitary conditions shall be maintained in the storage, preparation and distribution of food; effective procedures for cleaning all equipment and work areas shall be followed consistently.

S. Dishwashing procedures and techniques shall be established, understood and carried out in compliance with the State Sanitary Code.

T. Written reports of inspections made by State or local health authorities shall be available at the facility for review by the Department of Health.

U. Waste which is not removed by mechanical means shall be kept in leak-proof non-absorbent containers with close fitting covers and shall be removed from the kitchen daily; containers shall be thoroughly cleaned inside and out and disinfected as needed.

V. Dry or staple food items shall be stored in covered containers off the floor in a ventilated room not subject to sewage or waste water back-flow, or contamination by condensation, leakage, rodents or vermin.

804. DIETARY FACILITIES

Dietary areas shall be provided for the general dietary needs of the institution which shall include an area or areas for the preparation of special diets and dining with table service.

1. All dietary areas shall be appropriately located, adequate in size, well lighted, ventilated and maintained.

2. The type, size and layout of equipment shall provide for ease of cleaning, optimal work flow, and adequate food production to meet the scope and complexity of the regular and therapeutic dietary requirements of the residents.

3. Equipment and work areas shall be clean and orderly with effective procedures for cleaning all equipment and work areas to safeguard the health of the patient-residents/residents.

4. Handwashing facilities, including hot and cold water, soap, and individual towels, preferably paper towels, are provided in or near kitchen areas.

805 DIETARY AND NUTRITIONAL CRITERIA

The dietary and nutritional criteria for patient-resident/resident shall include, but not necessarily, be limited to the following:

1. Lever A (upper level medical)	Level B (lower level non-medical)
a. Provision of special diets and dietary consultation.	a. Continuing supervision of special dietary intake in stabilized medical condition as preventive care.
b. Observation and supervision of special diet	b. Supervision of dietary intake for maintenance

as it relates to the continuing stabilization of medical condition.

of adequate nutritional state and prevention of deficiencies.

c. Continuing attention to basic nutritional needs for maintenance of current health status and prevention of deficiencies.

CHAPTER IX

HOUSEKEEPING SERVICES

900. GENERAL REQUIREMENT

The Intermediate Care Facility shall provide the housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

901. HOUSEKEEPING STANDARDS

A. Housekeeping services shall be adequate to maintain clean, safe and orderly surroundings for patient-resident/residents and personnel.

B. A work plan for cleaning operations shall be established and kept on file in the facility.

C. Housekeeping personnel shall be trained in acceptable procedures of cleaning.

D. Safety aspects of good housekeeping practice shall be followed by all personnel.

E. Appropriate and adequate cleaning equipment and supplies shall be provided for all housekeeping procedures required within the facility.

902. PRACTICES AND PROCEDURES

A. The facility shall provide sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner.

B. Housekeeping personnel shall keep the facility free from offensive odors, dirt, rubbish, dust and hazards to safety.

NOTE: Storage areas, attics and cellars shall be kept safe and free from accumulations of extraneous materials such as refuse, discarded furniture and old newspapers. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

C. Floors shall be systematically cleaned regularly. Waxes on floors shall provide a nonslip finish and throw or scatter rugs shall not be used except for nonslip entrance mats.

903. PEST CONTROL

The facility shall be maintained free from insects and rodents.

1. A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. Care shall be taken to use the least toxic and least flammable effective insecticides and rodenticides. These supplies shall be stored in non-resident areas and in nonfood preparation and storage areas. Poisons shall be kept under lock.

2. Harborages and entrances for insects and rodents shall be eliminated.

3. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises in conformity with State and local practices. Containers shall be cleaned regularly.

904. LINEN

The facility shall have available at all times a quantity of linen essential for the proper care and comfort of residents. Linens shall be handled, stored and processed so as to control the spread of infection.

1. The linen supply shall be at least three times the usual occupancy.

2. Clean linen shall be stored in clean, dry, dust-free areas easily accessible to the nurses' station.

3. Soiled linen shall be stored in separate well ventilated areas and shall not be permitted to accumulate in the facility. Soiled linen and clothing shall be stored separately in suitable bags or containers.

4. Soiled linen shall not be sorted, laundered, rinsed or stored in bathrooms, resident rooms, kitchens, or food storage areas.

CHAPTER X

MEDICAL AND CLINICAL RECORDS

1000. GENERAL REQUIREMENT

A. The Intermediate Care Facility maintains an organized patient-resident/resident record system which assures that there is available to professional and other staff directly involved with the patient-resident/resident and to appropriate representatives of the State agency a record for each patient-resident/resident which includes as a minimum:

1. Identification information and admission data including past medical and social history;

2. Copies of all initial and periodic examinations and evaluations including all plans of care and service and periodic summaries of patient-resident/resident progress which shall be reviewed and revised every 30 days for level A (upper level medical) and every 60 days for level B (lower level non-medical).

3. Entries describing all treatments and services rendered and medications ordered and/or administered;

4. All symptoms and other indications of illness or injury brought to the attention of the staff by the patient-resident/resident or from other sources including the date, time, and action taken regarding each;

5. An individual record for each patient-resident/resident covering his medical, nursing and related care in accordance with accepted professional standards.

B. All information contained in the patient-resident/resident's record shall be privileged and confidential. Written consent of the patient-resident/resident (or of a designated responsible agent acting on his behalf) shall be required for release of information.

C. Records are adequately safe-guarded against destruction, loss, or unauthorized use;

D. All records are retained in accordance with State statutes.

1001. MAINTENANCE OF CLINICAL RECORDS

The Intermediate Care Facility shall maintain a separate clinical record for each patient-resident/resident with all entries kept current, dated, and signed by appropriate personnel.

The record shall include:

1. Identification and summary sheet(s) including patient-resident/resident's name, Social Security Number, Health Services Program Number, Person Number, marital status, age, sex, home address, and religion; names, addresses and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis; final diagnosis; condition on discharge; disposition and discharge summary.

2. Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential.

3. Authentication of hospital diagnoses, if applicable, in the form of a hospital summary discharge sheet, or transcript, or a report from the physician who attended the patient-resident/resident in the hospital, or a transfer form used under a transfer agreement.

4. Signed physician's orders, including all medications, treatments, diet, restorative and special medical procedures required for the safety and well-being of the patient-resident/resident.

5. Signed physician's progress notes including significant changes in the patient-resident/resident's condition, written at the time of each visit which shall not be more than every 30 days for level A (upper level medical) or every 60 days for level B (lower level non-medical).

6. Signed nurse's notes containing observations made by the nursing personnel including appropriate records of medication and treatment given; untoward reaction, if any, and observations of the patient-resident/resident's current condition. In addition, a summary of condition shall be entered into each patient-resident/resident's record as noted in Section 611.- NURSES NOTES.

   Incident Reports:

   If an incident has occurred including errors in the administration of medication, involving a patient-resi-

dent/resident, a reference shall be made in the nursing notes with the completed incident report appended to the patient-resident/resident's record with a duplicate on file with the Administrator. The report shall include the date, time, extent of the incident, circumstances under which it occurred; witnesses, if any; action taken and any other relevant information. All information shall be signed by the reporting nurse and counter-signed by the attending physician within 48 hours. Copy of form of Department of Health shall be forwarded to the Department.

7. Signed medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the patient-resident/resident.

8. Signed laboratory and x-ray reports.

9. Consultation reports.

10. Reports of any professional services.

11. Therapy records.

12. All entries on the resident's clinical record shall be current, dated and signed by the physician, nurse or therapist, where applicable.

1002. DECEASED RESIDENT RECORD

The clinical record of a deceased patient-resident/resident shall be fully completed promptly. It shall include, the following:

1. Records made by the physician during the critical stages of illness.

2. Written documentation of death pronouncement by the physician and completion of death certificate with duplicate copy attached to patient-resident/ resident's record.

3. Complete nurse's notes containing all necessary and pertinent information documenting the patient-resident/ resident's progress during the illness and demise, notification of physician and next of kin.

4. Written records of the disposition of the remains in nurse's notes.

1003. RETENTION OF RECORDS

All clinical records of discharged patient-resident/residents shall be completed promptly and shall be filed and retained in

accordance with State statute.

1. In the event the facility transfers ownership, the new licensee shall be responsible for the retention and storage of medical records for the required length of time.

2. An inventory shall be included in the transfer. In the event of discontinuance of operation the owner shall be responsible for the records.

1004. TRANSFER OF RECORDS

If a patient-resident/resident is transferred to or from another health care facility, a copy of the clinical record or an abstract thereof shall accompany the patient-resident/resident. This may be the standard transfer form, but additional aspects of the patient's condition should be noted.

1005. CONFIDENTIALITY OF RECORDS

All information contained in the clinical records shall be treated as confidential and shall be disclosed only to authorized persons.

1006. STAFF RESPONSIBILITY FOR RECORDS

If the facility does not have a full or part-time medical record librarian, an employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed, and preserved in accordance with accepted procedures. The designated individual shall be trained by a person skilled in record maintenance and preservation.

CHAPTER XI

THERAPY AND REHABILITATION SERVICES

1100. THERAPY AND REHABILITATION SERVICES

If therapy and rehabilitation services are made available, either on-site or off-site, as an integral part of a comprehensive medical care program, such services shall include not only the administration of the prescribed therapy by qualified personnel, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient-resident/resident upon discharge from the facility.

1. Rehabilitation services includes physical therapy, occupational therapy, speech therapy and hearing services, and the use of such supplies and equipment are necessary in the provision of such services.

1101. REQUIREMENTS FOR THERAPY AND REHABILITATION SERVICES

Previous physical medicine and rehabilitation services shall be noted on the patient-resident/resident's clinical record as to the scope and extent of the services previously provided, length of time given and results obtained.

1. The physician, in communication with the therapist, shall prescribe (authorize in writing) the specific means and methods to be used by the therapist and the frequency of therapy services.

2. Therapy shall be related to the active treatment regimen designed by the physician to elevate the resident to his maximum level of function which has been lost or reduced by reason of injury or illness.

3. "Physical therapy as needed" or a similarly worded blanket prescription does not suffice as an accepted order since no specific treatment is named and the physical therapist is in effect prescribing the resident's regimen.

4. The modalities, diagnostic tests, procedures and activities recommended by the therapists as necessary or appropriate to the patient-resident/resident's therapeutic regimen and the frequency of prescribed treatments shall be approved by the physician prior to implementation.

5. Written reports of evaluative and diagnostic tests performed and the specific treatments administered

to patient-residents/residents shall be retained in the clinical records. Progress notes shall be kept current by the therapist.

6. The qualified therapists providing therapeutic services shall cooperate with the medical and nursing staff in developing a total and continued plan of care for the patient-resident/residents.

7. The therapists shall participate in the on-going educational program established for the nursing and ancillary personnel in the facility.

1102. PROCEDURES FOR PRESCRIBING THERAPY AND REHABILITATION SERVICES

A. The physician shall place detailed orders on the patient-resident/resident's chart prior to the treatment being initiated, specifying goals or potentials and the need for therapy. "Physical therapy three times weekly" is not acceptable.

B. The physician shall instruct the therapist, or others of the allied health professions, to file notes in the patient-resident/resident's chart similar to nursing notes at least weekly, reflecting the patient-resident/resident's response to treatment.

C. The physician shall review the patient-resident/resident's record at least every 30 days in level A (upper level medical) or every 60 days in level B (lower level non-medical) to determine if treatment is being provided according to his orders and shall so indicate by signing the treatment records. Treatment that is being provided which has not been prescribed or authorized by the physician shall be discontinued immediately.

1103. DISTINCTION BETWEEN THERAPY, REHABILITATION SERVICES AND RESTORATIVE NURSING CARE

Restorative nursing procedures performed by licensed nurses, if approved by the physician, supplements and complements the other professional therapies and services and are part of intermediate care facility care when they are related to the total plan of rehabilitative care.

1. Restorative nursing care includes such measures as maintaining good body alignment both in and out of bed; proper positioning of bedfast patient-residents/residents; active and passive range of motion exercises; keeping patient-resident/residents active and out of bed unless contraindicated by physician's orders; developing the patient-resident/resident's

independence in the activities of daily living by teaching self-care; transfer and ambulation activities; promoting safety through maximum preventive infection, and correlating nursing with physical, occupational, speech and other therapies.

2. Nursing personnel shall assist patient-resident/residents in practicing the use of prosthetic and orthotic devices during the functional activity in the resident care area to prepare them for independence in the activity in the resident care area to prepare them for independence in the activity, e.g. use of adaptive eating devices at meal time.

3. A licensed nurse shall assist in the evaluation and appraisal of the resident's physical status and abilities in functional activity and, as part of the professional team, shall assist in the development of patient-resident/resident's rehabilitation program, periodic reassessment and plan for discharge.

CHAPTER XII

PHYSICAL ENVIRONMENT

1200. PHYSICAL ENVIRONMENT AND SANITATION

The Intermediate Care Facility shall maintain adequate conditions relating to environment and sanitation. It shall be constructed, equipped and maintained to provide a safe, functional, sanitary and comfortable environment. Its electrical and mechanical systems (including water supply and sewage disposal) shall be designed, constructed and maintained in accordance with recognized safety standards and comply with applicable State and local codes and regulations:

1. The facility shall comply with applicable State and local codes, governing construction, except in existing facilities where waivers are applicable;

2. Corridors used by patient-resident/residents shall be equipped with firmly secured handrails;

3. Blind, nonambulatory or physically handicapped patient-resident/residents shall not be housed above the street level floor unless the facility is 1-hour protected non-combustible construction (as defined in National Fire Protection Association (Code 101) Standard #220), or fully sprinklered 1-hour protected ordinary construction or fully sprinklered 1-hour protected wood frame construction;

4. Reports of periodic inspections of the structure by the local fire department shall be on file in the facility.

5. Laundry facilities (when applicable) shall be located in areas separate from patient-resident/resident units and shall be provided with the necessary washing, drying and ironing equipment, and

6. Elevators shall be installed in the facility if patient-resident/resident rooms are located on floors above the street level; in existing facilities these requirements should be examined as to need.

1201. BEDROOMS

Patient-resident/resident bedrooms shall be designed and equipped for comfort and privacy.

1. Each room shall have or shall be conveniently located near adequate toilet and bathing facilities which are appropriate in size and design to meet the needs of both ambulatory and nonambulatory patient-resident/residents.

2. Each room shall have direct access to a corridor and outside exposure with the floor at or above grade level, except in existing buildings one room may intervene as long as the doors are not held closed with locking hardware.

3. Rooms shall have no more than four beds with not less than 3 feet between beds.

1202. ISOLATION

Provision shall be made for isolating patient-resident/residents with infectious deceases in well-ventilated single bedrooms having separate toilet and bathing facilities pending transfer to another appropriate facility.

1203. TREATMENT ROOMS

Areas utilized to provide therapy services shall be of sufficient size and appropriate design to accommodate necessary equipment, conduct examinations and provide treatment.

1204. MULTI-PURPOSE ROOMS

The facility shall provide one or more areas for resident dining and diversional and social activities:

1. There shall be at least one dayroom area on each resident floor. Areas used for corridor traffic shall not be considered as dayroom space, and

2. If a multipurpose room is used for dining and diversional and social activities, there shall be sufficient space to accommodate all activities and prevent their interference with each other.

1205. ENVIRONMENTAL CONDITIONS

A. Lighting levels in all areas of the facility shall be adequate and void of high brightness, glare and reflecting surfaces that produce discomfort. Lighting levels shall be in accordance with recommendations of the Illuminating Engineering Society. The use of candles, kerosene oil lanterns and other open flame methods of illumination is prohibited.

B. An emergency electrical service, which may be battery operated if effective for 4 or more hours, shall cover lights at nursing stations, telephone switchboard, night lights, exit and corridor lights, boiler room and the fire alarm system.

C. The heating and air-conditioning systems, if applicable, shall be capable of maintaining adequate temperatures and providing freedom from drafts.

D. An adequate supply of hot water for patient-resident/ resident use shall be available at all times. Temperature of hot water used by residents shall be automatically regulated and shall not exceed 110°F.

E. The facility shall be well-ventilated through the use of windows, mechanical ventilation or a combination of both. Rooms, recreation, and dining areas which do not have outside windows and which are used by patient-residents/ residents or personnel shall be provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy.

F. All inside bathrooms and toilet rooms shall have forced ventilation to the outside.

G. Laundry facilities, when applicable, shall be located in areas separate from patient-resident/resident units and shall be provided with necessary washing, drying and ironing equipment.

1206. ELEVATORS

Elevators shall be installed in the facility if resident bedrooms are located on floors above the street level.

1. The installation of elevators and dumbwaiters shall comply with all applicable codes.

2. Elevators shall be of sufficient size to accommodate a wheeled stretcher.

3. A service contract for elevators shall be on file at the facility and available for review by the Department of Health.

1207. RESIDENT NURSING UNIT

A. Each patient-resident/resident unit shall have at least the following basic service areas: Nurses' station, medicine storage and preparation area, space for storage of linen, equipment and supplies and a utility room.

B. The nurses' call system shall register calls at the nurses' station from each patient-resident/resident bed, patient-resident/resident toilet room and each bathtub or shower.

C. Equipment necessary for charting and recordkeeping shall be provided.

D. The medication preparation area shall be well-illuminated and provided with hot and cold running water.

E. The utility room shall be located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment and supplies.

F. Toilet and handwashing facilities shall be provided.

1208. RESIDENTS' BEDROOMS AND TOILET FACILITIES

Patient-resident/resident's bedrooms shall be designed and and equipped for adequate care, comfort and privacy. Each bedroom has or shall be conveniently located near adequate toilet and bathroom facilities. Each bedroom shall have direct access to a corridor and outside exposure with the floor at or above grade level.

1. Rooms shall have no more than four beds with not less than 3 feet between beds and at the foot of beds.

2. In addition to basic resident care equipment, each patient-resident/resident unit shall have a nurses' call signal, and individual reading light, bedside cabinet, comfortable chair and storage space for clothing and other possessions. In multiple bedrooms, each bed shall have flameproof cubicle curtains or their equivalent.

3. Each patient-resident/resident room shall have a lavatory with both hot and cold running water, unless provided in adjacent toilet or bathroom facilities.

4. On floors where wheelchair patient-resident/residents are located, there shall be at least one toilet room large enough to accommodate wheelchairs.

5. Each bathtub or shower shall be in a separate room or compartment which is large enough to accommodate a wheelchair and attendant.

6. At least one watercloset, enclosed in a separate room or stall, shall be provided for each eight beds.

7. Substantially secured grab bars shall be installed in all water closet and bathing fixture compartments.

8. Doors to patient-resident/resident bedrooms shall never be locked.

1209. DAYROOM AND DINING AREA

The Intermediate Care Facility shall provide one or more attractively furnished multipurpose areas of adequate size for resident dining, diversional and social activities.

1. At least one dayroom or lounge conveniently located, shall be provided to accommodate the diversional and social activities of the patient-resident/residents. In addition, several smaller dayrooms, convenient to patient-resident/resident bedrooms, are desirable.

2. Dining areas shall be large enough to accommodate all patient-resident/residents able to eat out of their rooms. These areas shall be well-lighted and well-ventilated.

3. If a multipurpose room is used for dining and diversional and social activities there shall be sufficient space to accommodate all activities and prevent their interference with each other.

1210. KITCHEN OR DIETARY AREA

The Intermediate Care Facility shall have a kitchen or dietary area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation and serving of food as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas shall comply with local health or food handling codes. Food preparation space shall be arranged for the separation of functions, located to permit efficient service to patient-resident/residents and shall not be used for nondietary functions.

1211. BUILDING

Standards for design details and construction shall conform to those promulgated by the US Public Health Service for a Long-Term Care Facility and the New Jersey Standards for Construction of a Long-Term Care Facility.

1. These standards shall apply to all new construction, whether a complete new Intermediate Care Facility or an addition to an existing institution.

2. The building shall be maintained in good repair and kept free of hazards at all times.

3. Reports of inspections of the building shall be made by the Department of Health and shall be on file in the facility.

4. If the facility is not of fire resistive construction, blind, non-ambulatory or physically handicapped persons shall be housed on the first floor.

1212 FIRE PROTECTION AND SAFETY

A. Provision shall be made for immediate contact with the local fire department in case of a fire, preferably by direct alarm.

B. A written report of a fire or any other unusual event shall be forwarded as soon as possible to the Division and the Department of Health.

C. Employees shall be instructed in the use of fire fighting equipment and in the rapid evacuation of the building.

1. Instruction shall be planned on a regular basis to accommodate changes in personnel. Under no circumstances shall such instruction be given less than annually.

2. Simulated drills shall be held at irregular intervals on all tours of duty. These shall be conducted on each shift at least four times a year.

3. A record shall be maintained of staff performance, results of each drill held and the corrective measures taken to resolve any difficulties encountered.

4. Appropriate regulations and safety measures shall be instituted to eliminate possible fire hazards from smoking by residents, visitors or personnel.

1213. FIRE EXTINGUISHERS

A. Adequate and appropriate fire extinguishers shall be readily accessible in all areas of the facility.

B. Fire extinguishers shall be checked annually and shall be labeled with the date of the last inspection.

1214. REPORTS AND REGULATIONS

A written report of unusual incidents and accidents occurring to a patient-resident/resident, employee, visitor or other person shall be forwarded to the Division of Health Facilities of the Department of Health.

1215. OXYGEN CYLINDERS

Oxygen cylinders shall be stored in a well ventilated area and shall be secured to prevent toppling. Tanks of compressed

gases shall not be covered with cotton or plastic material at any time.

1216. LIGHTING AND VENTILATION

A. Artificial lighting shall be by electricity only.

B. Adequate and satisfactory lighting levels shall be maintained in all areas of the facility.

C. All residents' rooms, corridors, bathrooms and stairways shall be provided with night lights.

D. All areas used by patient-resident/residents and personnel shall be provided with proper ventilation.

E. The heating plant shall be capable on maintaining a minimum temperature of 75 degrees Fahrenheit during the coldest weather.

1217. SANITATION

A. The water supply shall be of safe and sanitary quality suitable for drinking purposes and shall be obtained from a water supply which conforms with the standards of the State Department of Health.

B. Sewage shall be disposed of in accordance with the requirements of the local ordinances and the standards of the local and State Department of Health.

1218. FIRE REGULATIONS

A. Fire regulations shall be prominently posted and carefully observed.

B. Doorways, passageways and stairwells shall be wide enough for easy evacuation of patient-residents/residents and shall be kept free from obstruction at all times. Corridors shall be equipped with firmly secured handrails on each side. Stairwells, elevators and all vertical shafts with openings shall have fire doors kept normally in a closed position. Exit facilities shall comply with State and local codes and regulations.

C. The building shall be maintained in good repair and kept free of hazards, such as those created by any damaged or defective parts of the building.

1219. LIFE SAFETY CODE

If an Intermediate Care Facility is determined to have deficiencies under the requirements for environment and

sanitation or the Life Safety Code, it may be licensed as an Intermediate Care Facility for a period not exceeding 2 years following the date of such determination provided that:

1. The facility submits a written plan of correction which contains:

   a. The specific steps it will take to meet all such requirements; and

   b. A timetable, not exceeding 2 years from the date of the initial licensing, detailing the corrective steps to be taken and when correction of deficiencies will be accomplished. Additional time may be allowed in cases where evidence is presented that supplies and contractors are unavoidably delayed.

2. The Department makes a finding that the facility can meet such requirements through the corrective steps and they can be completed during the 2 year allowable period of time;

3. During the period allowed for corrections, the facility is in compliance with existing State fire, safety and sanitation codes and regulations;

4. The institution is surveyed by qualified personnel at least semi-annually until corrections are completed, and the Department finds on the basis of such surveys that the facility has in fact made substantial effort and progress in its plan of correction as evidenced by supporting documentation, signed contracts and/or work orders, and a written justification of such findings is maintained on file; and

5. At the completion of the period allowed for corrections, the Intermediate Care Facility is in compliance with the Life Safety Code (NFPA, 21st Edition 1967), and the requirements for environment and sanitation, except for any provision waived by the Department. Waivers granted are not considered deficiencies, but are reviewed annually.

CHAPTER XIII

DISASTER PLAN

1300. DISASTER PLAN

The facility shall have a written procedure to be followed in case of fire, explosion or other disaster. The procedure must specify persons to be notified, locations of alarm signals and extinguishers, evacuation routes, procedures for evacuating helpless residents, frequency of fire drills and assignments of specific tasks and responsibilities to personnel for each drill.

1. The plan shall be developed with the assistance of qualified fire and safety experts.

2. Simulated drills testing the effectiveness of the plan shall be conducted on each shift at least three times a year with a written record of such drills which includes the date, hour, description of drill, staff participation and person in charge.

3. The plan shall be posted throughout the facility.

CHAPTER XIV

CIVIL RIGHTS

1400. PROHIBITIONS AGAINST DISCRIMINATION

All facilities receiving payments through State and Federal funds for Intermediate Care Facility services shall be subject to all applicable Federal, State, and local laws and regulations with respect to civil rights, including Section 601 of the Civil Rights Act of 1964, and Title VI of the Social Security Act.

1. Section 601 of the Civil Rights Act of 1964 prohibits discrimination in any program or activity receiving Federal financial participation.

2. Title VI of the Social Security Act prohibits any agency directly or through contractual or other arrangements, to subject an individual to segregation or separate treatment on the grounds of race, color or national origin in any matter related to his receipt of any aid, care, services or other benefits provided under the program.

3. The Department's surveys which may be incorporated in surveys for other purposes, shall be evaluative of the non-discriminatory nature of the facility's policies and practices and of its contractual and other arragements.

1401. GUIDELINES FOR COMPLIANCE

A. Intermediate Care Facilities which are in compliance with Title VI of the Civil Rights Act shall be characterized by an absence of separation, exclusion, discrimination or other distinction on the basis of race, color or national origin in any activity conducted by, for, or in the facility affecting the care and treatment of residents.

B. Admissions and referrals

1. Patient-residents/residents shall be admitted to the facility without discrimination and inquiries shall not be made regarding race, color, or national origin prior to admission.

2. The facility shall utilize its sources of referrals in a manner which assures opportunity for admission without regard to race, color, or national origin,

in relation to the population of the service area or potential service area.

3. Admission shall not be restricted to members of any group or order which discriminates.

4. The facility's policies regarding deposits, extension of credit and other financial matters shall be applied uniformly and without regard to race, color or national origin.

5. Information regarding the cost and availability of accommodations shall be made uniformly available to all without regard to race, color or national origin.

C. Records.

Records shall be maintained uniformly without discrimination for all patient-resident/residents. Identification by race, color and national origin on records is not considered to be discriminatory and may be used to demonstrate compliance with Title VI.

D. Services and physical facilities.

1. Patient-resident/residents' privileges and care services such as medical and dental care; nursing; laboratory services; pharmacy; physical, occupational and recreational therapies; social services; volunteer services; dietary service and housekeeping services shall be provided on a nondiscriminatory basis.

2. Physical facilities including lounges, dining facilities, lavatories, beauty and barber shops shall be provided and used without discrimination.

3. Rules of courtesy shall be uniformly applied without regard to race, color, or national origin in all situations including face-to-face contact, written records and communications.

4. Assignment of staff to patient-resident/residents shall not be governed by the race, color or national origin of either patient-resident/resident or staff.

5. Intermediate Care Facilities which have dual facilities (buildings, waiting rooms, entrances, dining facilities, etc.) shall demonstrate that such facilities are not operated in a discriminatory manner.

E. Room assignment and transfers.

1. Patient-residents/residents shall be assigned to rooms, wards, floors, sections, buildings and other areas without regard to race, color, or national origin. Assignment shall result in a multi-racial occupancy of multi-bed accommodations, which reflects the proportion of minority use of the facity.

2. Patient-residents/residents shall not be asked whether they are willing to share accommodations with persons of a different race, color, or national origin. Requests shall not be honored if based on racial or ethnic considerations. Exceptions may be made only if the attending physician or nursing home administrator certifies in writing that in his judgement there are valid medical reasons or special compelling circumstances in the individual case. Such certifications shall not be used to permit segregation as a routine practice in the facility.

F. Attending physicians' privileges.

Privileges of attending residents in the facility shall be granted to physicians and other health professionals without discrimination.

G. Notification of non-discriminatory policy.

1. The facility shall adopt and, where appropriate, shall provide its patient-residents/residents, employees, attending physicians and others providing services to patient-residents/residents, with copies of written statements which set forth the facility's non-discriminatory policies and practices. These policies shall be included in any publication of staff regulations and in public information brochures, and shall be kept current and periodically reviewed with employees.

2. The facility shall effectively convey to the community, to hospitals and other referral sources, its non-discriminatory policy and the nature and extent of services available.

H. Referrals.

The facility's referrals, including but not limited to referrals to other facilities and care programs, shall be made in a manner which does not result in discrimination.

APPENDIX A

MINIMUM WEEKLY NURSING HOURS*
INTERMEDIATE CARE FACILITIES
LEVEL A (UPPER LEVEL MEDICAL)

Census	Tot. Hrs.	Tot. Lic.	Min. R.N.	L.P.N.	Other	Census	Tot. Hrs.	Tot. Lic.	Min. R.N.	L.P.N.	Other
1-9	336	168	56	112	168	30	525	168	66	102	357
10	336	168	56	112	168	31	543	168	69	99	375
11	336	168	56	112	168	32	560	168	69	99	392
12	336	168	56	112	168	33	578	168	72	96	410
13	336	168	56	112	168	34	595	168	75	93	427
14	336	168	56	112	168	35	613	168	75	93	445
15	336	168	56	112	168	36	630	168	78	90	462
16	336	168	56	112	168	37	648	168	81	87	480
17	336	168	56	112	168	38	665	168	84	84	497
18	336	168	56	112	168	39	683	168	87	81	515
19	336	168	56	112	168	40	700	168	87	81	532
20	350	168	56	112	182	41	718	168	90	78	550
21	368	168	56	112	200	42	735	168	93	75	567
22	385	168	56	112	217	43	753	168	96	72	585
23	403	168	56	112	235	44	770	168	96	72	602
24	420	168	56	112	252	45	788	168	99	69	620
25	438	168	56	112	270	46	805	168	102	66	637
26	455	168	57	111	287	47	823	168	102	66	655
27	473	168	60	108	305	48	840	168	105	63	672
28	490	168	63	105	322	49	858	168	108	60	690
29	508	168	63	105	340	50	875	168	111	57	707

*2½ hours of care per patient per day; round the clock coverage by licensed personnel; R.N. ratio of 1 to 5, with 25% credit for L.P.N.'s

In calculating the required nursing hours in any institution over 100 beds, do not, under any circumstances, add the figures in the 1 to 57 census since their use will distort the essential coverage.

Census	Tot. Hrs.	Tot. Lic.	Min. R.N.	L.P.N.	Other	Census	Tot. Hrs.	Tot. Lic.	Min. R.N.	L.P.N.	Other
51	893	168	111	57	725	76	1330	222	168	54	1108
52	910	168	114	54	742	77	1348	225	168	57	1123
53	928	168	117	51	760	78	1365	228	171	57	1137
54	945	168	120	48	777	79	1383	231	174	57	1152
55	963	168	120	48	795	80	1400	233	174	59	1167
56	980	168	123	45	812	81	1418	236	177	59	1182
57	998	168	126	42	830	82	1435	239	180	59	1196
58	1015	169	126	43	846	83	1453	242	183	59	1211
59	1033	172	129	43	861	84	1470	245	183	62	1225
60	1050	175	132	43	875	85	1488	248	186	62	1240
61	1068	178	135	43	890	86	1505	251	189	62	1254
62	1085	181	135	46	904	87	1523	254	192	62	1269
63	1103	184	138	46	919	88	1540	257	192	65	1283
64	1120	187	141	46	933	89	1558	260	195	65	1298
65	1138	190	144	46	948	90	1575	263	198	65	1312
66	1155	193	144	49	962	91	1593	266	201	65	1327
67	1173	196	147	49	977	92	1610	268	201	67	1342
68	1190	198	149	49	992	93	1628	271	204	67	1357
69	1208	201	150	51	1007	94	1645	274	207	67	1371
70	1225	204	153	51	1021	95	1663	277	207	70	1386
71	1243	207	156	51	1036	96	1680	280	210	70	1400
72	1260	210	159	51	1050	97	1698	283	213	70	1415
73	1278	213	159	54	1065	98	1715	286	216	70	1429
74	1295	216	162	54	1079	99	1733	289	216	73	1444
75	1313	219	165	54	1094	100	1750	292	219	73	1458

APPENDIX B

MINIMUM WEEKLY NURSING HOURS*
INTERMEDIATE CARE FACILITIES
LEVEL B (LOWER LEVEL NON-MEDICAL)

Census	Total Hours	Total Lic.	Other	Census	Total Hours	Total Lic.	Other
1-38	336	168	168	56	490	168	322
39	341	168	173	57	499	168	331
40	350	168	182	58	508	168	340
41	359	168	199	59	516	168	348
42	368	168	200	60	525	168	357
43	376	168	208	61	534	168	366
44	385	168	217	62	543	168	375
45	394	168	226	63	551	168	383
46	403	168	235	64	560	168	392
47	411	168	243	65	569	168	401
48	420	168	252	66	578	168	410
49	429	168	261	67	586	168	418
50	438	168	270	68	595	168	427
51	446	168	278	69	604	168	436
52	455	168	287	70	613	168	445
53	464	168	296	71	621	168	453
54	473	168	305	72	630	168	462
55	481	168	313	73	639	168	471

*1¼ hours of care per patient per day; round the clock coverage by licensed personnel and others

In calculating the required nursing hours in any institution over 100 beds, do not, under any circumstances, add the figures in the 1 to 57 census since their use will distort the essential coverage.

Census	Total Hours	Total Lic.	Other	Census	Total Hours	Total Lic.	Other
74	648	168	480	92	805	168	637
75	656	168	488	93	814	168	646
76	665	168	497	94	823	168	655
77	674	168	506	95	831	168	663
78	683	168	515	96	840	168	672
79	691	168	523	97	849	170	679
80	700	168	532	98	858	172	686
81	709	168	541	99	866	173	693
82	718	168	550	100	875	175	700
83	726	168	558				
84	735	168	567				
85	744	168	576				
86	753	168	585				
87	761	168	593				
88	770	168	602				
89	779	168	611				
90	788	168	620				
91	796	168	628				

P522

Amendment to All Licensure
Standards for Health Care Facilities
June 1979

If the main entrance door, the back entrance door, and/or doors opening onto roofs and balconies are self-locking, such doors shall have a sounding device, such as a bell, buzzer, or chimes, which is in operating condition. This sounding device shall be affixed to the outside of the door or to the adjacent exterior wall and shall be audible to a nursing station or other area that is staffed 24 hours a day, seven days a week, for use in the event that a person is unable to enter the building.

Initial Adoption HCAB - 4/5/79
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Effective-7/5/79